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, 2022

Paid through October 31, 2022

MYERS AND STAUFFER LC

CERTIFIED PUBLIC ACCOUNTANTS

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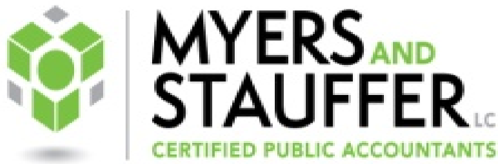

State of Iowa
Department of Health and Human Services, Iowa Medicaid
Des Moines, Iowa

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, 2022. 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 88 percent for the state fiscal year ended June 30, 2022.

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
Kansas City, Missouri
January 30, 2024

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through October 31, 2022

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through October 31, 2022				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 3,378,866,866	$ 128,144,737	$ 3,507,011,603
1.2	Activities that Improve Health Care Quality	$ 58,936,402	$ (21,627,792)	$ 37,308,610
1.3	**MLR Numerator**	$ 3,437,803,268	$ 106,516,945	$ 3,544,320,213
1.4	Non-Claims Costs (Not Included in Numerator)	$ 130,395,178	$ -	$ 130,395,178
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 3,713,498,814	$ 152,229,957	$ 3,865,728,771
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 43,208,080	$ (6,208,997)	$ 36,999,083
2.3	**MLR Denominator**	$ 3,670,290,734	$ 158,438,954	$ 3,828,729,688
3.	**MLR Calculation**			
3.1	Member Months	5,400,336	2,485	5,402,821
3.2	Unadjusted MLR	93.7%	-1.1%	92.6%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	93.7%	-1.1%	92.6%
4.	**Remittance**			
4.1	Contract Includes Remittance Requirement	No		No
4.2	State Minimum MLR Requirement	88.0%		88.0%

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. Adjustments identified during the course of the examination were not tested to determine any impact on Non-Claims Costs. Accordingly, we express no opinion on the Non-Claims Costs line.*

Schedule of Adjustments and Comments for the State Fiscal Year Ended June 30, 2022

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust incurred claims per health plan supporting documentation

The health plan reported paid claims based on the specified runout period, including estimated incurred but not reported (IBNR), for the medical loss ratio (MLR) reporting period. A comparison was performed between a revised paid lag table with additional runout through May of 2023 to the health plan's reported paid claims and IBNR estimate, which indicated the reported incurred claims, including IBNR, were understated. An adjustment was proposed to increase incurred claims per health plan supporting documentation. The incurred claims and IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	$5,288,747

Adjustment #2 – To adjust incurred claims per health plan supporting documentation

The health plan reported paid claims that did not reconcile to the original paid claims lag tables, as of the MLR Calculation specified runout period. An adjustment was proposed to reduce incurred claims based on health plan supporting documentation for the specified runout period. The incurred claims and IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	($510,960)

Adjustment #3 – To remove high-cost drugs carved-out of capitation rate development

The health plan included amounts related to the high-cost drug Zolgensma, which should be excluded from MLR reporting. Zolgensma is reimbursed separately to the health plan and not included in capitation rate development. An adjustment was proposed to remove the high-cost drug expense from

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

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($1,719,287)

Adjustment #4 – To adjust related party expense per health plan supporting documentation

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

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($521,714)
1.2	Activities that Improve Health Care Quality	$84,211

Adjustment #5 – To adjust vision vendor expenses

The health plan reported services for third party vendor, Superior Vision (vision). Superior Vision was reported 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 and profit components of the PMPM amount from incurred claims. The incurred claims and 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**
1.1	Incurred Claims	($2,979,894)

Adjustment #6 – To adjust transportation vendor expenses

The health plan reported services for third party vendor, Access2Care (transportation). Access2Care was reported based on a fee-for-service (FFS) arrangement. A certification statement was submitted from the vendor for actual claim payments incurred for services performed for the MLR reporting period, which did not reconcile to the reported amounts by the health plan. An adjustment was proposed to reduce the amounts paid based on the vendor certification statement. The incurred claims and 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**
1.1	Incurred Claims	($127,508)

Adjustment #7 – To adjust incurred claims expense to final net payments to pharmacies

The health plan reported pharmacy incurred claims expense for the third party vendor pharmacy benefit manager (PBM), CVS Health, 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 PBM. An adjustment was proposed to reduce incurred claims by the amount related to the transaction fees in order to reflect the final amount paid to the pharmacies. The incurred claims and 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**
1.1	Incurred Claims	($1,080,645)

Adjustment #8 – To adjust PBM vendor rate guarantee calculation per PBM supporting documentation

The health plan reported pharmacy incurred claims for the third party vendor PBM. It was determined contracted rate guarantee calculations were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact for the Medicaid line of business was a reduction in reimbursement to pharmacies. An adjustment was proposed to remove the Medicaid calculated amount for the MLR reporting period from incurred claims.

