Virginia Premier Health Plan, Inc.

Commonwealth Coordinated Care Plus

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 January 1, 2020 through June 30, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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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 Commonwealth Coordinated Care Plus Program (CCC Plus) for the period of January 1, 2020 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 CCC Plus 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 January 1, 2020 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

Myers and Stauffer LC
Glen Allen, Virginia
August 15, 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	$401,816,794	$15,647,280	$417,464,074
1.2	Improving health care quality expenses	$12,647,949	($1,278,675)	$11,369,274
1.3	**Total Adjusted MLR Numerator**	**$414,464,743**	**$14,368,605**	**$428,833,348**
Medical Loss Ratio Denominator				
2.1	Revenue	$467,842,614	$19,807,094	$487,649,708
2.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
2.3	**Total Adjusted MLR Denominator**	**$467,842,614**	**$19,807,094**	**$487,649,708**
Credibility Adjustment				
3.1	Member Months to determine credibility	498,526		498,526
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	88.6%		87.9%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**88.6%**		**87.9%**
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	88.6%		87.9%
5.4	MLR denominator	$467,842,614		$487,649,708
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	$61,905,030	$2,407,833	$64,312,863
1.2	Improving health care quality expenses	$1,828,606	$0	$1,828,606
1.3	**Total Adjusted MLR Numerator**	**$63,733,636**	**$2,407,833**	**$66,141,469**
Medical Loss Ratio Denominator				
2.1	Revenue	$65,197,150	$799,347	$65,996,497
2.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
2.3	**Total Adjusted MLR Denominator**	**$65,197,150**	**$799,347**	**$65,996,497**
Credibility Adjustment				
3.1	Member Months to determine credibility	70,320		70,320
3.2	Credibility adjustment	2.5%		2.5%
MLR Calculation				
4.1	Unadjusted MLR	97.8%		100.2%
4.2	Credibility adjustment	2.5%		2.5%
4.3	**Adjusted MLR**	**100.3%**		**102.7%**
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	100.3%		102.7%
5.4	MLR denominator	$65,197,150		$65,996,497
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	$467,842,614	$19,807,094	$487,649,708
1.2	Federal and State taxes and licensing or regulatory fees	$0	$0	$0
1.3	**Total Adjusted Underwriting Gain Denominator**	**$467,842,614**	**$19,807,094**	**$487,649,708**
Medical Expenses				
2.1	Claims	$401,816,794	$15,647,280	$417,464,074
2.2	Improving health care quality expenses	$12,647,949	($1,278,675)	$11,369,274
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$414,464,743**	**$14,368,605**	**$428,833,348**
Non-Claims Costs				
3.1	Administrative Expenses	$29,119,586	$1,709,791	$30,829,377
3.2	Less: Unallowable Expenses	$0	$0	$0
3.3	**Allowable Administrative Expenses**	**$29,119,586**	**$1,709,791**	**$30,829,377**
Underwriting Gain				
4.1	Underwriting Gain $	$24,258,285		$27,986,983
4.1	Less: Remittance Amount Due to State for Coverage Year	$0		$0
4.2	Adjusted Underwriting Gain $	$24,258,285		$27,986,983
4.3	**Underwriting Gain %**	**5.2%**		**5.7%**
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	1.1%		1.4%
5.4	**Amount to Remit**	**$5,111,503**		**$6,678,746**

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, nursing facilities owned by Type One 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	$16,078,396
2.1	Revenue	$16,078,396

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$16,078,396
2.1	Claims	$16,078,396

Non-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, patient payments, maternity kick payments, Rx reinsurance 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	$3,728,698

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	$3,728,698

Non-Expansion Adjustment #3 – To adjust to reverse the health plan's unnecessary adjustment for pharmacy administrative cost.

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	$478,000

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$478,000
3.1	Administrative Expenses	($478,000)

Non-Expansion Adjustment #4 –To adjust to reclassify claims payments made to Consumer Direct Care Network (CDCN), the consumer directed service payroll vendor, in excess of claims expense reported by CDCN from claims expense to administrative expense.

