United Healthcare of the Mid-Atlantic, 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 July 1, 2020 through June 30, 2021

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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 United Healthcare of the Mid-Atlantic (United) related to the Commonwealth Coordinated Care Plus Program (CCC Plus) for the period of July 1, 2020 through June 30, 2021. United'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 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 United 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
July 24, 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	$500,205,746	($182,281)	$500,023,465
1.2	Improving health care quality expenses	$18,221,614	$658,852	$18,880,466
1.3	**Total Adjusted MLR Numerator**	**$518,427,360**	**$476,571**	**$518,903,931**
Medical Loss Ratio Denominator				
2.1	Revenue	$647,071,304	($3,031,154)	$644,040,150
2.2	Federal and State taxes and licensing or regulatory fees	$11,993,737	$0	$11,993,737
2.3	**Total Adjusted MLR Denominator**	**$635,077,567**	**($3,031,154)**	**$632,046,413**
Credibility Adjustment				
3.1	Member Months to determine credibility	324,749	0	324,749
3.2	Credibility adjustment	1.1%		1.1%
MLR Calculation				
4.1	Unadjusted MLR	81.6%		82.1%
4.2	Credibility adjustment	1.1%		1.1%
4.3	**Adjusted MLR**	82.7%		83.2%
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	82.7%		83.2%
5.4	MLR denominator	$635,077,567		$632,046,413
5.5	**Remittance amount due to State for Coverage Year**	$14,606,784		11,376,835

Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$98,447,066	$0	$98,447,066
1.2	Improving health care quality expenses	$3,101,304	$0	$3,101,304
1.3	**Total Adjusted MLR Numerator**	**$101,548,370**	**$0**	**$101,548,370**
Medical Loss Ratio Denominator				
2.1	Revenue	$126,542,080	($13,930,808)	$112,611,272
2.2	Federal and State taxes and licensing or regulatory fees	$623,386	$0	$623,386
2.3	**Total Adjusted MLR Denominator**	**$125,918,694**	**($13,930,808)**	**$111,987,886**
Credibility Adjustment				
3.1	Member Months to determine credibility	53,386	0	53,386
3.2	Credibility adjustment	2.8%		2.8%
MLR Calculation				
4.1	Unadjusted MLR	80.6%		90.7%
4.2	Credibility adjustment	2.8%		2.8%
4.3	**Adjusted MLR**	**83.4%**		**93.5%**
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	83.4%		93.5%
5.4	MLR denominator	$125,918,694		$111,987,886
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	$647,071,304	($6,752,052)	$640,319,252
1.2	Federal and State taxes and licensing or regulatory fees	$11,993,737	($3,720,898)	$8,272,839
1.3	**Total Adjusted Underwriting Gain Denominator**	**$635,077,567**	**($3,031,154)**	**$632,046,413**
Medical Expenses				
2.1	Claims	$500,205,746	($182,281)	$500,023,465
2.2	Improving health care quality expenses	$18,221,614	$658,942	$18,880,556
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$518,427,360**	**$476,661**	**$518,904,021**
Non-Claims Costs				
3.1	Administrative Expenses	$37,988,889	($13,958,154)	$24,030,735
3.2	Less: Unallowable Expenses	$239,625	$338,696	$578,321
3.3	**Allowable Administrative Expenses**	**$38,228,514**	**($13,619,458)**	**$24,609,056**
Underwriting Gain				
4.1	Underwriting Gain $	$78,421,693		$88,533,336
4.1	Less: Remittance Amount Due to State for Coverage Year	($14,606,784)		($11,376,835)
4.2	Adjusted Underwriting Gain $	$63,814,909		$77,156,501
4.3	**Underwriting Gain %**	**10.0%**		**12.2%**
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	3.5%		5.7%
5.4	**Amount to Remit**	**$22,534,867**		**$36,073,484**

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 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, Health Insurer Fee (HIF) payments, maternity kick payments, discrete incentive program payments, clinical efficacy payments, performance withhold 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	($3,031,154)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.1	Revenue	($3,031,154)

Non-Expansion Adjustment #2 – To adjust to reclassify non-allowable Health Care Quality Improvement (HCQI) expenses.

The health plan reported HCQI based on an analysis of whole cost centers that they determined to be HCQI, the majority of which is driven by full time equivalents (FTEs). During the examination, several FTEs included in HCQI did not qualify as HCQI utilizing the job description. Additionally, the health plan provided a rate build for HCQI Account 78495 showing indirect expenses that are unallowable as HCQI. 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	($830,894)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.2	Improving health care quality expenses	($830,894)
3.1	Administrative Expenses	$830,894

Non-Expansion Adjustment #3 – To adjust to remove Health Insurer Fee (HIF) expense and 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 have been removed from the Underwriting Gain per the CCC Plus MCO Contract, Section 19.8.

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
1.1	Revenue	($3,720,898)
1.2	Federal and State taxes and licensing or regulatory fees	($3,720,898)

Non-Expansion Adjustment #4 – To adjust administrative expense to apply adjustments identified during the 2019 and 2020 administrative cost procedures.

Procedures are applied to administrative costs through a separate engagement. The health plan included interest payments for late claims, margin (profit) associated with related parties OptumHealth Care Solutions, OptumInsight, and Dental Benefit Providers, and costs related to OptumHealth Physical Health were not supported in 2020. There was also a positive adjustment necessary to include expenses erroneously coded to Medallion 3.0. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.477 and 42 CFR § 413.17.

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
3.2	Less: Unallowable Expenses	$338,696

Non-Expansion Adjustment #5 – To adjust to remove the profit margin and reclassify the HCQI costs associated with UBH.

The health plan reported a per-member-per-month (PMPM) capitation expense for behavioral health services arranged by UBH which was split between claims expense and administrative expense by the health plan. During the examination, it was determined that the administrative portion included HCQI expenses incurred by UBH as well as non-allowable related party profit. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150. Related party reporting requirements are addressed in CMS Publication 15-1, Chapter 10.

Proposed MLR Adjustment		
Line #	Line Description	Amount
1.2	Improving health care quality expenses	$1,489,836

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.2	Improving health care quality expenses	$1,489,836
3.1	Administrative Expenses	($14,789,048)

Non-Expansion Adjustment #6 – To adjust behavioral health expenses to actual costs incurred.

The health plan reported expense for behavioral health services arranged by United Behavioral Health (UBH). During the examination, it was determined that this expense was greater than the actual claims incurred and paid by UBH. 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), 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	($70,308)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	($70,308)

Non-Expansion Adjustment #7 – To adjust pharmacy expenses related to OptumRx, Inc. to actual costs incurred.

The health plan reported claims expense net of rebates for pharmacy services arranged by OptumRx, Inc. During the examination, it was determined that claims were overstated and rebates were understated in comparison to the amount reported by OptumRx, Inc. Expense was adjusted to agree to claims and rebates reported by OptumRx, Inc.

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	($111,973)

Proposed Underwriting Gain Adjustment		
Line #	Line Description	Amount
2.1	Claims	($111,973)

Expansion Adjustment #1 – 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, Health Insurer Fee (HIF) payments, maternity kick payments, clinical efficacy payments, performance withhold payments, Rx reinsurance recoupments, 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	($13,930,808)