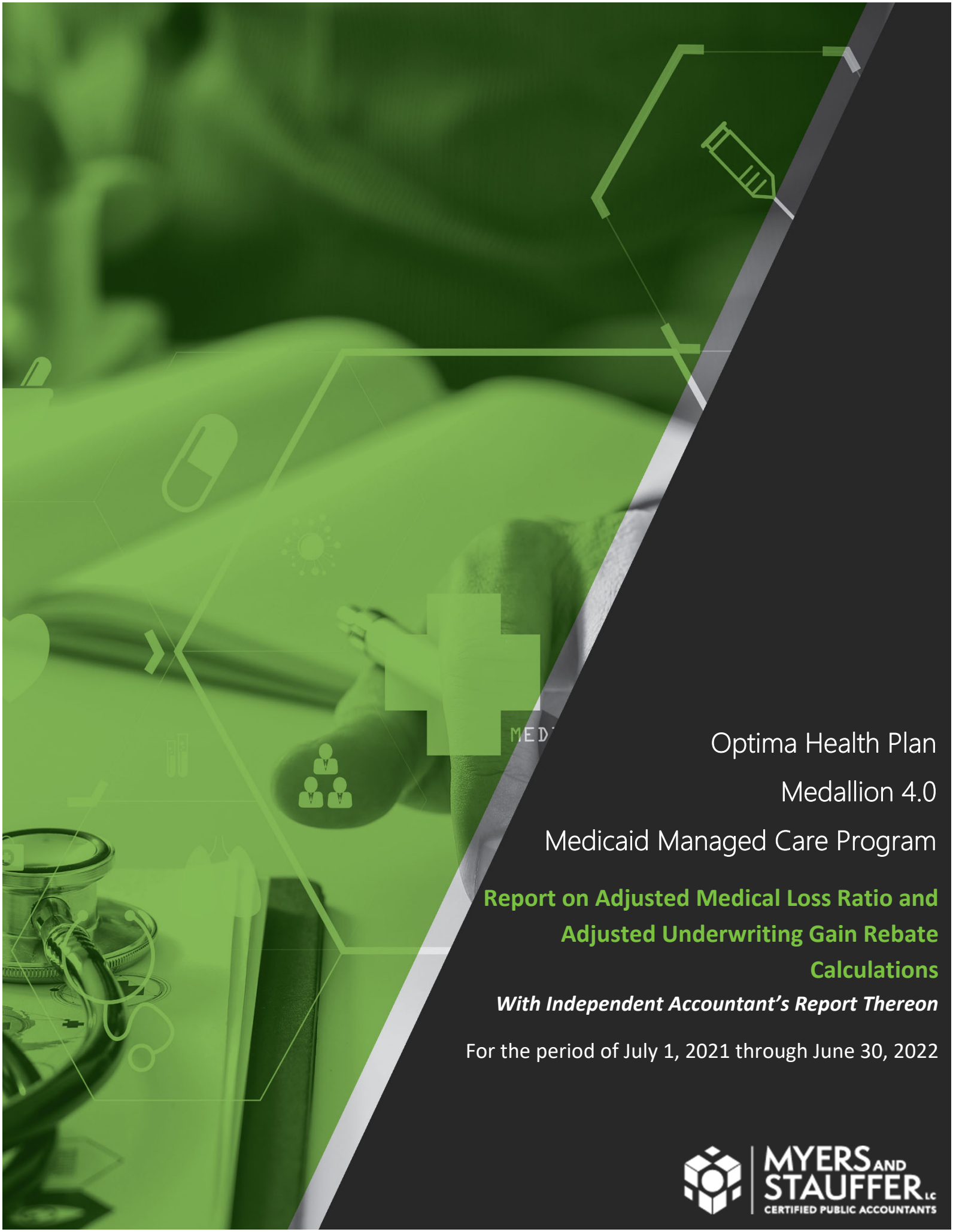

Optima Health Plan

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, 2021 through June 30, 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Virginia Department of Medical Assistance Services
Richmond, Virginia

