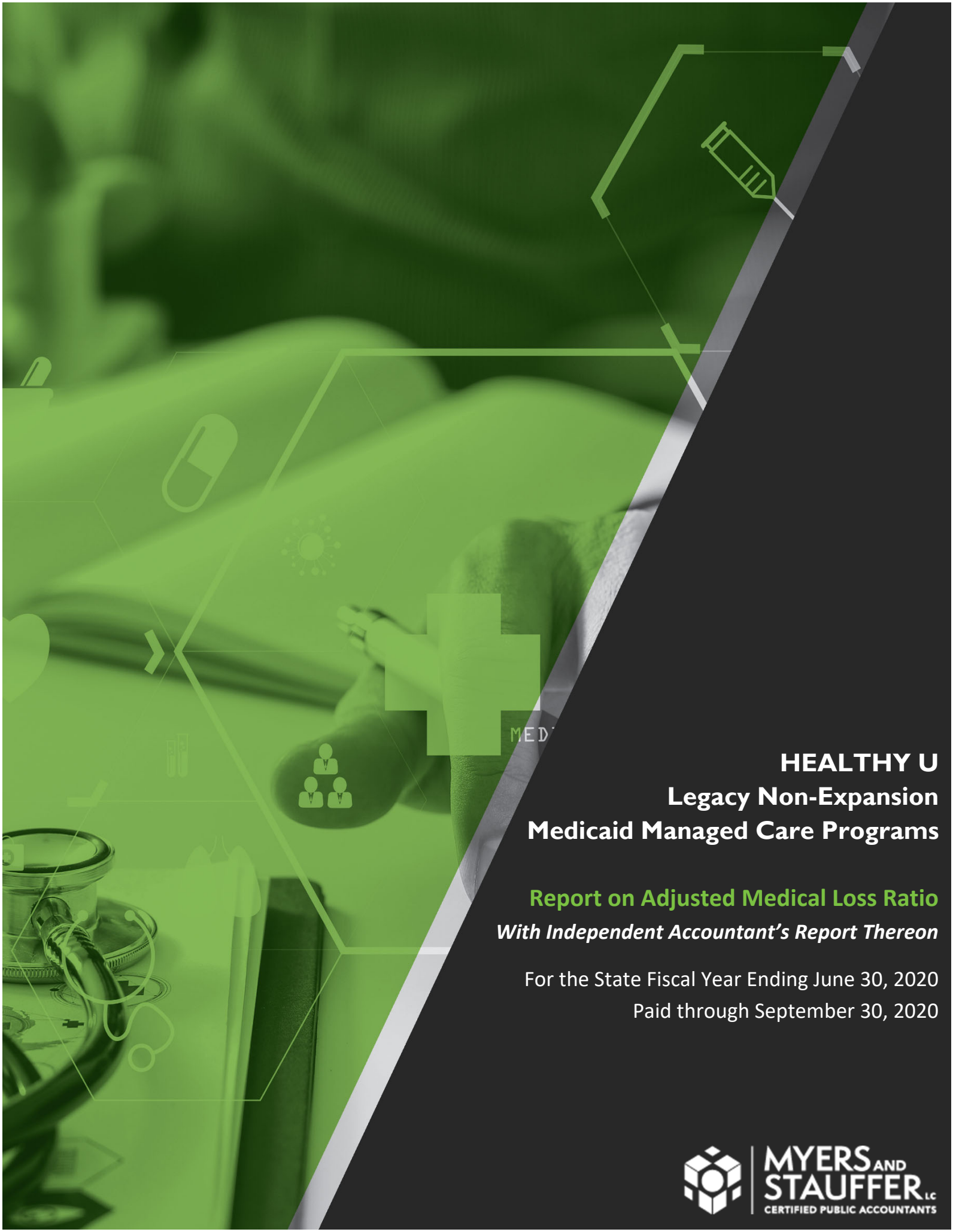

HEALTHY U
Legacy Non-Expansion Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ending June 30, 2020

Paid through September 30, 2020

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 Healthy U Accountable Care Organization for the state fiscal year ending June 30, 2020. Healthy U's management is responsible for presenting the Medical Loss Ratio (MLR) Report 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, 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, 2020.

