HealthKeepers, Inc.
Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations for Family Access to Medical Insurance Security Plan
(With Independent Accountant's Report Thereon)

Virginia Department of Medical Assistance Services
Richmond, Virginia

For the period of July 1, 2017 through November 30, 2018

Prepared by:

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

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 HealthKeepers, Inc. (HealthKeepers) related to the Family Access to Medical Insurance Security Plan (FAMIS) Program for the period of July 1, 2017 through November 30, 2018. HealthKeepers' management is responsible for presenting the Medical Loss Ratio and Underwriting Gain Rebate Calculations in accordance with the criteria set forth in FAMIS contract and Centers for Medicare & Medicaid Services (CMS) federal guidance 42 CFR 438.8. 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 were prepared for the purpose of complying with the criteria, and are 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 of HealthKeepers are presented in accordance with the above referenced criteria, in all material respects, the Adjusted MLR Percentage Achieved does not exceed the minimum requirement of eighty-five percent (85%), and the Adjusted Underwriting Gain Percentage Achieved is greater than the maximum requirement of three percent (3%) for the period of July 1, 2017 through November 30, 2018. In accordance with contractual obligations, MLR and Underwriting Gain remittance amounts are due to the Department of Medical Assistance Services.

This report is intended solely for the information and use of the Virginia Department of Medical Assistance Services and HealthKeepers 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, VA
January 25, 2023

Adjusted Medical Loss Ratio for the Period Ending November 30, 2018

Adjusted Medical Loss Ratio for the Period Ending November 30, 2018				
Line #	**Revenue or Expense**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Medical Loss Ratio Numerator				
1.1	Claims	$ 52,605,099	$ 170,086	$ 52,775,185
1.2	Improving health care quality expenses	$ 2,125,368	$ (228,603)	$ 1,896,765
1.3	**Total Adjusted MLR Numerator**	**$ 54,730,467**	**$ (58,517)**	**$ 54,671,950**
Medical Loss Ratio Denominator				
2.1	Revenue	$ 74,181,372	$ 1,137,681	$ 75,319,053
2.2	Federal and State taxes and licensing or regulatory fees	$ 4,912,490	$ 317,431	$ 5,229,921
2.3	**Total Adjusted MLR Denominator**	**$ 69,268,882**	**$ 820,250**	**$ 70,089,132**
Credibility Adjustment				
3.1	Member Months to determine credibility	299,107	-	299,107
3.2	Credibility adjustment	1.2%	0.0%	1.2%
MLR Calculation				
4.1	Unadjusted MLR	79.0%	-1.0%	78.0%
4.2	Credibility adjustment	1.2%	0.0%	1.2%
4.3	**Adjusted MLR**	**80.2%**	**-1.0%**	**79.2%**
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	80.2%	-1.0%	79.2%
5.4	MLR denominator	$ 69,268,882	$ 820,250	$ 70,089,132
5.5	**Remittance amount due to State for Coverage Year**	**$ 3,316,856**	**$ 748,314**	**$ 4,065,170**