Independent Accountant's Report

We have examined the Medical Loss Ratio Report and Adjusted Underwriting Gain Rebate Calculations of Optima Health Plan (health plan) related to the Medallion 4.0 program for the period of July 1, 2021 through June 30, 2022. The health plan's management is responsible for presenting information contained in the Medical Loss Ratio Report in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance (federal criteria). They are also responsible for presenting information contained in the Underwriting Gain Rebate Calculation in accordance with this federal criteria as well as the Medallion 4.0 contract (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 from information contained in the Medical Loss Ratio Report 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, 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, 2021 through June 30, 2022. 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 the health plan 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
September 9, 2024

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 713,485,837	$ (8,060,239)	$ 705,425,598
1.2	Activities that Improve Health Care Quality	$ 13,346,762	$ (2,149,982)	$ 11,196,780
1.3	MLR Numerator	$ 726,832,599	$ (10,210,221)	$ 716,622,378
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 839,657,646	$ 6,173,886	$ 845,831,532
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 235,977	$ -	$ 235,977
2.3	MLR Denominator	$ 839,421,669	$ 6,173,886	$ 845,595,555
3.	**MLR Calculation**			
3.1	Member Months	2,354,624	0	2,354,624
3.2	Unadjusted MLR	86.6%		84.7%
3.3	Credibility Adjustment	0.0%		0.0%
3.4	Adjusted MLR	86.6%		84.7%
4.	**Remittance**			
4.2	State Minimum MLR Requirement	85.0%		85.0%
4.3	Remittance Calculation	$ -		$ 2,536,787

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 660,318,145	$ (2,850,083)	$ 657,468,062
1.2	Activities that Improve Health Care Quality	$ 11,257,024	$ (1,813,353)	$ 9,443,671
1.3	MLR Numerator	$ 671,575,169	$ (4,663,436)	$ 666,911,733
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 733,238,542	$ (4,784,757)	$ 728,453,785
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 199,523	$ -	$ 199,523
2.3	MLR Denominator	$ 733,039,019	$ (4,784,757)	$ 728,254,262
3.	**MLR Calculation**			
3.1	Member Months	1,132,963	0	1,132,963
3.2	Unadjusted MLR	91.6%		91.6%
3.3	Credibility Adjustment	0.0%		0.0%
3.4	Adjusted MLR	91.6%		91.6%
4.	**Remittance**			
4.2	State Minimum MLR Requirement	85.0%		85.0%
4.3	Remittance Calculation	$ -		$ -

Adjusted Underwriting Gain for the State Fiscal Year Ended June 30, 2022

Adjusted Underwriting Gain for the State Fiscal Year Ended June 30, 2022				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Denominator**			
1.1	Premium Revenue	$ 839,657,646	$ 6,173,886	$ 845,831,532
1.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 235,977	$ -	$ 235,977
1.3	**Underwriting Gain Denominator**	$ 839,421,669	$ 6,173,886	$ 845,595,555
2.	**Medical Expenses**			
2.1	Incurred Claims	$ 713,485,837	$ (8,060,239)	$ 705,425,598
2.2	Improving health care quality expenses	$ 13,346,762	$ (2,149,982)	$ 11,196,780
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	$ 726,832,599	$ (10,210,221)	$ 716,622,378
3.	**Non Claims Cost**			
3.1	Administrative Expenses	$ 44,058,632	$ 8,198,720	$ 52,257,352
3.2	Less: Unallowable Expenses	$ (1,618,227)	$ (1,148,363)	$ (2,766,590)
3.3	**Allowable Administrative Expenses**	$ 42,440,405	$ 7,050,357	$ 49,490,762
4.	**Underwriting Gain**			
4.1	Underwriting Gain $	$ 70,148,666		$ 79,482,415
4.1	Less: Remittance Amount Due to State for Coverage Year	$ -		$ (2,536,787)
4.2	Adjusted Underwriting Gain $	$ 70,148,666		$ 76,945,628
4.3	**Underwriting Gain %**	8.4%		9.1%
5.	**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%		3.0%
5.4	**Amount to Remit**	$ 22,483,008		$ 25,788,881

Schedule of Adjustments and Comments for the Period Ending June 30, 2022

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 incurred claims expense to agree to supported and allowable amounts.

