Virginia Premier Health Plan, Inc.

Commonwealth Coordinated Care Plus Medicaid Managed Care Program

Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations

With Independent Accountant's Report Thereon

For the period of July 1, 2021 through June 30, 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Virginia Department of Medical Assistance Services
Richmond, Virginia

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations of Virginia Premier Health Plan, Inc. (health plan) related to the Commonwealth Coordinated Care Plus Program (CCC Plus) 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 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 CCC Plus 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 modified opinion.

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.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

In our opinion, except for the effect of the item addressed in the Schedule of Reporting Caveats, 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, 2021 through June 30, 2022. Related to non-expansion, the Adjusted Medical Loss Ratio (MLR) Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Adjusted

Underwriting Gain Percentage Achieved exceeds the maximum requirement of three percent (3%). In accordance with contractual obligations, an Underwriting Gain remittance amount is due to the Department of Medical Assistance Services. Related to expansion, the Adjusted MLR Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Underwriting Gain is not applicable per contractual requirements.

This report is intended solely for the information and use of the Virginia Department of Medical Assistance Services and 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	$ 976,807,565	$ (7,662,480)	$ 969,145,085
1.2	Activities that Improve Health Care Quality	$ 23,968,144	$ (1,571,607)	$ 22,396,537
1.3	MLR Numerator	$ 1,000,775,709	$ (9,234,087)	$ 991,541,622
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 1,137,101,327	$ 6,348,588	$ 1,143,449,915
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ -	$ -	$ -
2.3	MLR Denominator	$ 1,137,101,327	$ 6,348,588	$ 1,143,449,915
3.	**MLR Calculation**			
3.1	Member Months	500,487	0	500,487
3.2	Unadjusted MLR	88.0%		86.7%
3.3	Credibility Adjustment	0.0%		0.0%
3.4	Adjusted MLR	88.0%		86.7%
4.	**Remittance**			
4.2	State Minimum MLR Requirement	85.0%		85.0%
4.3	Remittance Calculation	$ -		$ -

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	$ 206,962,850	$ 1,297,081	$ 208,259,931
1.2	Activities that Improve Health Care Quality	$ 5,662,964	$ -	$ 5,662,964
1.3	MLR Numerator	$ 212,625,814	$ 1,297,081	$ 213,922,895
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 221,577,064	$ (5,777,522)	$ 215,799,542
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ -	$ -	$ -
2.3	MLR Denominator	$ 221,577,064	$ (5,777,522)	$ 215,799,542
3.	**MLR Calculation**			
3.1	Member Months	93,263	0	93,263
3.2	Unadjusted MLR	96.0%		99.1%
3.3	Credibility Adjustment	2.1%		2.1%
3.4	Adjusted MLR	98.1%		101.2%
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	$ 1,137,101,327	$ 6,348,588	$ 1,143,449,915
1.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ -	$ -	$ -
1.3	**Underwriting Gain Denominator**	$ 1,137,101,327	$ 6,348,588	$ 1,143,449,915
2.	**Medical Expenses**			
2.1	Incurred Claims	$ 976,807,565	$ (7,662,480)	$ 969,145,085
2.2	Improving health care quality expenses	$ 23,968,144	$ (1,571,607)	$ 22,396,537
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	$ 1,000,775,709	$ (9,234,087)	$ 991,541,622
3.	**Non Claims Cost**			
3.1	Administrative Expenses	$ 58,640,533	$ 2,170,176	$ 60,810,709
3.2	Less: Unallowable Expenses	$ (3,128,193)	$ (252,947)	$ (3,381,140)
3.3	**Allowable Administrative Expenses**	$ 55,512,340	$ 1,917,229	$ 57,429,569
4.	**Underwriting Gain**			
4.1	Underwriting Gain $	$ 80,813,278		$ 94,478,724
4.1	Less: Remittance Amount Due to State for Coverage Year	$ -		$ -
4.2	Adjusted Underwriting Gain $	$ 80,813,278		$ 94,478,724
4.3	**Underwriting Gain %**	7.1%		8.3%
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	2.1%		2.6%
5.4	**Amount to Remit**	$ 23,350,119		$ 30,087,613

Schedule of Reporting Caveats

During our examination, the following reporting issues were identified.