Adjusted Underwriting Gain for the Period Ending November 30, 2018

Adjusted Underwriting Gain for the Period Ending November 30, 2018				
Line #	**Revenue or Expense**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Medical Loss Ratio Denominator				
1.1	Revenue	$ 74,181,372	$ 1,137,681	$ 75,319,053
1.2	ACA Health Insurer Fee Tax Gross-up included in 1.1	$ -	$ 148,285	$ 148,285
1.3	Federal and State taxes and licensing or regulatory fees	$ 4,912,490	$ 169,146	$ 5,081,636
1.4	**Total Adjusted Underwriting Gain Denominator**	**$ 69,268,882**	**$ 820,250**	**$ 70,089,132**
Medical Expenses				
2.1	Claims	$ 52,605,099	$ 170,086	$ 52,775,185
2.2	Improving health care quality expenses	$ 2,125,368	$ (228,603)	$ 1,896,765
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$ 54,730,467**	**$ (58,517)**	**$ 54,671,950**
Non-Claims Costs				
3.1	Administrative Expenses	$ 9,063,301	$ 200,733	$ 9,264,034
3.2	Less: Unallowable Expenses	$ (1,345,501)	$ -	$ (1,345,501)
3.3	**Allowable Administrative Expenses**	**$ 7,717,800**	**$ 200,733**	**$ 7,918,533**
Underwriting Gain				
4.1	Underwriting Gain $	$ 6,820,615	$ 678,034	$ 7,498,649
4.1	Less: Remittance Amount Due to State for Coverage Year	$ (3,316,856)	$ (748,314)	$ (4,065,170)
4.2	Adjusted Underwriting Gain $	$ 3,503,759	$ (70,280)	$ 3,433,480
4.3	**Underwriting Gain %**	**5.1%**	**-0.2%**	**4.9%**
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	1.0%	-0.1%	0.9%
5.4	**Amount to Remit**	**$ 712,846**	**$ (47,443)**	**$ 665,403**

Report Disclosure

Note 1 - Spread Pricing

The health plan reported expenses for pharmacy services arranged by Express Scripts. The health plan pays their Pharmacy Benefit Manager (PBM) an overall amount greater than the amount that their PBM pays to the pharmacy providers for the covered drugs of Anthem HealthKeeper's, Inc. (Anthem) members. This practice is referred to as spread pricing in the industry. During the examination, it was determined that $880,687 in spread pricing was present within the medical claims expense.

Reed Smith LLP submitted a letter on behalf of their client, HealthKeeprs, Inc., on October 16, 2020 to request the Department refrain from making an official or final determination until they had carefully reviewed Anthem's position regarding the treatment of PBM spread pricing. In a response dated December 15, 2022, the Department noted that spread pricing is not an incurred claim in calculating the MLR pursuant to the Medicaid Managed Care Final Rule (Final Rule). The Department further noted that the Final Rule did not apply to FAMIS for the 2018 contract year as the Final Rule was applicable to Children's Health Insurance Program (CHIP) managed care contracts for contracts beginning on or after July 1, 2018. FAMIS is Virginia's CHIP program and the period under review relates to the 2018 contract year which ran from July 1, 2017 through November 30, 2018. Through the letter dated December 15, 2022, DMAS has allowed spread pricing for the purposes of calculating the MLR rebate. Had spread pricing been removed the adjusted MLR would be 77.9%.

Schedule of Adjustments and Comments for the Period Ending November 30, 2018

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.

Adjustment #1 – To adjust the Health Insurer Fee (HIF) to supporting documentation

The health plan reported HIF revenue and expense based on a full calendar year for 2018. Based on the period under review for FAMIS 3.0, the period only included eleven of the twelve months in calendar year 2018, therefore, the HIF revenue and expense was over-reported. An adjustment was proposed to report the appropriate portion of the HIF related to the period, utilizing the trial balance to calculate the prorated HIF adjustment amounts. Additionally, the health plan did not properly segregate the tax gross up on the revenues within the underwriting gain, therefore, the taxes and licensing or regulatory fees inappropriately included the amount. An adjustment was proposed to report the appropriate portion of the HIF related taxes for the period under review on the gross up line. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.89(f)(2).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Revenue	($111,965)
2.2	Federal and State taxes and licensing or regulatory fees	($111,965)

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Revenue	($111,965)
1.2	ACA Health Insurer Fee Tax Gross-up included in 1.1	$148,285
1.3	Federal and State taxes and licensing or regulatory fees	($260,250)

Adjustment #2 – To adjust transportation expenses to actual cost incurred

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, 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 Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	($2,072)

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	($2,072)
3.1	Administrative Expenses	$2,072

Adjustment #3 – To adjust vision expenses to actual cost incurred

The health plan reported a per-member-per-month (PMPM) capitation expense for vision services arranged by Davis Vision. During the examination, it was determined that this capitation expense was less than the actual claims incurred and paid by Davis Vision. 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 Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	$213,788

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	$213,788

Adjustment #4 – To remove non-allowable 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. 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).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	($228,603)

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	($228,603)
3.1	Administrative Expenses	$228,603

Adjustment #5 – To adjust medical expenses 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 medical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.89(e)(2).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	($42,929)

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	($42,929)

Adjustment #6 – To remove non-allowable interest expense on paid claims

The health plan included interest on late claim payments as an administrative expense in the underwriting gain calculation. Interest on paid claims is a not considered an allowable administrative expense. The proposed adjustment is to remove the expense from the underwriting gain. The administrative reporting requirements are addressed in the 45 CFR § 75.441.