The reported incurred claims expense of $707,274,544 was adjusted to agree to the supported amount of $704,191,259. An adjustment has been proposed for the difference of ($3,083,285). The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($3,083,285)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($3,085,285)

Non-Expansion Adjustment #2 – To adjust to reclassify MultiPlan vendor expenses that do not meet the definition of incurred claims.

The health plan reported expenses for payments made to MultiPlan in the amount of $507,294 and identified these payments were for claims repricing and provider network access. An adjustment was proposed to remove this expense as it does not meet the definition of incurred claims. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($507,294)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($507,294)
3.1	Administrative Expenses	$507,294

Non-Expansion Adjustment #3 – To adjust to reclassify payments made to Sentara Behavioral Health Services, the behavioral health vendor, in excess of claims expense to administrative expense.

The health plan reported claims expense for behavioral health services arranged by Sentara Behavioral Health Services. During the examination, it was determined that the reported claims expense was greater than the actual claims incurred and paid by Sentara Behavioral Health Services. An adjustment was proposed to agree the reported behavioral health expense to incurred claims expense reported by Sentara Behavioral Health. The incurred claims and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and in CMS Publication 15-1, Chapter 10.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($2,480,143)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($2,480,143)
3.1	Administrative Expenses	$2,480,143

Non-Expansion Adjustment #4 – To adjust to reverse the health plan's reclassification of capitated payments made to Southeastrans, the transportation vendor, to agree to claims expense incurred by the vendor.

The health plan reported a per-member-per-month (PMPM) capitation expense for transportation services arranged by Southeastrans and reclassified a portion to administrative expense. During the examination, it was determined that this capitation expense was less than the actual claims incurred and paid by Southeastrans. An adjustment was proposed to agree to the trial balance amount, or the total payments incurred related to Southeastrans. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$1,620,151

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	$1,620,151
3.1	Administrative Expenses	($1,620,151)

Non-Expansion Adjustment #5– To adjust to remove claims payments made to DentaQuest, the dental vendor, as dental services have been carved out of managed care beginning 7/1/2021.

The health plan reported claims expense for Dataquest, the dental vendor. Dental services have been carved out of Medicaid managed care effective July 1, 2021. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($155,985)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($155,985)

Non-Expansion Adjustment #6 – To adjust to reclassify Performance Management Bonus (PMB) payments that do not meet the definition of incurred claims.

The health plan reported PMB payments in the amount of $5,032,089 and identified these payments were provider incentive payments for keeping an open panel for Medicaid members. It was determined, based on the provider contract arrangements, the payments were not based on clinical or quality metrics. An adjustment was proposed to remove the non-qualifying provider incentive payments per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140(b)(2)(iii).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($5,032,089)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($5,032,089)
3.1	Administrative Expenses	$5,032,089

Non-Expansion Adjustment #7 – To adjust to offset rebates and other payments, fees, and adjustments reported by Optum Rx, Inc., the Pharmacy Benefit Manager (PBM), against incurred claims expense.

The health plan reported pharmacy rebates received from Optum Rx, their PBM, as an offset to incurred claims expense. During the examination, it was determined that rebates received by Optum Rx were greater than the amount reported by the health plan. Optum Rx also identified other payments, fees, and adjustments that should be offset against incurred claims expense. An adjustment was proposed to agree rebates to the amount confirmed by the PBM and to offset additional other payments, fees, and adjustments identified by the PBM. The pharmacy rebate and fees reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and in the Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($204,465)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($204,465)

Non-Expansion Adjustment #8 – To reclassify non-allowable Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) expenses.

The health plan reported HCQI and HIT expenses based on departments they determined to be HCQI and/or HIT related. During the examination, it was noted that several job descriptions had non qualifying characteristics that did not meet the definitions of HCQI or HIT. An adjustment was proposed to reclassify these non-qualifying HCQI and HIT expenses from HCQI to administrative expenses. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	($2,149,982)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Activities that Improve Health Care Quality	($2,149,982)
3.1	Administrative Expenses	$2,149,982

Non-Expansion Adjustment #9 – To adjust to reclassify fraud reduction expense, erroneously excluded by the plan.

