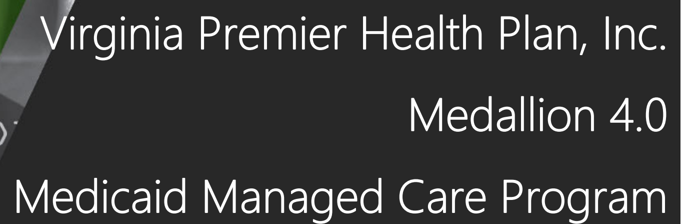

Virginia Premier Health Plan, Inc.

Medallion 4.0

Medicaid Managed Care Program

Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations

With Independent Accountant's Report Thereon

For the period of July 1, 2019 through June 30, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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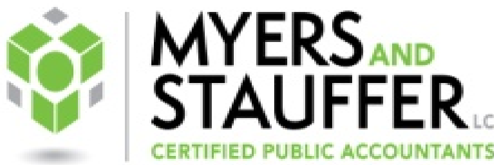

Independent Accountant's Report

Virginia Department of Medical Assistance Services
Richmond, Virginia

We have examined the accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations of Virginia Premier Health Plan, Inc. (Virginia Premier) related to the Medallion 4.0 Program for the period of July 1, 2019 through June 30, 2020. Virginia Premier's management is responsible for presenting the Medical Loss Ratio and Underwriting Gain Rebate Calculations in accordance with the criteria set forth in the Medallion 4.0 contract and Centers for Medicare & Medicaid Services (CMS) federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations based on our examination.

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

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

The accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations were prepared for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the above referenced accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations are presented in accordance with the above referenced criteria, in all material respects, for the period of July 1, 2019 through June 30, 2020. Related to non-expansion, the Adjusted Medical Loss Ratio (MLR) Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Adjusted Underwriting Gain Percentage Achieved exceeds the maximum requirement of three percent (3%). In accordance with contractual obligations, an Underwriting Gain remittance amount is due to the Department of Medical Assistance Services. Related to expansion, the Adjusted MLR Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Underwriting Gain is not applicable per contractual requirements.

This report is intended solely for the information and use of the Virginia Department of Medical Assistance Services and Virginia Premier and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC
Glen Allen, Virginia
November 1, 2022

Adjusted Medical Loss Ratio for the Period Ending June 30, 2020

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$525,646,592	$61,787,200	$587,433,792
1.2	Improving health care quality expenses	$11,662,875	($2,434,658)	$9,228,217
1.3	**Total Adjusted MLR Numerator**	**$537,309,467**	**$59,352,542**	**$596,662,009**
Medical Loss Ratio Denominator				
2.1	Revenue	$626,369,650	$68,745,727	$695,115,377
2.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
2.3	**Total Adjusted MLR Denominator**	**$626,369,650**	**$68,745,727**	**$695,115,377**
Credibility Adjustment				
3.1	Member Months to determine credibility	2,053,644	0	2,053,644
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	85.8%		85.8%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**85.8%**		**85.8%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	Y		Y
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	85.8%		85.8%
5.4	MLR denominator	$626,369,650		$695,115,377
5.5	**Remittance amount due to State for Coverage Year**	**$0**		**$0**

Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$316,417,531	$41,130,515	$357,548,046
1.2	Improving health care quality expenses	$7,176,125	($1,191,764)	$5,984,361
1.3	**Total Adjusted MLR Numerator**	**$323,593,656**	**$39,938,751**	**$363,532,407**
Medical Loss Ratio Denominator				
2.1	Revenue	$385,403,010	$12,958,784	$398,361,794
2.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
2.3	**Total Adjusted MLR Denominator**	**$385,403,010**	**$12,958,784**	**$398,361,794**
Credibility Adjustment				
3.1	Member Months to determine credibility	707,669	0	707,669
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	84.0%		91.3%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**84.0%**		**91.3%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	Y		Y
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	84.0%		91.3%
5.4	MLR denominator	$385,403,010		$398,361,794
5.5	**Remittance amount due to State for Coverage Year**	**N/A**		**N/A**