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
3.1	Administrative Expenses	($28,643)

Adjustment #7 – To adjust revenues to the state's 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 performance incentives that were initially reported in Medallion 3.0. 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 Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Revenue	$53,352

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Revenue	$53,352

Adjustment #8 – To adjust revenues to the state's 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 pharmacy reinsurance. 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 Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Revenue	$1,248,392

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Revenue	$1,248,392

Adjustment #9 – To adjust revenues to the state's data

The health plan reported revenue amounts that did not reflect the appropriate 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 the appropriate amount revenues related to capitation. 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 Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Revenue	($52,098)

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Revenue	($52,098)

Adjustment #10 – To include additional taxes related to the adjustments made for revenues and expenses

The health plan calculated the state and federal taxes utilizing an effective tax rate based on the underwriting gain calculation. Therefore, the taxes were reported based on the as-filed data. Additional revenues were made via adjustment numbers 6, 8, 9, and 10 above. This results in an increase in the taxes that should have been reported and therefore an additional reduction to the MLR and underwriting gain denominator amounts. The proposed adjustment is to include the additional taxes related to the re-calculation based on the adjusted revenues and expenses. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	$429,396

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.3	Federal and State taxes and licensing or regulatory fees	$429,396

Adjustment #11 – To net fraud reduction expenses against fraud recoveries in paid claims

The health plan reported fraud reduction expenses on the as-filed template, however, the fraud recoveries were not separated from medical claims expense on the template. Due to the fraud recoveries not being reported on the correct line within the template, the fraud reduction expenses were not included in the as-filed numerator. An adjustment was proposed to include the amount of fraud reduction expenses, limited by their fraud recoveries amounts, in medical expenses to offset the amounts previously reported in their claims totals in the MLR calculation and to reclassify these expenses from non-claims administrative expenses within the underwriting gain calculation. The fraud reduction reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(iii)(B).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	$1,299

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	$1,299
3.1	Administrative Expenses	($1,299)

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

September 1, 2020

Julie Pierce, Dir Fin Acctg/Rptg/Analysis Financial Accounting - Medicaid
HealthKeepers, Inc.
4425 Corporation Lane
Virginia Beach, VA 23462

Dear Ms. Pierce:

Please acknowledge whether you accept or disagree with our proposed adjustments summarized below and applicable to our examination of HealthKeepers, Inc.'s FAMIS MLR and Underwriting Gain rebate calculations for the period of July 1, 2017 through November 30, 2018. Also, please explain any disagreement you may have with the proposed issues.

Please provide your response by September 15, 2020.

HealthKeepers, Inc. FAMIS
July 1, 2017 through November 30, 2018

	Adjustment	Plan's Response			
1.	Adjust HIF expense to amount in trial balance for the amount reported as UG Administrative unallowable amount. Reclassify HIF tax gross-up from HIPF and Gross-up.	Accept	X	Disagree	
2.	The health plan reported a PMPM amount for SoutheastTrans. The difference in the PMPM and incurred claims was removed from clinical expenses.	Accept		Disagree	X
3.	The health plan reported a PMPM amount for Davis Vision. The difference in the PMPM and incurred claims was removed from clinical expenses.	Accept		Disagree	X
4.	Remove spread pricing from pharmacy claims expense.	Accept		Disagree	X
5.	Remove non-allowable costs from HCQI expenses.	Accept	X	Disagree	
6.	The plan provided a reconciliation from the trial balance to the MLR to include restated amounts for runout. The	Accept	X	Disagree	

ending total had an unexplained variance that would add 42K to claims expense.

