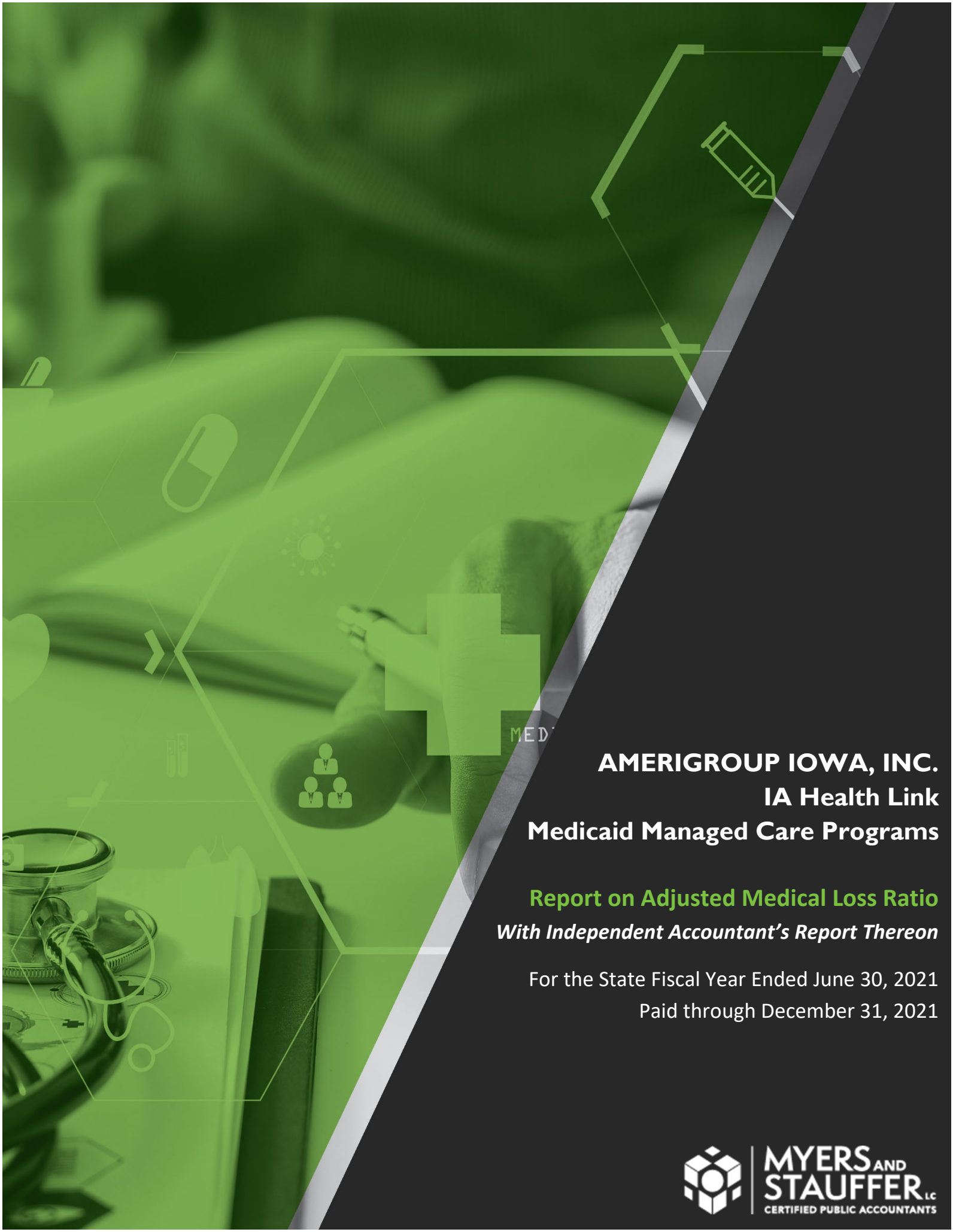

AMERIGROUP IOWA, INC.
IA Health Link
Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2021

Paid through December 31, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State of Iowa
Department of Human Services, Iowa Medicaid
Des Moines, Iowa

Independent Accountant's Report

We have examined the Medical Loss Ratio Calculation of Amerigroup Iowa, Inc. (health plan) for the state fiscal year ended June 30, 2021. The health plan's management is responsible for presenting information contained in the Medical Loss Ratio Calculation in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio 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 is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. 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, 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 relating to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio Calculation 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 Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio exceeds the state requirement of eighty-nine percent (89%) for the state fiscal year ended June 30, 2021.