Adjusted Underwriting Gain for the Period Ending June 30, 2020

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Denominator				
1.1	Revenue	$626,369,650	$68,745,727	$695,115,377
1.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
1.3	**Total Adjusted Underwriting Gain Denominator**	**$626,369,650**	**$68,745,727**	**$695,115,377**
Medical Expenses				
2.1	Claims	$525,646,592	$61,787,200	$587,433,792
2.2	Improving health care quality expenses	$11,662,875	($2,434,658)	$9,228,217
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$537,309,467**	**$59,352,542**	**$596,662,009**
Non-Claims Costs				
3.1	Administrative Expenses	$38,218,391	$1,508,597	$39,726,988
3.2	Less: Unallowable Expenses	$0	$0	$0
3.3	**Allowable Administrative Expenses**	**$38,218,391**	**$1,508,597**	**$39,726,988**
Underwriting Gain				
4.1	Underwriting Gain $	$50,841,792		$58,726,380
4.1	Less: Remittance Amount Due to State for Coverage Year	$0		$0
4.2	Adjusted Underwriting Gain $	$50,841,792		$58,726,380
4.3	**Underwriting Gain %**	**8.1%**		**8.4%**
Underwriting Gain Remittance Calculation				
5.1	Member Month Requirement Met?	Y		Y
5.2	At least 12 months contract experience at the beginning of the Contract Year?	Y		Y
5.3	Percent to Remit	2.6%		2.7%
5.4	**Amount to Remit**	**$16,025,351**		**$18,936,459**

Schedule of Adjustments and Comments for the Period Ending June 30, 2020

During our examination we noted certain matters involving costs, that in our determination did not meet the definitions of allowable medical expenses and other operational matters that are presented for your consideration.

Non-Expansion Adjustment #1 – To adjust revenues and claims to include related directed payments.

The MLR Report did not reflect directed payments in the numerator nor the denominator of the calculation. It was determined the Managed Care contracts refer to 42 CFR § 438.6(c) in speaking to directed payments related to private acute care hospitals and State University teaching hospital physicians; and therefore should be included in the MLR calculation. Premium revenue and incurred claims were adjusted to include the payments and associated expense per state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$60,922,108
2.1	Revenue	$60,922,108

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$60,922,108
2.1	Claims	$60,922,108

Non-Expansion Adjustment #2 – To adjust revenues to agree to state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, and Rx reinsurance recoupments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	Line Description	Amount
2.1	Revenue	$7,823,619

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.1	Revenue	$7,823,619

Non-Expansion Adjustment #3 – Reclassify payments made to Kaiser in excess of medical and pharmaceutical claims expense reported by Kaiser from claims expense to administrative expense.

The health plan reported Kaiser Expenses at a percent of capitation payments for medical and pharmaceutical services arranged by Kaiser. The health plan allocated 96% of this capitated expense to claims expense and the remaining 4% to administrative expense. During the examination, Kaiser provided support for allocated costs which were separated between claims and administrative expenses at 94.07% and 5.93%, respectively. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to supported allocated costs. The excess has been reclassified to administrative expense.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that “an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees”. Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	($891,417)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	($891,417)
3.1	Administrative Expenses	$891,417

Non-Expansion Adjustment #4 – To adjust Healthcare Quality Improvement (HCQI) expense to agree to supporting documentation.

The health plan reported care manager compensation and outreach compensation within HCQI expense. Based on support provided, these expenses were not allocated appropriately between each line of business. The submitted HCQI expenses were adjusted to agree to the updated shared services allocation. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	($1,936,894)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	($1,936,894)

Non-Expansion Adjustment #5 – To adjust shared services allocated claims expense to agree to supporting documentation.

The health plan reported a reduction to claims expense related to a shared services allocation to capture costs that relate to other lines of business. The health plan updated the allocation to show the exact expenses per line of business. The submitted shared services allocated claims expense was adjusted to agree to the updated allocation. The clinical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$4,573,365

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$4,573,365

Non-Expansion Adjustment #6 – To adjust miscellaneous non-emergent transportation expense to agree to supporting documentation.

The health plan reported expenses related to miscellaneous non-emergent transportation in claims expense. These expenses included transportation compensation, auto insurance, dispatch services, fuel,

cab/van services, and vehicle repair. Based on support provided, these expenses were not allocated appropriately between each line of business. The submitted miscellaneous transportation expenses were adjusted to agree to the updated shared services allocation. The clinical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	($2,531,350)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	($2,531,350)

Non-Expansion Adjustment #7 – To adjust to reverse the health plan's unnecessary adjustment for pharmacy administrative costs.