The incurred claims and 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
1.1	Incurred Claims	($247,319)

Adjustment #9 – To adjust pharmacy rebates per PBM supporting documentation

The health plan reported prescription drug rebates received and accrued. It was determined the amount reported was understated based on supporting documentation submitted from the PBM. An adjustment was proposed to increase the prescription drug rebates based on PBM supporting documentation. Pharmacy rebates are a reduction to incurred claims, therefore the increase in rebates is shown as a negative adjustment. The prescription drug rebates received and accrued reporting requirement are 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
1.1	Incurred Claims	($163,345)

Adjustment #10 – To remove unsupported provider care coordination expenses

The health plan reported provider care coordination expenses within incurred claims. It was determined, based on the provider contracts and discussions with the health plan, these payments were related to care coordination services. The health plan pays a PMPM payment to providers for performing care coordination services and are not based on clinical or quality metrics, therefore, the amounts did not qualify as provider incentive payments. Additionally, since the health plan could not obtain actual cost details from the providers related to these services, the amounts could not be reported as HCQI expenses. An adjustment was proposed to remove the unsupported care coordination payments. 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 Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	($8,205,395)

Adjustment #11 – To adjust provider incentives payments per health plan supporting documentation

The health plan reported provider incentive payments for the MLR reporting period. It was determined the health plan supporting documentation amounts reported were overstated, attributed primarily to over capturing estimated payments that were ultimately not earned and paid to providers for the MLR reporting period. An adjustment was proposed to reduce provider incentives 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).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($13,306,208)

Adjustment #12 – To adjust claims paid outside the claims system and cost settlements per health plan supporting documentation

The health plan reported additional incurred claims expense related to claims reimbursed outside the claims system and provider cost settlements for the MLR reporting period. Amounts reported were understated based on health plan supporting documentation. An adjustment was proposed to increase incurred claims per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$1,836,420

Adjustment #13 – To remove non-qualifying HCQI/ HIT expense

The health plan reported HCQI and health information technology (HIT) expenses based on salaries and benefits, vendor costs, and overhead costs. It was determined the health plan included non-qualifying expenses based on federal guidance. An adjustment was proposed to remove non-qualifying salaries, benefits, vendor costs, and overhead. The HCQI/ HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	($21,712,003)

Adjustment #14 – To adjust VAS expenses per health plan supporting documentation

The health plan reported state approved value added services (VAS) expenses for the MLR reporting period. Based on supporting documentation, the health plan understated the VAS expenses. An adjustment was proposed to increase VAS expensed per health plan supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$36,530

Adjustment #15 – To adjust premium revenues and incurred claims to incorporate state directed payment programs

The health plan reported state directed payments in the numerator and the denominator for the MLR reporting period. It was determined that both directed expenses and revenues were understated based on comparison to state data for the University of Iowa Hospitals and Clinics Average Commercial Rate (UIHC ACR), American Rescue Plan Act (ARPA), Nursing Facility Covid Relief Rate (NF CRR), and Ground Emergency Medical Transportation (GEMT). An adjustment was proposed to increase the state directed payments and associated expense per state data. See below for additional tables to break out the specific payments. The state directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2), 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**
1.1	Incurred Claims	$148,919,230
2.1	Premium Revenue	$148,896,914

UIHC ACR - Hospital	
Description	**Amount**
Total Directed Payment Revenue	$71,710,103
Total Directed Payment Expense	$71,710,103

UIHC ACR - Physician	
Description	**Amount**
Total Directed Payment Revenue	$11,735,356
Total Directed Payment Expense	$11,735,356

ARPA	
Description	**Amount**
Total Directed Payment Revenue	$64,734,571
Total Directed Payment Expense	$64,734,571

NF CRR	
Description	**Amount**
Revenue - State Data	$420,951
Risk Corridor Settlement	$314,040
Total Directed Payment Revenue	$734,990
Total Directed Payment Expense	$739,200
Expense Claimed by Health Plan	$0
Incurred Claims Adjustment	$739,200

GEMT	
Description	**Amount**
Total Directed Payment Revenue	($18,107)
Total Directed Payment Expense	$0

Adjustment #16 – To include incurred claims related to LTSS services

The health plan reported a reduction for incurred claims regarding long term support services (LTSS) related to the NF CRR state directed payment. Incurred claims related to the NF CRR reconciliation were included within Adjustment #15. However, the reduction of LTSS paid claims was overstated and improperly excluded from the MLR Calculation. An adjustment was proposed to include the remaining LTSS incurred claims. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$926,085

Adjustment #17 – 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. 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**
2.1	Premium Revenue	$2,200,743

Adjustment #18 – To adjust withhold payments per state data

The health plan reported an estimated amount for the anticipated earned withholds related to achieved pay for performance metrics. An adjustment was proposed to report earned withhold payments per state data. The withhold payments 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**
2.1	Premium Revenue	$1,132,300

Adjustment #19 – To adjust member months per state data

The health plan reported member month amounts did not reflect accurate amounts for the MLR reporting period. An adjustment was proposed to reflect member months per state data. 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**
3.1	Member Months	2,485

Adjustment #20 – To adjust income taxes per health plan supporting documentation

The health plan reported income taxes that did not reconcile to 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. An adjustment was proposed to decrease taxes to the appropriate amounts per the supporting documentation. 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**
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	($6,208,997)