7.	Remove non-allowable interest expense on late claims payments.	Accept _____	X	Disagree _____
8.	Allocate FAMIS portion of performance incentive award payments to revenue calculation. The plan originally included all amounts in Medallion 3.0's MLR.	Accept _____	X	Disagree _____
9.	Add reinsurance to revenue calculation. Reinsurance was not included by the plan.	Accept _____	X	Disagree _____
10.	Reduce capitation payments to match amounts reported by state.	Accept _____	X	Disagree _____
11.	Include additional taxes related to revenues added in adjustments 8-10.	Accept _____	X	Disagree _____

Acknowledged by:
HealthKeepers, Inc.

Mark Blessinger, Actuarial Director
Officer or other Authorized Person

9/17/2020
Date

Anthem HealthKeepers is providing this letter in response to Myers and Stauffers' (M&S) preliminary findings. Anthem HealthKeepers disagrees that any type of spread expense associated with a subcontracted vendor benefit expenses should be reclassed as an administrative expense out of a benefit expense for use in the MLR & UW Gain calculations. We ask that M&S delay finalizing their audit findings until DMAS has a chance to weigh in on the treatment of these expenses under the provisions of the contract. Nick Merciez discussed in the exit interview that DMAS has not made any changes to rates, contracts or calculation instructions and that preliminary audit findings assumes a revision to existing practice has been made.

Anthem disagrees with M&S interpretation of the MLR & UW Gain programs treatment of these subcontracted expenses. Anthem has been very transparent in the treatment of these expenses including conversations with Chris Gorden regarding Anthem's inclusion of these expenses in the financials. We raised this issue on multiple occasions and were not instructed to change the treatment of these expenses.

There should be consistency in how these expenses are treated between capitation development and financial reporting. DMAS has included these expenses as medical costs in the development of the capitation premium and financial reporting up until SFY21 rating period. The MCOs agree to operate under a contract with these known parameters and this retroactive change would be in conflict with that agreement. DMAS has not changed any of their financial templates nor instructions to reflect a change in the treatment of these expenses. Only starting in the SFY21 contract period have these expenses been reclassed into administrative when developing the capitation rates, a clear recognition of a collective and agreed change under the contract that had not been made prior to SFY21.

42 CFR 438.8 does not prescribe the method for calculating remittances, but rather state MLR remittances would be dependent on the requirements in state contracts. CMS released clarifications on May 15, 2019 that stated these expenses were not allowed as benefit expenses for contracts starting on or after July 1, 2018 when reporting to CMS. However this was later clarified when CMS released more guidance on June 5, 2020 in the CMCS Informational Bulletin (CIB), Medicaid Managed Care Frequently Asked Questions (FAQs) –Medical Loss Ratio. CMS discusses third-party vendors (PBM/spread) and notes that the applicability of this specific policy is dependent on the requirements in the state contracts. This guidance is not a directive to require remittances or make retrospective changes to existing contracts. CMS encourages states to clarify this requirement with plans on a prospective basis to ensure they have the necessary data for future MLR Reporting. DMAS has not changed their state MLR requirements and the MCOs have continued to operate and report consistent with state instruction.

ReedSmith
Driving progress
through partnership

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October 16, 2020

By Electronic Mail

Chris Gordon, Chief Financial Officer
Virginia Department of Medical Assistance Services
chris.gordon@dmas.virginia.gov

Re: Proposed Accounting Treatment of PBM Spread in MLR under HealthKeepers, Inc. for Anthem HealthKeepers Plus Virginia MCO Contracts

Mr. Gordon:

We represent and write this letter on behalf of our client, HealthKeepers, Inc. for Anthem HealthKeepers Plus Virginia ("Anthem"), to address the retroactive treatment proposed in Myers & Stauffer ("M&S") draft audit findings to the Virginia Department of Medical Assistance Services ("DMAS") of Anthem's Pharmacy Benefit Manager ("PBM") spread for the purposes of the calculation of Medical Loss Ratio (MLR) under Anthem's Virginia MCO Medicaid contracts during the 2017-2020 time period.