This report is intended solely for the information and use of the Iowa Medicaid, CBIZ Optumas, 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
Kansas City, Missouri
May 30, 2023

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2021 Paid Through December 31, 2021

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2021 Paid Through December 31, 2021				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Numerator				
1	Adjusted Incurred Claims	$ 2,863,827,645	$ 63,556,933	$ 2,927,384,578
2	Health Care Quality Improvement Expenses	$ 55,437,364	$ (7,663,615)	$ 47,773,749
3	Total Adjusted MLR Numerator	$ 2,919,265,009	$ 55,893,318	$ 2,975,158,327
Denominator				
4	Premium and Other Revenue	$ 3,236,265,661	$ 120,091,973	$ 3,356,357,634
5	Taxes and Fees	$ 89,453,190	$ (27,358,750)	$ 62,094,440
6	Total Adjusted MLR Denominator	$ 3,146,812,471	$ 147,450,723	$ 3,294,263,194
MLR Calculation				
7	MLR Percentage Achieved	92.77%	-2.5%	90.3%
8	Credibility Adjustment	0.00%	0.0%	0.0%
9	Adjusted MLR Percentage Achieved	92.77%	-2.5%	90.3%
Remittance Calculation				
10	MLR Requirement	89.00%		89.0%
11	Percentage Below Requirement	0.00%	0.0%	0.0%
12	Dollar Amount of Remittance Requirement	$ -	$ -	$ -
Member Months				
13	Member Months	5,094,377	2,484	5,096,861
Informational Only*				
14	Other Non-Claims Costs	$ 283,436	$ 19,836,558	$ 20,119,994

**The Non-Claims Costs line has not be subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. This includes adjustments identified during the course of the examination directly affecting the Non-Claims Costs line. Accordingly, we express no opinion on the Non-Claims Costs line.*

Schedule of Adjustments and Comments for the State Fiscal Year Ended June 30, 2021

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust related party expense to supporting documentation

The health plan reported medical services for a related party capitated provider, CareMore, based on a per-member per-month (PMPM) arrangement. After testing of the submitted documentation for the actual cost of the services performed, it was determined the health plan overstated the total medical cost. Additionally, the health plan did not report the health care quality improvements (HCQI) and non-claims costs portion of the expenses. An adjustment was proposed to decrease the reported medical expenses based on the actual cost incurred and increase HCQI expenses and non-claims costs. The related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), 438.8(e)(3), and CMS Publication 15-1, Chapter 10.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	($880,991)
2	Health Care Quality Improvement Expenses	$335,693
14	Other Non-Claims Costs	$2,756,296

Adjustment #2 – To adjust provider incentives payments per supporting documentation

The health plan reported provider incentive payments for the Medical Loss Ratio (MLR) reporting period. Supporting documentation demonstrated amounts reported within the MLR were overstated, attributed primarily to over capturing estimated amounts to be paid that were ultimately not earned and paid out to the providers for the MLR reporting period. Additionally, provider settlements unknown at the time of filling became known during the examination and were determined to be related to the MLR reporting period. An adjustment was proposed to decrease provider incentives payments per supporting documentation. The medical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	($1,209,326)

Adjustment #3 – To reclassify provider incentives to HCQI expenses

The health plan reported provider incentive payments related to care coordination services that qualify as HCQI expenses. A provider incentive arrangement was based on a quality metric and if not achieved 50% of the care coordination PMPM amount would be recouped. The quality metric was achieved related to the MLR reporting period. Therefore, 50% of the PMPM earned will remain classified as provider incentive payments. An adjustment was proposed to reclassify the other 50% of the PMPM to HCQI expenses. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	($5,539,755)
2	Health Care Quality Improvement Expenses	$5,539,755

