

The background features a blurred medical scene with a person lying down. A large green cross is centered over the person. Various medical icons are overlaid in a light green color, including a syringe, a pill, a virus, a stethoscope, and a group of people. A dark grey diagonal band runs from the top right to the bottom left, containing the text.

Anthem HealthKeepers, 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** LLC
CERTIFIED PUBLIC ACCOUNTANTS



Table of Contents

■ Table of Contents	1
■ Independent Accountant’s Report	2
■ Adjusted Medical Loss Ratio for the Period Ending June 30, 2021	4
• Non-Expansion	4
• Expansion	5
■ Adjusted Underwriting Gain for the Period Ending June 30, 2021	6
• Non-Expansion	6
■ Schedule of Adjustments and Comments for the Period Ending June 30, 2021	7



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 Anthem HealthKeepers, Inc. (Anthem) related to the Medallion 4.0 Program for the period of July 1, 2020 through June 30, 2021. Anthem'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 Anthem 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 22, 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	\$865,043,157	\$(9,689,888)	\$855,353,269
1.2	Improving health care quality expenses	\$25,168,011	\$(3,573,764)	\$21,594,247
1.3	Total Adjusted MLR Numerator	\$890,211,168	\$(13,263,652)	\$876,947,516
Medical Loss Ratio Denominator				
2.1	Revenue	\$1,157,893,048	\$(5,983,114)	\$1,151,909,934
2.2	Federal and State taxes and licensing or regulatory fees	\$61,985,396	\$1,439,795	\$63,425,191
2.3	Total Adjusted MLR Denominator	\$1,095,907,652	\$(7,422,909)	\$1,088,484,743
Credibility Adjustment				
3.1	Member Months to determine credibility	3,597,321	0	3,597,321
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	81.2%		80.6%
4.2	Credibility adjustment	0.0%		0.0%
4.3	Adjusted MLR	81.2%		80.6%
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%		80.6%
5.4	MLR denominator	\$1,095,907,652		\$1,088,484,743
5.5	Remittance amount due to State for Coverage Year	\$41,644,491		\$47,893,329



Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	\$470,272,001	\$116,601,316	\$586,873,317
1.2	Improving health care quality expenses	\$9,619,707	\$(1,380,076)	\$8,239,631
1.3	Total Adjusted MLR Numerator	\$479,891,708	\$115,221,240	\$595,112,948
Medical Loss Ratio Denominator				
2.1	Revenue	\$645,886,391	\$35,982,068	\$681,868,459
2.2	Federal and State taxes and licensing or regulatory fees	\$41,838,916	\$(22,110,233)	\$19,728,683
2.3	Total Adjusted MLR Denominator	\$604,047,475	\$58,092,301	\$662,139,776
Credibility Adjustment				
3.1	Member Months to determine credibility	1,258,468	0	1,258,468
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	79.4%		89.9%
4.2	Credibility adjustment	0.0%		0.0%
4.3	Adjusted MLR	79.4%		89.9%
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	79.4%		89.9%
5.4	MLR denominator	\$604,047,475		\$662,139,776
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	\$1,157,893,048	\$(17,248,370)	\$1,140,644,678
1.2	Federal and State taxes and licensing or regulatory fees	\$61,985,396	\$(6,750,729)	\$55,234,667
1.3	Total Adjusted Underwriting Gain Denominator	\$1,095,907,652	\$(10,497,641)	\$1,085,410,011
Medical Expenses				
2.1	Claims	\$865,043,157	\$(9,689,888)	\$855,353,269
2.2	Improving health care quality expenses	\$25,168,011	\$(3,573,764)	\$21,594,247
2.3	Total Adjusted Underwriting Gain Claims Expenses	\$890,211,168	\$(13,263,652)	\$876,947,516
Non-Claims Costs				
3.1	Administrative Expenses	\$74,214,720	\$6,283,666	\$80,498,386
3.2	Less: Unallowable Expenses	\$(2,492,780)	\$(4,967,997)	\$(7,460,777)
3.3	Allowable Administrative Expenses	\$71,721,940	\$1,315,669	\$73,037,609
Underwriting Gain				
4.1	Underwriting Gain \$	\$133,974,544		\$135,424,886
4.1	Less: Remittance Amount Due to State for Coverage Year	\$(41,644,491)		\$(47,893,329)
4.2	Adjusted Underwriting Gain \$	\$92,330,053		\$87,531,557
4.3	Underwriting Gain %	8.4%		8.1%
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	2.7%		2.5%
5.4	Amount to Remit	\$29,726,412		\$27,484,628



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 remove Health Insurer Fee (HIF) expense and the revenue included in the Underwriting Gain calculation.