As you know, Anthem has served as an MCO Medicaid Contractor with the Commonwealth of Virginia under the previous Medallion 3.0 and FAMIS programs and currently under Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) during 2017-2020, and Anthem proudly continues to provide MCO services to Virginia Medicaid recipients today. This letter states Anthem's position on what it believes is the proper accounting treatment of PBM spread for MLR calculation purposes under Anthem's MCO Contracts during the relevant contract time periods based on the terms of these Contracts, the continuous and transparent course of conduct, and the mutual understanding between Anthem and DMAS regarding the PBM spread accounting issue.

Until SFY 2021, Anthem and DMAS consistently had treated PBM spread as a medical benefit expense under Anthem's Virginia MCO contracts for MLR purposes. As you know, PBM spread refers to expenses an MCO pays to PBMs with whom the MCO contracts to manage prescription drug benefits for plan members that the PBM does pay to pharmacies. All of Anthem's encounter submissions and financial reporting clearly demonstrated how Anthem treated and accounted for its PBM spread expenses. Each of Anthem's Virginia MCO contracts expressly reference 42 C.F.R. § 438.8 as the definition by which the MLR should be calculated. Specifically, § 438.8 instructs that States "must ensure, through its contracts starting on or after July 1, 2017," that each MCO calculate and report a MLR to CMS in accordance with § 438.8. The regulation does not, however, specify or require that MCOs and States include any contractual language in their MCO Contracts regarding how the MLR is to be calculated generally, and certainly not with respect to the treatment of PBM spread.

Prior to May, 2019, there were no discussions between Anthem and DMAS about whether PBM spread, nor similarly positioned costs under arrangements with ancillary providers such as transportation companies, should be included as a medical benefit expense for MLR calculation purposes under Anthem's VA MCO Contracts. Prior to any specific direction from CMS, it was common practice for MCOs to include all PBM and ancillary provider costs as medical benefit expenses unless the State specifically instructed the MCO to do otherwise.

On May 15, 2019, CMS issued clarifications providing that CMS had intended the spread paid to a PBM and ancillary providers to be excluded from medical benefit expenses when calculating MLR for MCO Medicaid contracts starting on or after July 1, 2017. Neither at that time, nor since, has DMAS provided Anthem with any communication indicating that Anthem would be required to change or revise the MLR Rebate filings or MLR calculations it previously had submitted to DMAS under the VA MCO Contracts. Indeed, Anthem would not have expected any such retroactive revision obligation because such a retroactive change to the PBM spread and MLR calculations would materially impact the capitated rates DMAS was obligated by Contract, Virginia law and Federal law to pay Anthem for those prior contract periods. In addition, a retroactive change to the PBM spread and MLR calculations of this magnitude would undoubtedly affect the actuarial soundness of the capitated rates DMAS was obligated to pay Anthem under the VA MCO Contracts as well as under Federal law. *See, e.g.*, 42 C.F.R. § 438.4(c) ("Capitation rates for MCOs…must be reviewed and approved by CMS as actuarially sound"); 42 CFR § 438.4(a) ("Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph 438.4(b)"); 42 C.F.R. § 438.6(c)(2)("All contract arrangements that direct the MCO's… expenditures…must be developed in accordance with § 438.4, the standards specified in § 438.5, generally accepted actuarial principles and practices, and have written approval prior to implementation").

As an example, since CMS issued its May 15, 2019 Clarification, Virginia made several rate changes and increases, but none of them altered the treatment of PBM spread as a medical benefit expense for MLR calculation purposes. *See* 2019 Midyear CCC+ (7/1/19); FY20 Medallion 4.0 (7/1/19); 1H20 CCC+ (1/1/20).