Adjustment #4 – To adjust third party vision vendor expenses

The health plan reported vision services of a third party vendor, Superior Vision, based on a PMPM arrangement. A certification statement was submitted from the vendor for actual claim payments incurred for services performed for the MLR reporting period. An adjustment was proposed to remove the administrative component of the PMPM amount from incurred claims cost and reclassify it to non-claims costs. The third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	($1,912,824)
14	Other Non-Claims Costs	$1,912,824

Adjustment #5 – To adjust incurred claims expense to estimated final net payments to pharmacies

The health plan reported pharmacy incurred claims expense based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims expense was overstated due to excluding the transaction fees assessed to the pharmacies by the pharmacy benefit manager (PBM), within incurred claims expense to reflect the final paid to the pharmacy. Documentation to support the total amount of transaction fees was ultimately submitted but not at a level of detail to perform any verification of the information. Therefore, an estimate of the fee was calculation based on claims sample testing. An adjustment was proposed to reduce incurred claims

expense for the estimated transaction fees assessed to pharmacies. The third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	($2,414,534)
14	Other Non-Claims Costs	$2,414,534

Adjustment #6 – To adjust pharmacy rebates

The health plan reported prescription drug rebates received and accrued. It was determined the amount reported was understated based on support provided by the PBM and health plan. An adjustment was proposed to increase the prescription drug rebates based on supporting documentation. Pharmacy rebates are a reduction to incurred claims cost, therefore the increase in rebates is shown as a negative adjustment. The reporting requirement for prescription drug rebates received and accrued is addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(ii)(B) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	($76,343)

Adjustment #7 – To remove non-qualifying HCQI and EQR expense

The health plan reported HCQI expenses based on salaries and benefits, as well as overhead costs. It was determined the health plan included non-qualifying expenses based on federal guidance. Additionally, the health plan reported external quality review (EQR) expenses that did not reconcile to supporting documentation. An adjustment was proposed to remove non-qualifying salaries, benefits, and overhead and reclassify the expense to non-claims costs, and adjust EQR expenses to supporting documentation. The HCQI and EQR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2	Health Care Quality Improvement Expenses	($13,539,063)
14	Other Non-Claims Costs	$12,752,903

Adjustment #8 – To include expanded home delivered meals for members per supporting documentation

Based on state guidance, for the duration of the period in which Iowa's COVID-19 Emergency Waivers approved by CMS were in place, an expanded home delivered meals benefit was a covered service. During the reconciliation process of supporting documentation to the MLR Calculation, the health plan identified expenses for this program that were not reported. Additionally, there were a small amount of provider settlements not accounted for in the reported amount, as well as a slight overstatement of the estimated incurred but not reported (IBNR) amount. An adjustment was proposed to include expenses associated with the expanded home delivered meals to members, provider settlements, and IBNR variance. The medical expense reporting requirement are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Adjusted Incurred Claims	$2,498,257

Adjustment #9 – To adjust income taxes per supporting documentation and remove state corporate income tax

The health plan reported income taxes that did not reconcile to the supporting documentation. It was determined the health plan appropriately removed taxes for investment income and factored in the change in deferred tax assets noted in the audited financial statements. However, the health plan inappropriately added back the tax effect of the accrued risk corridor. Additionally, the health plan reported state corporate income tax expense of $19,758,677. Based on Iowa Administrative Code Chapter 422 Section 34, health plans are exempt from corporate taxation. Given the health plan was not subject to this taxation, the reported expense does not qualify as an allowable tax for MLR purposes. Iowa Medicaid intends to coordinate with the Iowa Department of Revenue regarding any applicable refunds. An adjustment was proposed to decrease taxes to the appropriate amounts per the supporting documentation and remove state corporate income taxes. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and Centers for Medicare & Medicaid Services Medical Loss Ratio Annual Reporting Form Filing Instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
5	Taxes and Fees	($24,585,460)

Adjustment #10 – To adjust revenues per state data

The health plan reported revenue amounts that did not reflect payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the revenues per state data for capitation payments, maternity payments, and withhold payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR Calculation based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Premium and Other Revenue	$57,923,619

Adjustment #11 – To adjust premium revenues and incurred claims to incorporate approved directed payment programs

The MLR Calculation did not reflect directed payments in the numerator nor the denominator of the calculation. It was determined the University of Iowa Hospitals and Clinics Physician Average Commercial Rate (UIHC ACR), Nursing Facility Covid Relief Rate (NF CRR), and Ground Emergency Medical Transportation (GEMT) payments are approved under 42 CFR § 438.6(c); and therefore should be included in the MLR calculation.