The health plan has included HIF expense in taxes and licensing or regulatory fees and HIF revenue was included in the Underwriting Gain calculation. HIF revenue includes a gross up amount to reimburse the health plan for the tax impact of HIF. HIF expense and revenue has been removed from the Underwriting Gain per the Medallion 4.0 Managed Care Services Agreement, Section 15.11.

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.1	Revenue	\$(11,265,256)
1.2	Federal and State taxes and licensing or regulatory fees	\$(8,190,524)

Non-Expansion Adjustment #2 – To adjust claims expense to agree to supporting documentation.

The health plan reported medical expenses based on the trial balance. However, during the examination, the health plan provided documentation to support the most recent data available for the expenses, which included a reconciliation to adjust restated amounts into the period under review. 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	\$234,706

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$234,706



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Non-Expansion Adjustment #3 – To adjust directed payments included in revenues and 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	\$(5,983,114)
2.1	Revenue	\$(5,983,114)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.1	Revenue	\$(5,983,114)
2.1	Claims	\$(5,983,114)

Non-Expansion Adjustment #4 – 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, HIF payments, Rx reinsurance payments, maternity kick 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	Revenues	\$(715,030)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.1	Revenue	\$(715,030)

Non-Expansion Adjustment #5 –To adjust transportation claims related to Access2Care to actual costs incurred.

The health plan reported a Cost Plus expense for transportation services arranged by Access2Care. During the examination, it was determined that this expense was greater than the actual claims incurred



SCHEDULE OF ADJUSTMENTS AND COMMENTS

and paid by Access2Care. Since these claims were incurred for members of the Virginia Medicaid program, the 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	\$(49,392)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$(49,392)
3.1	Administrative Expenses	\$49,392

Non-Expansion Adjustment #6 – To adjust to include incurred claims related to the dental vendor, DentaQuest.

The health plan reported claims expenses using a restated methodology. The restated expenses allocated dental services arranged by DentaQuest to Expansion in full. The actual claims incurred and paid by DentaQuest related to Non-Expansion have been included through this adjustment.

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	\$271,544



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$271,544

Non-Expansion Adjustment #7 – To adjust transportation expenses related to Southeastrans to actual costs incurred.

The health plan reported a Cost Plus expense for transportation services arranged by Southeastrans. During the examination, it was determined that this expense was greater than the actual claims incurred and paid by Southeastrans. Since these claims were incurred for members of the Virginia Medicaid program, the 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	\$(1,822,380)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$(1,822,380)
3.1	Administrative Expenses	\$1,822,380

Non-Expansion Adjustment #8 – To adjust vision expenses to actual costs incurred.

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



SCHEDULE OF ADJUSTMENTS AND COMMENTS

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	\$(1,792,762)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$(1,792,762)
3.1	Administrative Expenses	\$1,792,762

Non-Expansion Adjustment #9 – To adjust pharmacy expenses related to IngenioRx and CVS Caremark to actual costs incurred.

The health plan reported claims expense net of rebates and amounts received from pharmacies for pharmacy services arranged by IngenioRx and CVS Caremark. During the examination, it was determined that rebates and amounts received from pharmacies related to rate guarantees and transmission fees, as a reduction to claims payments, were understated in comparison to the amount reported by IngenioRx and CVS Caremark. It was also determined that amounts received by CVS Caremark from pharmacies related to rate guarantees and transmission fees, as a reduction to claims payments, were not reported. Expense was adjusted to agree rebates to supporting documentation provided by CVS Caremark and offset amounts received by pharmacies.

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), CMCS Informational Bulletin: Medicaid Prescription Spread Pricing 05/15/2019, and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	\$(1,503,123)



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$(1,503,123)

Non-Expansion Adjustment #10 – To adjust to remove non-allowable Healthcare Quality Improvement (HCQI) expenses

The health plan reported Healthcare Quality Improvement Expenses (HCQI) based on an analysis of cost centers that they determined to be HCQI. During the examination, it was noted that several of the cost centers included in HCQI had non-qualifying expenses that did not meet the definitions of HCQI for MLR reporting purposes. Amounts were found at the cost center level, account level, and within the salaries review of job descriptions. 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	\$(3,573,764)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.2	Improving health care quality expenses	\$(3,573,764)
3.1	Administrative Expenses	\$3, 573,764

Non-Expansion Adjustment #11 – To adjust administrative expenses to remove start-up costs and include amortization expense related to start-up costs, per the 2020 and 2021 administrative cost procedures.

Adjustments are applied to administrative costs through a separate engagement. Start-up costs related to Medicaid Enterprise Systems and Provider Services Solution were included in administrative expenses which were removed and the related amortization expense was added. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.477 and CMS Pub. 15-1: §2132 – Start-Up Costs.

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
3.2	Less: Unallowable Expenses	\$(112,733)



SCHEDULE OF ADJUSTMENTS
AND COMMENTS

Non-Expansion Adjustment #12 – To adjust to agree to the MCO’s self-exclusion related to state and federal taxes to pro-rated amounts per the administrative cost procedures.