On November 18, 2019, you met with representatives of Anthem including Jennie Reynolds, President of Anthem HealthKeepers Plus Virginia; Aimee Dailey VP Finance Medicaid, Anthem; and Kate Tottle, VP and Chief Actuary – Medicaid, Anthem. During that meeting, you recognized and discussed with Anthem the disconnect between the contractual treatment of certain provider expenses and CMS' MLR regulatory guidance, the MCO capitation rates and the outcomes of various differing interpretations of MLR calculations. During that meeting, you acknowledged that DMAS had not taken a position on the issue of inclusion of PBM spread or other ancillary provider expenses within the MLR calculation, and you agreed you would follow up to ascertain and determine what DMAS' position would be on this issue in the future. After that meeting, Anthem confirmed with you that absent receipt of any specific instruction from DMAS to the contrary, Anthem would continue to follow its consistent practice of including PBM spread and similarly positioned ancillary provider expenses within medical benefit expenses when filing its MLR rebate and related underwriting calculations under its VA MCO Contracts.

Consistent with Anthem's discussions with you, on November 1, 2019, Anthem submitted to DMAS: (1) Anthem's FAMIS MLR and Underwriting Gain calculations for the July 1, 2017 through November 30, 2018 contract period; and (2) Anthem's Medallion 3.0 MLR and Underwriting Gain calculations for the July 1, 2017 through November 30, 2018 contract period. Subsequently, on December 1, 2019, Anthem submitted to DMAS Anthem's CCC Plus MLR and Underwriting Gain calculations for the January 1 through December 2018 contract period. In all of these submissions, Anthem consistently included PBM spread and similarly positioned ancillary provider costs within medical benefit expenses for purposes of the MLR rebate and related MLR calculations. Although the reporting instructions for these submissions provide for a post-submission review by DMAS and an MCO response, DMAS did not take any exception to the PBM spread accounting treatment included within Anthem's submissions. Moreover, subsequent to these November/December, 2019 submissions, DMAS has neither objected to Anthem's treatment of PBM spread for purposes of the MLR calculation, nor otherwise indicated that the State disagreed in any way with Anthem's MLR Rebate or related calculations, including, but not limited, to the inclusion of PBM spread as a medical benefit expense.

On June 5, 2020, CMS issued new guidance in the CMCS Informational Bulletin (CIB), *Medicaid Managed Care Frequently Asked Questions (FAQs) –Medical Loss Ratio*. This CMS Bulletin provided the States with explicit guidance on the treatment of "Third-Party Vendors (PBM/spread)" clarifying CMS' policy that PBM spread expenses should be considered "non-claim administrative expenses." CMS expressly emphasized in the Bulletin, however, that "***the applicability of this specific policy is dependent on the requirements in state contracts. This guidance is not a directive to require remittances or make retrospective changes to existing contracts. CMS encourages states to clarify this requirement with plans on a prospective basis to ensure they have the necessary data for future MLR reporting."*** (emphasis added). CMS' guidance was consistent with 42 C.F.R. § 438.8 which does not prescribe the method for calculating MLR remittances, but instead makes them dependent on the terms of the MCO contracts with the States.

Consistent with CMS' policy guidance, effective July 1, 2020, the Virginia Legislature passed and implemented a specific prohibition of spread pricing in State MCO Medicaid contracts. Following this new State requirement and CMS' policy guidance, for the FY21 CCC Plus+ (7/1/20) contract period, and for the FY21 Medallion 4.0 (7/1/20) contract period, the changes to the contract specifically addressed PBM spread in the rates. For the first time through these contract changes, the parties agreed that PBM spread would be excluded from the medical components of the rates where the State actuaries determined there was "excess" spread. These July, 2020 contract changes acknowledged that the new Virginia State law required the parties to make specific contract changes to address the new PBM spread limitations imposed by the Legislature, as the CMS guidance had directed. Even so, DMAS did not provide Anthem with any new or different financial templates or instructions to calculate MLR for any MCO contract for any prior or current contract periods.

There were further contract changes that occurred as a result of COVID-19 measures, which were all retroactive changes to the contract rates, until FY21, when such measures will be built into the rates. These COVID-19 related retroactive changes did not address any changes to the treatment of PBM spread or similarly positioned ancillary provider costs for any prior contract periods.