This report is intended solely for the information and use of the Department of Health, Milliman, and Healthy U 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
January 25, 2022

Adjusted Medical Loss Ratio for the State Fiscal Year Ending June 30, 2020 Paid Through September 30, 2020

Adjusted Medical Loss Ratio for the State Fiscal Year Ending June 30, 2020 Paid Through September 30, 2020				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1. Numerator				
1.1	Incurred Claims	$ 189,968,004	$ 78,962,512	$ 268,930,516
1.2	Quality Improvement	$ 3,291,560	$ (2,225,291)	$ 1,066,269
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 193,259,564	$ 76,737,221	$ 269,996,785
2. Denominator				
2.1	Premium Revenue	$ 202,340,346	$ 96,512,226	$ 298,852,572
2.2	Taxes and Fees	$ -	$ -	$ -
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 202,340,346	$ 96,512,226	$ 298,852,572
3. Credibility Adjustment				
3.1	Member Months	590,785	-	590,785
3.2	Credibility	Fully Credible		Fully Credible
3.3	Credibility Adjustment	0.00%	0.0%	0.0%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	95.51%	-5.2%	90.3%
4.2	Credibility Adjustment	0.00%	0.0%	0.0%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	95.51%	-5.2%	90.3%
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	95.51%		90.3%
5.4	Meets MLR Standard	Yes		Yes

Schedule of Adjustments and Comments for the State Fiscal Year Ending June 30, 2020

During our examination, we identified the following adjustments.

Adjustment #1 – To remove incurred claims related to expansion populations

The health plan reported medical and pharmacy claims related to expansion populations. The health plan submitted incurred claims data to support the medical expenses on the MLR Report and rate cells associated with expansion populations were identified. An adjustment was proposed to remove amounts related to expansion populations 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**
1.1	Incurred Claims	($3,415,341)

Adjustment #2 – To remove IBNR related to expansion populations

The health plan reported incurred but not reported (IBNR) amounts related to expansion populations. The health plan submitted lag tables, a summary level of the incurred claims data, as well as IBNR supporting documentation and rate cells associated with expansion populations were identified. An adjustment was proposed to remove amounts related to expansion populations per supporting documentation. The 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	($104,816)

Adjustment #3 – To remove the calculated IBNR modified amount

The health plan reported IBNR expenses that included an estimated calculation in addition to the lag table supporting documentation based on incurred claims. It was determined the IBNR modified amount claimed within the total IBNR reported was calculated based on a non-allowable reserve margin and administrative expenses. An adjustment was proposed to remove the calculated IBNR

modified amount. 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	($334,401)

Adjustment #4 – To adjust the allocation metric and remove non-qualifying HCQI expenses

The health plan reported health care quality improvement (HCQI) expenses utilizing an allocation of parent company salaries determined by percentage of claims volume. Based on supporting documentation, time spent was also tracked and recorded by employee for the amount of time allotted between lines of business. This was determined to be a more appropriate metric to allocate salaries and was utilized to recalculate the allocation of parent company HCQI salaries. The health plan however, did not track time spent to allocate the Medicaid populations between non-expansion and expansion populations. Therefore, after discussions with the health plan, membership was utilized to isolate the non-expansion population portion of time spent. Additionally, an adjustment was proposed to remove non-qualifying salaries and benefits from HCQI expenses. Job functions were reviewed and discussed with the health plan to arrive at final HCQI allocation percentage determinations. 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**
1.2	Quality Improvement	($2,225,291)

Adjustment #5 – To adjust prescription drug rebates received and accrued

The health plan included prescription drug rebates received and accrued on the MLR Report. It was determined the amount reported was understated based on support provided by the pharmacy benefit manager (PBM) which appropriately accounted for the removal of expansion populations within the total. 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).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($121,596)

Adjustment #6 – To adjust provider incentive payments to supporting documentation

The health plan included total incentives paid, or expected to be paid, to network providers on the MLR Report. Based on supporting documentation, it was determined the amount reported was overstated. Additionally, the reported expense related to Intensive Outpatient Clinic (IOC) services, performed by a related party, rather than provider incentives. Testing was conducted to ensure the amount reported was at the actual cost of the related entity. An adjustment was proposed to remove expenses for expansion populations as well as related party profit. The medical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and CMS Publication 15-1, Chapter 10.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($256,099)

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) and § 438.6(c). The health plan completed the MLR Report based on the template and instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$80,662,470
2.1	Premium Revenue	$80,662,470

Adjustment #8 – 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, maternity payments, and high cost drug pool 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 Report based on the template and instructions.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$15,849,756

Adjustment #9 – To remove the high cost drug pool revenue offset from incurred claims

The health plan reported high cost drug pool revenue paid by the state in incurred claims cost as an offset to the actual pharmacy incurred claims cost. After discussions with the health plan, it was agreed the amount would be reclassified to premium revenues as it was a payment received by the state. The associated high cost drug pool revenue was included within Adjustment #8 and adjusted per state data. An adjustment was proposed to include the amount offset from incurred claims on the MLR Report. 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**
1.1	Incurred Claims	$2,532,295