MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

September 10, 2021

Via Electronic Mail

Utah Department of Health, Division of Medicaid Health Financing
Aaron Eliason, Auditor IV
288 North 1460 West
Salt Lake City, UT 84116

Re: Adjusted Medical Loss Ratio Examination Report Transmittal

This letter is to inform you that Myers and Stauffer LC has completed the examination of Steward Health Choice Utah, Inc.'s Adjusted Medical Loss Ratio for the period of July 1, 2018 through June 30, 2019. As a courtesy to the Utah Department of Health and other readers, the health plan management's response letter is included, if provided, in addition to our examination report, as part of this transmittal packet. Myers and Stauffer LC, in no manner, expresses an opinion on the accuracy, truthfulness, or validity of the statements presented within the management's response letter.

Please contact us at the phone number below if you have questions.

Kind Regards,

Myers and Stauffer LC

Myers and Stauffer LC

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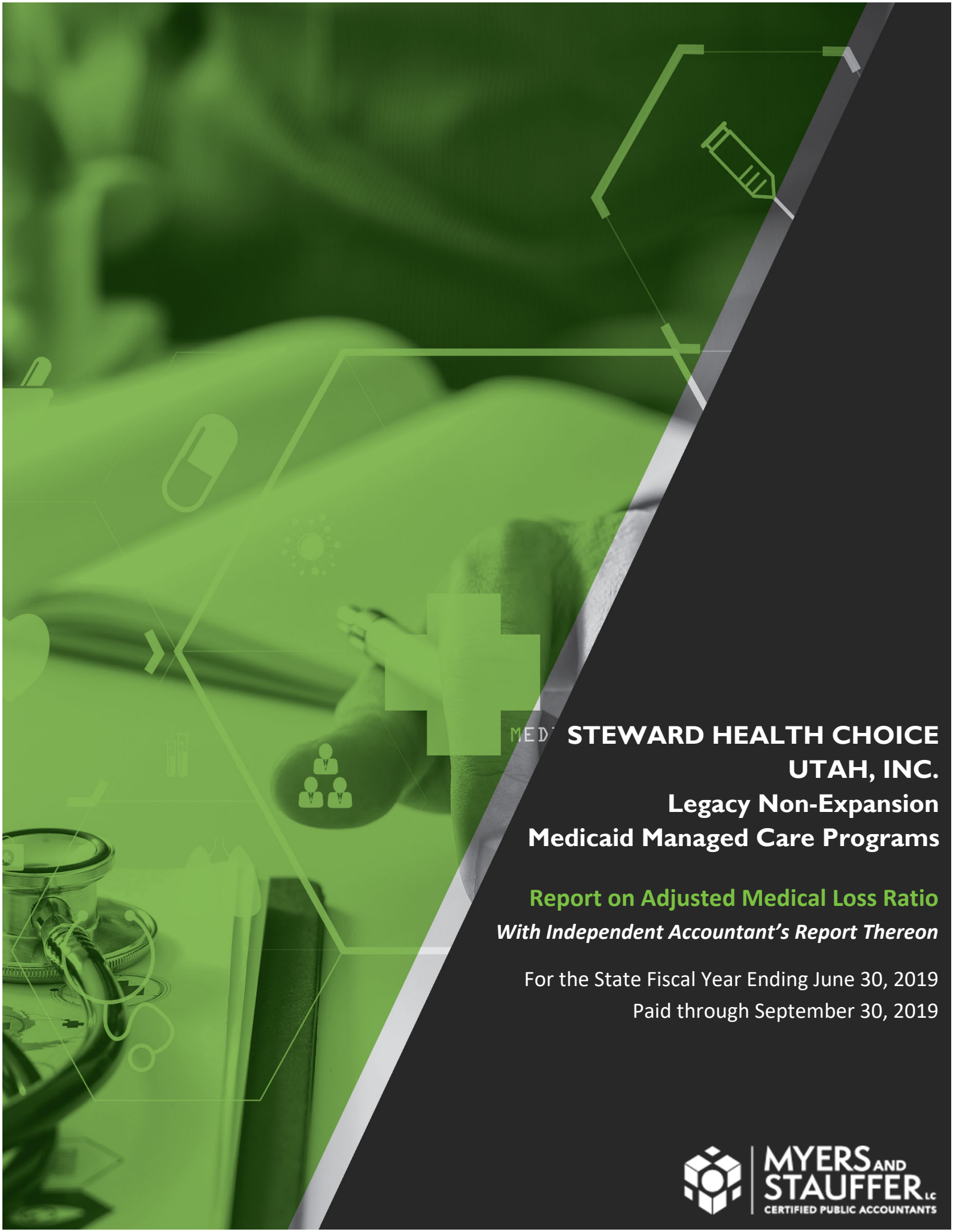

STEWARD HEALTH CHOICE UTAH, INC.

Legacy Non-Expansion Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ending June 30, 2019

Paid through September 30, 2019

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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State of Utah
Department of Health, Division of Medicaid and Health Financing
Salt Lake City, Utah

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio of Steward Health Choice Utah, Inc. (Health Choice) Accountable Care Organization for the state fiscal year ending June 30, 2019. Health Choice's management is responsible for presenting the Medical Loss Ratio (MLR) Reporting 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.

The accompanying Adjusted Medical Loss Ratio was prepared 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, except for the effect of the item addressed in the Schedule of Reporting Caveats, the above referenced accompanying Adjusted Medical Loss Ratio is presented in accordance with the above referenced criteria, in all material respects, and the Adjusted Medical Loss Ratio Percentage Achieved exceeds the Centers for Medicare & Medicaid Services (CMS) requirement of eighty-five percent (85%) for the state fiscal year ending June 30, 2019.