In the Fall of 2020, the State retained M&S to audit Anthem's MCO Medicaid contracts listed above. M&S concluded those audits on or about September 24, 2020. M&S' preliminary audit findings included a recommendation that DMAS retroactively re-class PBM spread expenses from prior contract years as an administrative, non-medical benefit expense for use in MLR calculations for those prior contract years. Anthem timely submitted a response to the M&S preliminary audit findings on September 18, 2020 stating Anthem's "disagreement that any type of spread expense associated with a subcontracted vendor benefit expenses should be re-classed as an administrative expense out of a benefit expense for use in the MLR & UW Gain calculations." Anthem explained that the retroactive PBM spread re-classification treatment proposed by M&S was not required by CMS regulations or Virginia law and would be inconsistent with the terms of the parties' MCO contracts. Indeed, the retroactive re-classification change M&S has proposed would fundamentally conflict with the terms of Anthem's contracts with DMAS during the prior years under which Anthem undisputedly was not required to treat PBM or ancillary provider spread expenses as non-medical benefit administrative expenses. M&S' proposed retroactive re-classification also would run counter to CMS' guidance suggesting that such accounting changes be made prospectively. Moreover, the proposed retroactive application of CMS' guidance would deprive MCOs of the ability to adjust their compensation for PBM services in a manner consistent with the revised accounting treatment, including compensation for quality related services that may otherwise be included in the PBM spread, but were not required to be defined at the time the VA MCO Contracts were executed.

Anthem further explained to DMAS that Anthem had transparently and consistently reported and treated PBM spread, in all encounter submissions, MLR calculations and financial reporting, as included within medical benefit expenses for MLR calculation purposes on all of Anthem's VA MCO contracts, during all contract periods prior to the SFY 2021 rating period. Anthem did so with DMAS' knowledge and consistent with DMAS' guidelines. Indeed, Anthem was consistently clear in its MLR reporting and candid in its direct discussions with you regarding the accounting treatment of PBM spread. In fact, Anthem discussed these issues with you directly on multiple occasions and you instructed Anthem to continue reporting the PBM spread as medical benefit expenses for these contract periods. Moreover, at no time did you or DMAS ever instruct Anthem to change the treatment of PBM spread for MLR calculation purposes for any prior contract periods. Therefore, Anthem submits that it would be unfair and inappropriate to require Anthem retroactively to reclassify these PBM spread expenses for prior contract periods.

In addition to not being required by law or permitted under the parties' MCO contracts, the unprecedented retroactive expense reclassification M&S proposed unquestionably would have a negative material impact on the capitated rates DMAS was obligated to pay Anthem for each of those prior contract years. DMAS has factored into the capitated rates for SFY21 the impact of the change in accounting treatment of PBM spread expenses for MLR calculation purposes, but such changes clearly were not considered or contemplated when the capitated rates were established by actuaries for the prior contract years. Accordingly, any such proposed retroactive reclassification of the magnitude proposed by M&S necessarily would require DMAS to re-determine, and CMS to approve, the capitated rates paid during those contract years to comply with Federal and contractual actuarial soundness requirements.

For the foregoing reasons, Anthem respectfully requests that DMAS refrain from making an official or final determination whether DMAS should follow M&S' audit findings until after DMAS had an opportunity to carefully review the chronology and course of conduct between the parties and Anthem's position regarding the proper treatment of PBM spread and similarly positioned ancillary provider costs during the prior years, as set forth above. Anthem would be happy to discuss this matter with you further. Anthem is confident, however, that after you review and fully consider Anthem's position, you will agree that the retroactive expense reclassification proposed by M&S is not required by state or federal law, would be contrary to the parties' mutual understanding and course of conduct, and would be inconsistent with the terms of the parties' VA MCO Contracts.

