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, 2020 through June 30, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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, 2020 through June 30, 2021. 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, 2020 through June 30, 2021. Related to non-expansion, the Adjusted Medical Loss Ratio (MLR) Percentage Achieved does not exceed 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, MLR and Underwriting Gain remittance amounts are 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

Myers and Stauffer LC
Glen Allen, Virginia
June 14, 2023

Adjusted Medical Loss Ratio for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$609,421,635	$16,430,547	$625,852,182
1.2	Improving health care quality expenses	$15,874,286	($3,006,357)	$12,867,929
1.3	**Total Adjusted MLR Numerator**	**$625,295,921**	**$13,424,190**	**$638,720,111**
Medical Loss Ratio Denominator				
2.1	Revenue	$770,311,795	$15,666,356	$785,978,151
2.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
2.3	**Total Adjusted MLR Denominator**	**$770,311,795**	**$15,666,356**	**$785,978,151**
Credibility Adjustment				
3.1	Member Months to determine credibility	2,248,092	0	2,248,092
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	81.2%		81.3%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**81.2%**		**81.3%**
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	81.2%		81.3%
5.4	MLR denominator	$770,311,795		$785,978,151
5.5	**Remittance amount due to State for Coverage Year**	**$29,271,848**		**$29,081,192**

Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$528,670,553	$25,066,010	$553,736,563
1.2	Improving health care quality expenses	$11,012,478	($2,203,967)	$8,808,511
1.3	**Total Adjusted MLR Numerator**	**$539,683,031**	**$22,862,043**	**$562,545,074**
Medical Loss Ratio Denominator				
2.1	Revenue	$589,533,546	$11,060,029	$600,593,575
2.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
2.3	**Total Adjusted MLR Denominator**	**$589,533,546**	**$11,060,029**	**$600,593,575**
Credibility Adjustment				
3.1	Member Months to determine credibility	948,734	0	$948,734
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	91.5%		93.7%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**91.5%**		**93.7%**
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	91.5%		93.7%
5.4	MLR denominator	$589,533,546		$600,593,575
5.5	**Remittance amount due to State for Coverage Year**	**N/A**		**N/A**

Adjusted Underwriting Gain for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Denominator				
1.1	Revenue	$770,311,795	$15,666,356	$785,978,151
1.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
1.3	**Total Adjusted Underwriting Gain Denominator**	**$770,311,795**	**$15,666,356**	**$785,978,151**
Medical Expenses				
2.1	Claims	$609,421,635	$16,430,547	$625,852,182
2.2	Improving health care quality expenses	$15,874,286	($3,006,357)	$12,867,929
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$625,295,921**	**$13,424,190**	**$638,720,111**
Non-Claims Costs				
3.1	Administrative Expenses	$37,009,692	$2,915,397	$39,925,089
3.2	Less: Unallowable Expenses	($1,544,509)	($89,023)	($1,633,532)
3.3	**Allowable Administrative Expenses**	**$35,465,183**	**$2,826,374**	**$38,291,557**
Underwriting Gain				
4.1	Underwriting Gain $	$109,550,691		$108,966,483
4.1	Less: Remittance Amount Due to State for Coverage Year	($29,271,848)		($29,081,192)
4.2	Adjusted Underwriting Gain $	$80,278,843		$79,885,291
4.3	**Underwriting Gain %**	**10.4%**		**10.2%**
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	3.9%		3.7%
5.4	**Amount to Remit**	**$30,208,576**		**$28,796,712**

Schedule of Adjustments and Comments for the Period Ending June 30, 2021

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 directed payments included in claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with 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	$19,070,898
2.1	Revenue	$19,070,898

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$19,070,898
2.1	Claims	$19,070,898

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, Rx reinsurance payments, clinical efficacy payments, and performance withhold 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	($3,404,542)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($3,404,542)

Non-Expansion Adjustment #3 – To adjust to 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 95.07% and 4.93%, 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**
2.1	Claims	($551,178)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($551,178)
3.1	Administrative Expenses	$551,178

Non-Expansion Adjustment #4 – To adjust to reclassify radiology administrative services provided by NIA, Inc. to administrative expense.