UIHC ACR Program

The following outlines the UIHC ACR directed payment revenue and expenses per state date. A reconciliation for the UIHC ACR directed payment was contractually in effect January 1, 2021 through June 30, 2021 of the MLR reporting period. The reconciliation calculation occurred subsequent to the filing of the MLR Calculation and was not reported by the health plan. A revenue adjustment was proposed to report the UIHC revenue, including the reconciliation settlement, per state data. An incurred claims adjustment was proposed to include the UIHC directed payment expense, per state data net of the amount misclassified as claims expense rather than directed payment expense in the reported health plan data.

UIHC ACR	
Description	**Amount**
Revenue - State Data	$57,197,145
Reconciliation Settlement	($3,446,836)
Total Directed Payment Revenue	$53,750,309
Total Directed Payment Expense	$44,173,911
Reclassification from Claims Expense	($933,264)
Incurred Claims Adjustment	$43,240,647

NR CCR Program

The following outlines the NF CRR directed payment revenue and expenses per state data. A risk corridor for the NF CRR was contractually in effect for the MLR reporting period. The risk corridor calculation occurred subsequent to the filing of the MLR Calculation and was not reported by the health plan. A revenue adjustment was proposed to report NF CRR revenue, including the risk corridor settlement, per state data. An incurred claims adjustment was proposed to include the NF CRR directed payment expense, per state data including the amount misclassified as directed payment expense rather than claims expense in the reported health plan data.

NF CRR	
Description	**Amount**
Revenue - State Data	$277,549
Risk Corridor Settlement	$589,674
Total Directed Payment Revenue	$867,223
Total Directed Payment Expense	$2,513,100
Reclassification to Claims Expense	$300,830
Incurred Claims Adjustment	$2,813,930

GEMT Program

An adjustment was proposed to report the GEMT revenue per state data and GEMT expense per health plan data.

GEMT	
Description	**Amount**
Total Directed Payment Revenue	$16,211,063
Total Directed Payment Expense	$12,415,985

Premium revenue and incurred claims were summarized and adjusted based on the above. Directed payments and associated expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and § 438.6(c). The health plan completed the MLR Calculation based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Premium and Other Revenue	$70,828,595
1	Adjusted Incurred Claims	$58,470,562

Adjustment #12 – To adjust HIF revenue and expenses per state data

The Health Insurer Fee (HIF) revenue and expenses reported by the health plan did not agree with the state data for the MLR reporting period. An adjustment was proposed to reflect HIF revenues and expenses per state data. The revenue and taxes and fees reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2), § 438.8(f)(3), and the CMS Health Insurance Providers Fee for Medicaid Managed Care Plans FAQ dated October 2014.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Premium and Other Revenue	$1,191,763
5	Taxes and Fees	($2,773,290)

Adjustment #13 – To include GME revenue and expenses per state data

The MLR Calculation did not reflect graduate medical education (GME) in the numerator nor the denominator of the calculation. GME payments are not considered pass-through payments and therefore should be included in the MLR calculation. An adjustment was proposed to reflect GME revenues and expenses per state data. The revenue and medical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and § 438.8(f)(2). The health plan completed the MLR Calculation based on the template instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Premium and Other Revenue	$14,621,888
1	Adjusted Incurred Claims	$14,621,888

Adjustment #14 – To adjust the risk corridor per state data

A risk corridor was contractually in effect for January 1, 2021 through June 30, 2021 of the MLR reporting period. The risk corridor calculation occurred subsequent to the filing of the MLR Calculation and was not reported by the health plan. All applicable MLR examination adjustments are reflected within the final risk corridor calculation. An adjustment was proposed to report the revenues per state data for the risk corridor recoupment. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Premium and Other Revenue	($24,473,892)

Adjustment #15 – To adjust member months per state data

The health plan reported member month amounts did not reflect the total member months per the state's data for its members applicable to the covered dates of service for the MLR reporting period. The health plan did not provide an explanation for this variance, therefore, the state data was utilized to adjust member months. The member month reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
13	Member Months	2,484