Caveat #1 – Pharmacy Expense

Pharmacy expenses reported in incurred claims by the health plan are arranged by Elixir Rx, the Pharmacy Benefit Manager (PBM). The majority share of Elixir Rx was acquired by MedImpact Healthcare Systems, Inc. February 1, 2024 and the remaining entity filed for bankruptcy. The contract between Elixir Rx and the health plan was part of the bankruptcy proceedings. The PBM advised that any remaining requests for supporting documentation would need to go through bankruptcy proceedings. The PBM did not provide adequate supporting documentation for the pharmacy expenses, net of rebates, reported in incurred claims. These expenses totaled to $137,746,322 for Non-Expansion and $42,669,686 for Expansion and are included in incurred claims in the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations.

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 to remove a duplicated expense related to Consumer Directed Care Network (CDCN), the consumer directed services payroll vendor.

The health plan reported claims expense for CDCN, the consumer directed services payroll vendor. Per supporting documentation provided by the plan this expense included a payment that was counted twice. An adjustment was proposed to remove the duplicated payment. 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	($4,405,714)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($4,405,714)

Non-Expansion Adjustment #2 – To adjust to agree claims expense related to Verida, Inc., the transportation vendor, to claims payments made by the vendor.

The health plan reported a per-member-per-month (PMPM) capitation expense for transportation services arranged by Verida, Inc. They made a reclassification in the amount of $5,619,979 from Incurred Claims expense to Administrative Expense. During the examination, it was determined that the net amount of capitation expense and the health plan's reclassification was less than the actual claims incurred and paid by Verida, Inc. An adjustment was proposed to increase transportation expense to agree to incurred claims expense reported by Verida, Inc. 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	$2,214,697

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	$2,214,697
3.1	Administrative Expenses	($2,214,697)

Non-Expansion Adjustment #3 – To adjust to agree payments made to CDCN, the consumer directed services payroll vendor, to payroll related expenses incurred by the vendor.

The health plan reported claims expense for CDCN, the consumer directed services payroll vendor. During the examination, it was determined that the payroll expense was overstated in comparison to vendor payroll and tax expense. An adjustment was proposed to agree the reported expense to actual claims cost utilizing supporting documentation. 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	($659,562)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Incurred Claims	($659,562)
3.1	Administrative Expenses	$659,562

Non-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	($1,571,607)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Activities that Improve Health Care	($1,571,607)
3.1	Administrative Expenses	$1,571,607

Non-Expansion Adjustment #5 – 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	($4,811,901)
2.1	Premium Revenue	($4,811,901)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Premium Revenue	($4,811,901)
2.1	Incurred Claims	($4,811,901)

Non-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, 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	$11,160,489

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Premium Revenue	$11,160,489

Non-Expansion Adjustment #7 – 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 marketing/advertising, contributions/donations, lobbying, bad debt, and unallowable employee events, meals, and entertainment expenses 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 Expenses	($252,947)

Non-Expansion Adjustment #8 – To adjust administrative expense to correct the split of administrative fees between Non-Expansion and Expansion.

Reported administrative costs were incorrectly separated between Non-Expansion and Expansion resulting in CCC Plus Non-Expansion administrative costs being understated. This was identified during 2022 administrative cost procedures. An adjustment was proposed to agree Non-Expansion administrative expenses to supporting documentation. 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**
3.1	Administrative Expenses	$2,153,704

Expansion Adjustment #1 – To adjust to remove a duplicated expense related to Consumer Directed Care Network (CDCN), the consumer directed services payroll vendor.

The health plan reported claims expense for CDCN, the consumer directed services payroll vendor. Per supporting documentation provided by the plan this expense included a payment that was counted twice. An adjustment was proposed to remove the duplicated payment. 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	($843,675)

Expansion Adjustment #2 – 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	$2,140,756
2.1	Premium Revenue	$2,140,756

Expansion Adjustment #3 – To adjust revenues to agree with state data.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, 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	($7,918,278)