Procedures are applied to administrative costs through a separate engagement. The health plan self-excluded income tax expense, however, the exclusion was understated in comparison to the amounts confirmed through the administrative cost procedures engagement. We have made an adjustment to agree to pro-rated exclusions verified through this separate engagement. The administrative cost principles are addressed in 45 CFR § 75.400 through 75.477.

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
3.2	Less: Unallowable Expenses	\$(4,275,325)

Non-Expansion Adjustment #13 – To adjust to remove fraud reduction expense, which was duplicated in claims and administrative expenses

The health plan duplicated fraud reduction expense within reported claims expenses and administrative expenses. We have made an adjustment to remove the duplicated administrative expense. The administrative reporting requirements are addressed in 45 CFR § 75.400 through 75.477.

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
3.2	Less: Unallowable Expenses	\$(579,939)

Non-Expansion Adjustment #14 – To adjust income tax expense to verified amounts.

The health plan calculated the state and federal taxes utilizing effective tax rates for 2020 and 2021 and applying them to an underwriting gain calculation. The adjusted tax expense was calculated using the adjusted revenues and expense and using a combined tax rate applicable to the period. The tax reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 § 438.8(f)(3) and 45 § CFR 158.162.

Proposed MLR Adjustment		
Line #	Line Description	Amount
2.2	Federal and State taxes and licensing or regulatory fees	\$1,439,795

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.2	Federal and State taxes and licensing or regulatory fees	\$1,439,795



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Non-Expansion Adjustment #15 - To adjust to reclassify reinsurance recoveries from claims expense to administrative expense.

The Medicaid Managed Care Final Rule provides that the net payments or receipts related to risk sharing mechanisms, such as reinsurance, may be includable within the Denominator of the MLR calculation when this risk sharing mechanism is described within the health plan's contract with the state. When this is not described within the contract, these net reinsurance amounts, by default, should be classified as non-claims costs and excluded from the MLR calculation. Reinsurance expenses are not described within the health plan's contract with the Virginia Department of Medical Assistance Services. These expenses and recoveries are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.6(b), 438.8(b), and 438.8(f)(2)(vi).

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	\$954,632

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	\$954,632
3.1	Administrative Expenses	\$(954,632)



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, Chesapeake Regional Medical Center, 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	\$119,095,302
2.1	Revenue	\$119,095,302

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, HIF payments, Rx reinsurance payments, maternity kick payments, clinical efficacy payments, 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	\$(83,113,234)

Expansion Adjustment #3– To adjust pharmacy expenses related to IngenioRx and CVS Caremark to actual costs incurred.

The health plan reported claims expense net of rebates and amounts received from pharmacies for pharmacy services arranged by IngenioRx and CVS Caremark. During the examination, it was determined that rebates and amounts received from pharmacies related to rate guarantees and transmission fees, as a reduction to claims payments, were understated in comparison to the amount reported by IngenioRx and CVS Caremark. It was also determined that amounts received by CVS Caremark from pharmacies related to rate guarantees and transmission fees, as a reduction to claims payments, were not reported. Expense was adjusted to agree rebates to supporting documentation provided by CVS Caremark and offset amounts received by pharmacies.



SCHEDULE OF ADJUSTMENTS AND COMMENTS

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), CMCS Informational Bulletin: Medicaid Prescription Spread Pricing 05/15/2019, and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.1	Claims	\$(1,353,207)

Expansion Adjustment #4 – To adjust to remove non-allowable Healthcare Quality Improvement (HCQI) expenses.

The health plan reported Healthcare Quality Improvement Expenses (HCQI) based on an analysis of whole cost centers that they determined to be HCQI. During the examination, it was noted that several of the cost centers included in HCQI had non-qualifying expenses that did not meet the definitions of HCQI for MLR reporting purposes. Amounts were found at the cost center level, account level, and within the salaries review of job descriptions. 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	\$(1,380,076)

Expansion Adjustment #5 – To adjust income tax to verified amounts

The health plan calculated the state and federal taxes utilizing effective tax rates for 2020 and 2021 and applying them to an underwriting gain calculation. The adjusted tax expense was calculated using the adjusted revenues and expense and using a combined tax rate applicable to the period. The tax reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 § 438.8(f)(3) and 45 § CFR 158.162).

Proposed MLR Adjustment		
Line #	Line Description	Amount
2.2	Federal and State taxes and licensing or regulatory fees	\$(22,110,233)



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Expansion Adjustment #6 – To adjust claims Incurred but Not Reported (IBNR) at the time of the MLR filing to IBNR as of March 2023.

The reported IBNR was adjusted to agree to the March 2023 lag table. We have made an adjustment for the difference of \$1,140,778 to Medical Loss Ratio line 1.1. 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	\$(1,140,778)