The health plan reported claims expense for consumer directed services arranged by CDCN. During the examination, it was determined that the reported claims expense was more than the actual claims incurred and paid by CDCN. 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 added to administrative costs and removed from 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	($2,187,791)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($2,187,791)
3.1	Administrative Expenses	$2,187,791

Non-Expansion Adjustment #5 – To adjust to reclassify compensation related to non-emergent transportation from Healthcare Quality Improvement (HCQI) to claims expense.

The health plan reported expenses related to non-emergent transportation in HCQI expense. These expenses included transportation compensation, fuel, cab/van services, vehicle repairs, and dispatch services that were verified to be allowable as claims expense. Based on the support provided, these expenses will be reclassified to claims expense. 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. 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**
1.1	Claims	$1,278,675
1.2	Improving health care quality expenses	($1,278,675)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$1,278,675
2.2	Improving health care quality expenses	($1,278,675)

Expansion Adjustment #1 – To adjust claims to agree to supporting documentation.

The health plan reported claims expenses at $61,905,030. Based on supporting documentation received, claims expenses were determined to be $61,458,538. The expenses were adjusted to agree to the provided supporting documentation. 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	($446,493)

Expansion Adjustment #2 – 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	$3,673,070
2.1	Revenue	$3,673,070

Expansion Adjustment #3 – 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, Rx reinsurance recoupments, performance withhold payments, and risk corridor 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	($2,873,723)

Expansion Adjustment #4 –To adjust to reclassify claims payments made to Consumer Direct Care Network (CDCN), the consumer directed service payroll vendor, in excess of claims expense reported by CDCN from claims expense to administrative expense.

The health plan reported claims expense for consumer directed services arranged by CDCN. During the examination, it was determined that the reported claims expense was more than the actual claims incurred and paid by CDCN. 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 added to administrative costs and removed from 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	($594,738)

Expansion Adjustment #5 – To adjust pharmacy rebates to the amount confirmed and supported by the Pharmacy Benefits Manager (PBM), Elixir.

The health plan did not report pharmacy rebates. Rebates confirmed and supported by the PBM, Elixir, have been offset against 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(e)(2)(ii)(B), 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	($224,006)

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

MYERS STAUFFER

July 6, 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 CCC Plus MLR and Underwriting Gain rebate calculations for the period of January 1, 2020 through June 30, 2020. Also, please explain any disagreement you may have with the proposed issues.

Please provide your response by July 12, 2022.

Magellan Complete Care of Virginia CCC Plus
January 1, 2020 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 reverse the MCO's unnecessary adjustment for pharmacy administrative cost.	Accept ✓	Disagree
4.	To adjust to reclassify claims payments made by the consumer directed service payroll vendor in excess of payments made to each vendor from administrative expense to claims expense.	Accept ✓	Disagree
5.	To adjust to reclassify compensation related to non-emergent transportation from Healthcare Quality Improvement (HCQI) to claims.	Accept ✓	Disagree

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MYERS STAUFFER

Magellan Complete Care of Virginia CCC Plus
January 1, 2020 through June 30, 2020
Expansion

	Adjustment	MCO's Response	
1.	To adjust administrative expense to agree to supporting documentation.	Accept ✓	Disagree
2.	To adjust claims to agree to supporting documentation.	Accept ✓	Disagree
3.	To adjust revenues and claims to include related directed payments.	Accept ✓	Disagree
4.	To adjust revenues to agree with state data.	Accept ✓	Disagree
5.	To adjust to reclassify claims payments made by the consumer directed service payroll vendor in excess of payments made to each vendor from administrative expense to claims expense.	Accept ✓	Disagree
6.	To adjust to agree pharmacy rebates to the amount confirmed and supported by the pharmacy vendor.	Accept ✓	Disagree

Acknowledged by:
VIRGINIA PREMIER HEALTH PLAN

Timothy E Carpenter
Officer or other Authorized Person

7/8/22
Date

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