The health plan reported a reclassification from claims expense to administrative expense for the Pharmacy Benefits Manager (PBM), Elixir. This reclassification was based on prior test work related to administrative costs, however, was deemed unnecessary for MLR purposes as the health plan reported pharmacy claims based on a lag table. The reclassification of administrative expense has been reversed.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	$750,000

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	$750,000
3.1	Administrative Expenses	($750,000)

Non-Expansion Adjustment #8 – To adjust Incurred But Not Reported (IBNR) at the time of the MLR filing to IBNR estimated as of November 30, 2021.

The reported IBNR of $1,176,968 was adjusted to agree to the November 30, 2021 lag tables. We have made an adjustment for the difference of ($806,638) to the Medical Loss Ratio line 1.1 and Underwriting Gain line 2.1. The IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($806,638)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($806,638)

Non-Expansion Adjustment #9 – To adjust to remove non-allowable HCQI expenses.

The health plan reported HCQI based on accounts they determined to be HCQI. During the examination, it was noted that several job description within the care management compensation account had non qualifying characteristics that did not meet the definitions of HCQI for MLR reporting purposes. The proposed adjustment is to remove non qualifying HCQI expenses from the MLR calculation and to reclassify these expenses to non-claims administrative expenses within the Underwriting Gain calculation. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	($497,765)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	($497,765)
3.1	Administrative Expenses	$497,765

Non-Expansion Adjustment #10 – To adjust to reclassify capitated payments made to DentaQuest, the dental vendor, in excess of claims expense reported by DentaQuest from claims expense to administrative expense.

The health plan reported a per-member-per-month (PMPM) capitation expense for dental services arranged by DentaQuest. During the examination, it was determined that this capitation expense was greater than the actual claims incurred and paid by DentaQuest. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation. The excess has been reclassified to administrative expense.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	($869,416)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	($869,416)
3.1	Administrative Expenses	$869,416

Non-Expansion Adjustment #11 – To adjust pharmacy rebates to the amount confirmed and supported by the PBM, Elixir.

The health plan reported pharmacy rebates using trial balance information. During the examination, it was determined that this expense was greater than total rebates collected by the PBM which were reduced by rebates refunded to drug manufacturers as they related to closed class drugs, which are not subject to rebates. The difference has been added to claims expense.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees".

Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$640,547

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$640,547

Expansion Adjustment #1 – To adjust revenues and claims to include related directed payments.

The MLR Report did not reflect directed payments in the numerator nor the denominator of the calculation. It was determined the Managed Care contracts refer to 42 CFR § 438.6(c) in speaking to directed payments related to private acute care hospitals and State University teaching hospital physicians; and therefore should be included in the MLR calculation. Premium revenue and incurred claims were adjusted to include the payments and associated expense per state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$38,829,329
2.1	Revenue	$38,829,329

Expansion Adjustment #2 – To adjust revenues to agree with state data

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, risk corridor recoupments, and Rx reinsurance payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	($25,870,545)

Expansion Adjustment #3 – To adjust to reconcile claims expense to supporting documentation.

The health plan reported medical expenses using data as of the MLR reporting date. However, during the examination, the health plan provided documentation showing additional claims paid on an updated lag table. The expenses were adjusted per the health plan support. The clinical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$1,722,280

Expansion Adjustment #4 – Reclassify payments made to Kaiser in excess of medical and pharmaceutical claims expense reported by Kaiser from claims expense to administrative expense.

The health plan reported Kaiser Expenses at a percent of capitation payments for medical and pharmaceutical services arranged by Kaiser. The health plan allocated 96% of this expense to claims expense and the remaining 4% to administrative expense. During the examination, Kaiser provided support for allocated costs which were separated between claims and administrative expenses at 94.07% and 5.93%, respectively. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to supported allocated costs. The excess has been reclassified to administrative expense.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($1,152,541)

Expansion Adjustment #5 – To adjust HCQI expense to agree to supporting documentation.

The health plan reported care manager compensation and outreach compensation within HCQI expense. Based on support provided, these expenses were not allocated appropriately for each line of business. The submitted HCQI expenses were adjusted to agree to the updated shared services allocation. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	($1,191,764)

Expansion Adjustment #6 – To adjust shared services allocated claims expense to agree to supporting documentation.

The health plan reported a reduction to claims expense related to a shared services allocation to capture costs that relate to other lines of business. The health plan updated the allocation to show the exact expenses per line of business. The submitted shared services allocated claims expense was adjusted to agree to the updated allocation. The clinical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$2,813,976

Expansion Adjustment #7 – To adjust miscellaneous non-emergent transportation expense to agree to supporting documentation.