This report is intended solely for the information and use of the Department of Health, Milliman, and Health Choice 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
August 27, 2021

Adjusted Medical Loss Ratio for the State Fiscal Year Ending June 30, 2019 Paid Through September 30, 2019

Adjusted Medical Loss Ratio for the State Fiscal Year Ending June 30, 2019 Paid Through September 30, 2019				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1. Numerator				
1.1	Incurred Claims	$ 58,385,641	$ 25,795,121	$ 84,180,762
1.2	Quality Improvement	$ 1,117,298	$ (128,101)	$ 989,197
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 59,502,939	$ 25,667,020	$ 85,169,959
2. Denominator				
2.1	Premium Revenue	$ 64,455,834	$ 26,950,302	$ 91,406,136
2.2	Taxes and Fees	$ -	$ 1,244,327	$ 1,244,327
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 64,455,834	$ 25,705,975	$ 90,161,809
3. Credibility Adjustment				
3.1	Member Months	225,223	-	225,223
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.41%	0.0%	1.4%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	92.32%	2.2%	94.5%
4.2	Credibility Adjustment	1.41%	0.0%	1.4%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	93.73%	2.2%	95.9%
5. Remittance Calculation				
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes
5.2	MLR Standard	85.00%		85.0%
5.3	Adjusted MLR	93.73%		95.9%
5.4	Meets MLR Standard	Yes		Yes

Schedule of Reporting Caveats

During our examination, the following reporting issues were identified.

Caveat #1 – MLR reporting period not aligning with the rating period

The Department of Health had a 12-month rating period of January 1, 2018 through December 31, 2018, followed by a 6-month rating period of January 1, 2019 through June 30, 2019, due to transitioning to a state fiscal year rating period. The MLR Report was developed by the Department of Health to capture data for the MLR reporting period of July 1, 2018 through June 30, 2019. Per 42 CFR § 438.8, the MLR reporting year should be consistent with the rating period selected by the state. For purposes of this engagement, the 12-month MLR reporting period was examined.

Schedule of Adjustments and Comments for the State Fiscal Year Ending June 30, 2019

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust administrative fees included in IBNR

The health plan reported incurred but not reported (IBNR) expenses including an estimated calculation in addition to the lag table supporting documentation based on incurred claims. The health plan was requested to explain the additional estimation. Upon review of the explanation, it was determined the amount was related to an additional 2.5 percent administration fee. An adjustment was proposed to remove the non-allowable administration expense from medical expense. The medical expense 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	($58,185)

Adjustment #2 – To adjust qualified taxes to actual incurred expense

The health plan did not report incurred income taxes on the MLR Report. Based on the audited financial statements, the health plan reflected incurred tax expense. Further inquiry was initiated to confirm the Medicaid portion of the tax expense. Per responses from the health plan, income taxes should have been reported according to the supporting documentation. An adjustment was proposed to include the tax expense. The taxes and fees reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Taxes and Fees	$703,009

Adjustment #3 – To adjust premium revenue to 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 MLR reporting period. An adjustment was proposed to report the revenues per state data for capitation payments, Health Insurer Fee (HIF) payments, and maternity payments. The revenues requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR Report based on the template and instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$55,451

Adjustment #4 – To adjust the HIF expense to state data

The health plan did not report the HIF expense for the MLR reporting period. The associated HIF revenues were included within Adjustment #3 and adjusted to state data. An adjustment was proposed to include HIF expense to reflect state data amounts. The taxes and fees reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and the CMS Health Insurance Providers Fee for Medicaid Managed Care Plans FAQ dated October 2014. The health plan completed the MLR Report based on the template and instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Taxes and Fees	$541,318

Adjustment #5 – To remove non-qualifying HCQI expenses

The health plan reported health care quality improvement (HCQI) expenses utilizing vendor data as well as salaries and benefits. After review and testing of the submitted documentation, it was determined certain salaries included within the MLR Report were non-qualifying expenses. Therefore, an adjustment was proposed to remove the non-qualifying salaries from HCQI expenses per supporting documentation. The HCQI reporting requirements are addressed in Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Quality Improvement	($128,101)

Adjustment #6 – To remove spread pricing from pharmacy expense

The health plan reported pharmacy expenses based on internal claims data, which included amounts the health plan paid to the pharmacy benefit manager (PBM). Based on claims detail sample testing, it was determined variances existed between the amounts paid to retail pharmacies compared to payments reflected in the health plan's data, and spread pricing was the difference in the two data sources. This margin charged to the health plan is considered PBM profit and is an unallowable medical expense. Therefore, an adjustment was proposed to remove the identified spread pricing to report actual pharmacy medical expenditures. The medical expense and third party reporting requirements related to spread pricing are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8 and the Center for Medicaid and 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	($1,041,545)

Adjustment #7 – To adjust premium revenue and incurred claims to include directed payments and associated expense

The MLR Report did not reflect directed payments in the numerator nor the denominator of the calculation. After discussions with the Department of Health, it was determined the private hospitals 26-36d-205, state hospital inpatient upper payment limit (UPL), state hospital outpatient UPL, and the University of Utah Medical Group payments are approved under 42 CFR § 438.6(c); and therefore should be included in the MLR calculation. Premium revenue and incurred claims were adjusted to include the payments and associated expense per state data. The directed payment and associated expense reporting requirements are addressed Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2), 42 CFR § 438.6(c), and 45 CFR § 158.130. The health plan completed the MLR Report based on the template and instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$26,894,851
2.1	Premium Revenue	$26,894,851

Appendix A: Health Plan Responses

The health plan did not provide responses for the state fiscal year included within the report.