The health plan reported expenses related to utilization management for high end radiology services provided by NIA, Inc. in claims expense. These expenses are administrative in nature and have been reclassified from claims to administrative expense. The clinical 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	($348,254)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Claims	($348,254)
3.1	Administrative Expenses	$348,254

Non-Expansion Adjustment #5 – To adjust to reclassify capitated payments made to Southeastrans, the transportation vendor, in excess of claims expense to administrative expense.

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

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	($114,733)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($114,733)
3.1	Administrative Expenses	$114,733

Non-Expansion Adjustment #6 – To adjust to reclassify capitated payments made to DentaQuest, the dental vendor, in excess of 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, expense was adjusted to actual claims cost utilizing supporting documentation.

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	($114,567)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($114,567)
3.1	Administrative Expenses	$114,567

Non-Expansion Adjustment #7 – To adjust to reclassify capitated payments made to VSP, the vision vendor, in excess of claims expense to administrative expense.

The health plan reported a per-member-per-month (PMPM) capitation expense for vision services arranged by VSP. During the examination, it was determined that this capitation expense was greater than the actual claims incurred and paid by VSP. Since these claims were incurred for members of the

Virginia Medicaid program, expense was adjusted to actual claims cost utilizing supporting documentation.

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	($937,055)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($937,055)
3.1	Administrative Expenses	$937,055

Non-Expansion Adjustment #8 – To adjust to reclassify non-allowable Healthcare Quality Improvement (HCQI) expenses.

The health plan reported HCQI based on departments they determined to be HCQI. During the examination, it was noted that several job descriptions 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	($3,006,357)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	($3,006,357)
3.1	Administrative Expenses	$3,006,357

Non-Expansion Adjustment #9 – To adjust administrative expense to agree to supporting documentation.

The health plan reported administrative expenses at $35,465,183. Based on supporting documentation received, administrative expenses were determined to be $33,308,436. The expenses were adjusted to agree to the provided supporting documentation. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.475.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.1	Administrative Expenses	($2,156,747)

Non-Expansion Adjustment #10 – To adjust administrative expense to apply adjustments identified during the 2020 and 2021 administrative cost procedures.

Procedures are applied to administrative costs through a separate engagement. The health plan included contributions/donations, lobbying expenses, interest on paid claims, corporate employee events, and bad debt, which are not considered allowable administrative expenses. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.475.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expenses	($89,023)

Non-Expansion Adjustment #11 – To adjust pharmacy expenses related to Elixir Solutions to offset post-point-of-sale claim transaction fees received from pharmacies.

The health plan reported claims expenses net of rebates for pharmacy services arranged by Elixir Solutions. During the examination, it was determined that Elixir Solutions reported offsetting revenue received from pharmacies related to post-point-of-sale claim transaction fees. Expense was adjusted to agree to post-point-of-sale claim transaction fees reported by Elixir Solutions.

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	($233,084)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($233,084)

Non-Expansion Adjustment #12 – To adjust claims Incurred but Not Reported (IBNR) at the time of the MLR filing to IBNR as of March 2023.

The reported IBNR of $791,506 was adjusted to agree to the March 2023 lag table. We have made an adjustment for the difference of $341,480 to 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	($341,480)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($341,480)

Expansion Adjustment #1 – To adjust directed payments included in claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with 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	$25,066,010
2.1	Revenue	$25,066,010

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, Rx reinsurance payments, clinical efficacy payments, risk corridor recoupments, and performance withhold 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	($14,005,981)

Expansion Adjustment #3 – To adjust to reclassify non-allowable Healthcare Quality Improvement (HCQI) expenses.

The health plan reported HCQI based on departments they determined to be HCQI. During the examination, it was noted that several job descriptions 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	($2,203,967)