The health plan reported expenses related to miscellaneous non-emergent transportation in claims expense. These expenses included transportation compensation, auto insurance, dispatch services, fuel, cab/van services, and vehicle repair. Based on the support provided, these expenses were not allocated appropriately between each line of business. The submitted miscellaneous transportation expenses were adjusted to agree to the updated shared services allocation. The clinical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($1,557,530)

Expansion Adjustment #8 – To adjust to reverse the health plan's unnecessary adjustment for pharmacy administrative costs.

The health plan reported a reclassification from claims expense to administrative expense for the Pharmacy Benefits Manager (PBM), Elixir. This reclassification was based on prior test work related to administrative costs, however, was deemed unnecessary for MLR purposes as the health plan reported pharmacy claims based on a lag table. The reclassification of administrative expense has been reversed.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees".

Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$475,000

The Virginia Department of Medical Assistance Services had no comments on the draft report.

MYERS AND STAUFFER LC

October 11, 2022

Tim Carpenter, CFO
Virginia Premier Health Plan
600 E Broad St.
Richmond, Virginia 23219

Dear Mr. Carpenter:

Please acknowledge whether you accept or disagree with our proposed adjustments summarized below and applicable to our examination of Virginia Premier Health Plan's Medallion 4.0 MLR and Underwriting Gain rebate calculations for the period of July 1, 2019 through June 30, 2020. Also, please explain any disagreement you may have with the proposed issues.

Please provide your response by October 17, 2022.

Virginia Premier Health Plan Medallion 4.0
July 1, 2019 through June 30, 2020
Non-Expansion

	Adjustment	MCO's Response	
1.	To adjust revenues and claims to include related directed payments.	Accept ✓	Disagree ____
2.	To adjust revenues to agree with state data.	Accept ✓	Disagree ____
3.	To adjust to reclassify claims payments made by Kaiser in excess of medical and pharmaceutical claims expense reported by Kaiser from claims expense to administrative expense.	Accept ✓	Disagree ____
4.	To adjust Healthcare Quality Improvement (HCQI) expense to agree to supporting documentation.	Accept ✓	Disagree ____
5.	To adjust shared services allocated claims expense to agree to supporting documentation.	Accept ✓	Disagree ____
6.	To adjust miscellaneous non-emergent transportation expense to agree to supporting documentation.	Accept ✓	Disagree ____

MYERS AND STAUFFER

	Adjustment	MCO's Response	
7.	To adjust to reverse the MCO's unnecessary adjustment for pharmacy administrative cost.	Accept ✓	Disagree ___
8.	To adjust Incurred But Not Received (IBNR) at the time of the MLR filing to IBNR estimated as of November 2021.	Accept ✓	Disagree ___
9.	To adjust to remove non-allowable HCQI expenses.	Accept ✓	Disagree ___
10.	To adjust to reclassify capitated payments made to DentaQuest, the dental vendor, in excess of claims expense reported by DentaQuest from claims expense to administrative expense.	Accept ✓	Disagree ___
11.	To adjust pharmacy rebates to the amount confirmed and supported by the PBM, Elixir.	Accept ✓	Disagree ___

Virginia Premier Health Plan Medallion 4.0
July 1, 2019 through June 30, 2020
Expansion

	Adjustment	MCO's Response	
1.	To adjust revenues and claims to include related directed payments.	Accept ✓	Disagree ___
2.	To adjust revenues to agree with state data.	Accept ✓	Disagree ___
3.	To adjust to reconcile claims expense to supporting documentation.	Accept ✓	Disagree ___
4.	To adjust to reclassify claims payments made by Kaiser in excess of medical and pharmaceutical claims expense reported by Kaiser from claims expense to administrative expense.	Accept ✓	Disagree ___
5.	To adjust HCQI expense to agree to supporting documentation.	Accept ✓	Disagree ___
6.	To adjust shared services allocated claims expense to agree to supporting documentation.	Accept ✓	Disagree ___

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		Accept	Disagree
7.	To adjust miscellaneous non-emergent transportation expense to agree to supporting documentation.	✓	
8.	To adjust to reverse the MCO's unnecessary adjustment for pharmacy administrative cost.	✓	

Acknowledged by:
VIRGINIA PREMIER HEALTH PLAN

Timothy E Carpenter

Officer or other Authorized Person

10/13/22

Date

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