The health plan failed to report fraud reduction expense in the amount of $350,637 in incurred claims. These expenses were confirmed to be less than fraud recoveries of $4,730,965. An adjustment was proposed to include the lesser amount of fraud reduction expenses in incurred claims. The fraud reduction expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(iii)(B).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$350,637

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	$350,637
3.1	Administrative Expenses	($350,637)

Non-Expansion Adjustment #10 – To adjust state directed payments and associated expense per 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 state directed payment and associated expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2) and 438.6(c).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$1,432,234
2.1	Premium Revenue	$1,432,234

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Premium Revenue	$1,432,234
2.1	Incurred Claims	$1,432,234

Non-Expansion Adjustment #11 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, pharmacy reinsurance recoupments, performance withhold program payments, and clinical efficacy payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$4,741,652

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Premium Revenue	$4,741,652

Non-Expansion Adjustment #12 – To adjust administrative expense to apply adjustments identified during the 2021 and 2022 administrative cost procedures.

Adjustments are applied to administrative costs through a separate engagement. The health plan included contributions and donations costs, marketing and advertising costs, lobbying expenses, late fees, and bad debt expense in administrative expenses. They also failed to remove start-up costs related to Medicaid programs and initiatives and include the related amortization. An adjustment was proposed to remove these unallowable expenses. Administrative cost principles are addressed in 45 CFR §§ 75.420 through 75.477 and CMS Publication 15-1, Chapters 10 and 21.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expense	($1,148,363)

Expansion Adjustment #1 – To adjust incurred claims expense to agree to supported and allowable amounts.

The reported incurred claims expense of $655,999,353 was adjusted to agree to the supported amount of $653,829,022. An adjustment has been proposed for the difference of ($2,170,330). The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($2,170,330)

Expansion Adjustment #2 – To adjust to reclassify payments made to Sentara Behavioral Health Services, the behavioral health vendor, in excess of claims expense to administrative expense.

The health plan reported claims expense for behavioral health services arranged by Sentara Behavioral Health Services. During the examination, it was determined that the reported claims expense was greater than the actual claims incurred and paid by Sentara Behavioral Health Services. An adjustment was proposed to agree the reported behavioral health expense to incurred claims expense reported by Sentara Behavioral Health. The incurred claims and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and in CMS Publication 15-1, Chapter 10.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($1,193,358)

Expansion Adjustment #3 – To adjust to reverse the health plan's reclassification of capitated payments made to Southeastrans, the transportation vendor, to agree to claims expense incurred by the vendor.

The health plan reported a per-member-per-month (PMPM) capitation expense for transportation services arranged by Southeastrans and reclassified a portion to administrative expense. During the examination, it was determined that this capitation expense was less than the actual claims incurred and paid by Southeastrans. An adjustment was proposed to agree to the trial balance amount, or the total

payments incurred related to Southeastrans. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$1,218,599

Expansion Adjustment #3– To adjust to reclassify Performance Management Bonus (PMB) payments that do not meet the definition of incurred claims.

The health plan reported PMB payments in the amount of $4,254,726 and identified these payments were provider incentive payments for keeping an open panel for Medicaid members. It was determined, based on the provider contract arrangements, the payments were not based on clinical or quality metrics. An adjustment was proposed to remove the non-qualifying provider incentive payments per health plan supporting documentation. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140(b)(2)(iii).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($4,254,726)

Expansion Adjustment #4 – To reclassify non-allowable Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) expenses.

The health plan reported HCQI and HIT expenses based on departments they determined to be HCQI and/or HIT related. During the examination, it was noted that several job descriptions had non qualifying characteristics that did not meet the definitions of HCQI or HIT. An adjustment was proposed to reclassify these non-qualifying HCQI and HIT expenses from HCQI to administrative expenses. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	(1,813,353)

Expansion Adjustment #5 – To adjust state directed payments and the associated expense per 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 state directed payment and associated expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2) and 438.6(c).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$3,549,732
2.1	Premium Revenue	$3,549,732

Expansion Adjustment #6 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, pharmacy reinsurance recoupments, performance withhold program payments, clinical efficacy payments, and risk corridor recoupments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	($8,334,489)