Sincerely,

/Lawrence S. Sher

Lawrence S. Sher

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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December 15, 2022

Christine Jordan, Director, VA Medicaid Finance
Anthem Healthkeepers Plus

Dear Christine,

Re: Treatment of PBM Spread in Calculating MLR

This notification is in response to Anthem's request that the Department of Medical Assistance Services (DMAS) refrain from making a final determination on the inclusion of spread-pricing within Pharmacy Benefit Manager (PBM) contracts within the Medical-Loss Ratio (MLR) calculation. This calculation is specific to Medallion 3 and FAMIS contract year dates from July 1, 2017, through November 30, 2018, and CCC Plus contract year beginning January 1, 2018, through December 31, 2018.
DMAS has reviewed the relevant contracts for the plans, the draft MLR calculations, audit reports prepared by Myers & Stauffer, relevant federal guidance issued by the Centers for Medicare & Medicaid Services (CMS), and the letter prepared by Reed Smith LLP dated October 16, 2020, on behalf of Anthem. The following points were considered in our review:

1. Section 12.11 of the Medallion 3 and FAMIS contracts specify that the Contractor shall be subject to a minimum MLR of eighty-five percent (85%) and that such MLR is required to be reported annually based on 42 CFR § 438.8, including any credibility adjustment.

2. Section 19.7 of the CCC Plus contract specifies that the Contractor shall be subject to a minimum MLR of eighty-five percent (85%) and that such MLR is required to be reported annually based on 42 CFR § 438.8, including any credibility adjustment.

3. Medallion 3 and FAMIS plans were required to report the contract year 2018 MLR amounts to DMAS by October 31, 2019.

4. CMS issued technical guidance CCIIO 2011-004, dated July 18, 2011, regarding the Medical Loss Ratio Interim Final Rule. Question 19 – ""*How should an issuer report amounts paid to third party vendors who pay others to provide clinical services to enrollees and who perform network development, administrative functions, claims processing, and utilization management?*" [states] "In general, 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." Further, the answer also states, "For example, when a pharmacy benefit manager (PBM) pays a retail pharmacy one amount for prescription drugs covered by the plan and charges the issuer a higher amount (the retail spread), the issuer may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims."

5. On May 6, 2016, the Medicaid Managed Care Final Rule was published in the federal register. On page 27522, CMS explains that under 42 C.F.R. § 438.8(e)(2)(v), incurred claims included in the numerator of the MLR must exclude non-claim costs such as amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management. The Medicaid Managed Care Final Rule MLR reporting requirement was effective beginning July 1, 2017, for Medallion 3, beginning July 1, 2018, for FAMIS, and beginning January 1, 2018, for CCC Plus.

6. On May 15, 2019, CMS issued an Informational Bulletin on the subject of Medical Loss Ratio Requirements Related to Third Party Vendors. The informational bulletin states that "In general, Medicaid requirements for managed care plans to account for expenditures by third-party vendors under subcontract follow the approach used to account for third-party expenditures in the MLR calculations for health insurance issuers subject to the requirements in 45 CFR Part 158." The statement references the answer to Question #19 in the CCIIO Technical Guidance CCIIO 2011 – 004 thereby requiring Medicaid Managed Care Plans to exclude PBM spread pricing from incurred claims for purposes of reporting.

Based on the above review and findings, spread pricing is not an incurred claim in calculating the MLR and any remittance due must reflect that determination. DMAS has concluded that the MSLC audit findings for PBM spread pricing costs included in the MLR audit results are valid for both Medallion 3 and CCC Plus contract years. Therefore, Anthem is required to remit to DMAS $8,713,396 as an MLR refund for the above-mentioned Medallion 3 contract year. Because the Medicaid Managed Care Final Rule did not apply to FAMIS for the 2018 contract year, we will contact MSLC instructing them to revise the FAMIS audit report to exclude the spread pricing

adjustment. Therefore, Anthem is only required to remit $4,065,170 as a refund for the 2018 FAMIS contract year.

Sincerely,

Timothy Merciez

T. Nicholas Merciez
Manager Provider Reimbursement

CC:
Chris Gordon
Jennie Reynolds
Usha Koduru