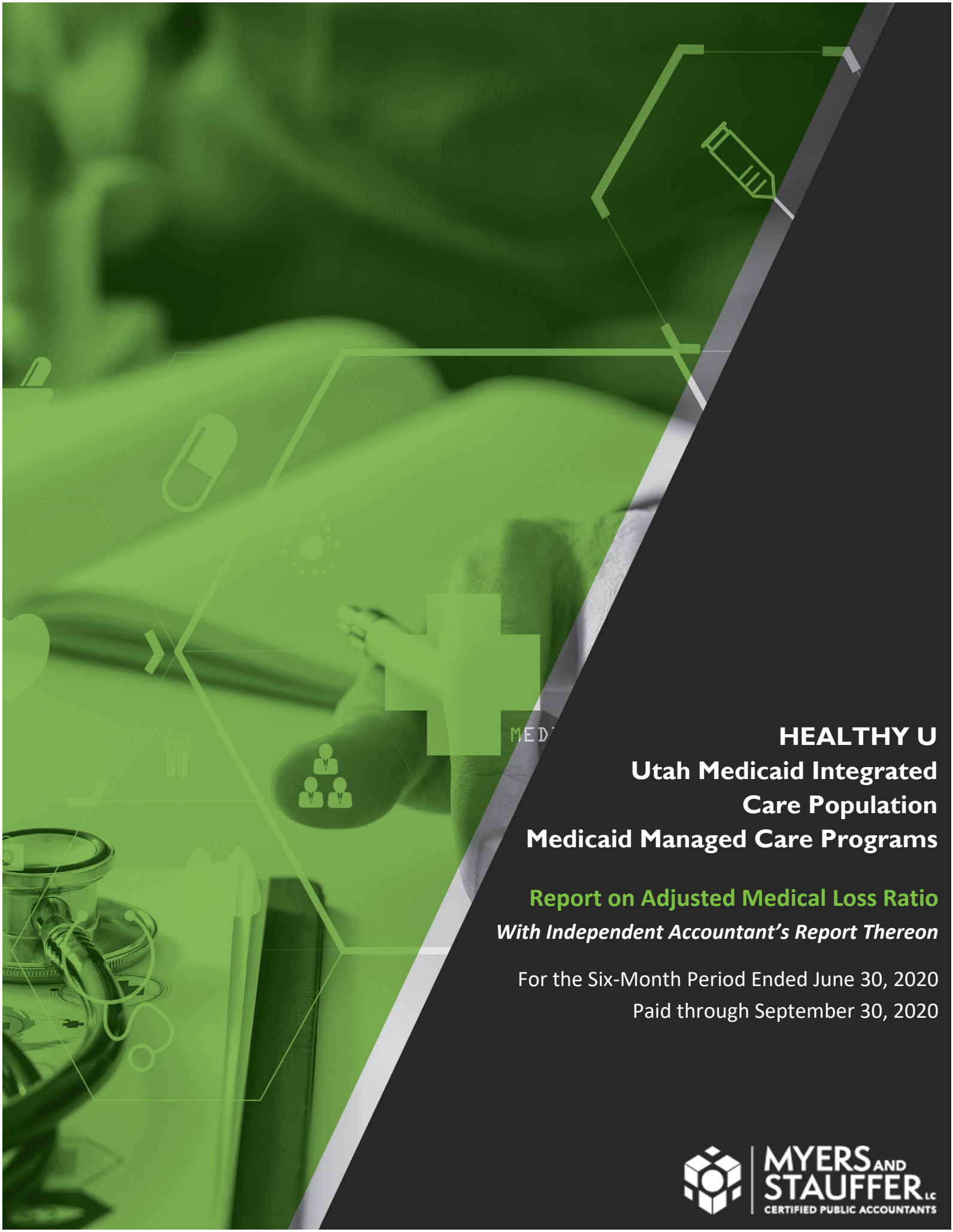

HEALTHY U
Utah Medicaid Integrated Care Population Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the Six-Month Period Ended 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 six-month period ended June 30, 2020. Healthy U's management is responsible for presenting the Medical Loss Ratio 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 exceeds the Centers for Medicare & Medicaid Services (CMS) requirement of eighty-five percent (85%) for the six-month period ended 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
June 8, 2022

Adjusted Medical Loss Ratio for the Six-Month Period Ended June 30, 2020 Paid Through September 30, 2020

Adjusted Medical Loss Ratio for the Six-Month Period Ended June 30, 2020 Paid Through September 30, 2020 Utah Medicaid Integrated Care Population						
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Preliminary Adjusted Amounts**	**Risk Corridor Cost Settlement Amount**	**Adjusted Amounts**
1. Numerator						
1.1	Incurred Claims	$ 22,543,537	$ (52,054)	$ 22,491,483		$ 22,491,483
1.2	Quality Improvement	$ 211,733	$ (124,994)	$ 86,739		$ 86,739
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 22,755,270	$ (177,048)	$ 22,578,222		$ 22,578,222
2. Denominator						
2.1	Premium Revenue	$ 23,451,891	$ (192,393)	$ 23,259,498	$ 2,175,995	$ 25,435,493
2.2	Taxes and Fees	$ -	$ -	$ -		$ -
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 23,451,891	$ (192,393)	$ 23,259,498	$ 2,175,995	$ 25,435,493
3. Credibility Adjustment						
3.1	Member Months	42,150	(374)	41,776		41,776
3.1a	Annualized Member Months[1]	84,300	(748)	83,552		83,552
3.2	Credibility	Partially Credible		Partially Credible		Partially Credible
3.3	Credibility Adjustment	2.2%	0.0%	2.2%		2.2%
4. MLR Calculation						
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	97.0%	0.1%	97.1%	-8.3%	88.8%
4.2	Credibility Adjustment	2.2%	0.0%	2.2%		2.2%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	99.2%	0.1%	99.3%	-8.3%	91.0%
5. Remittance Calculation						
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes		Yes
5.2	MLR Standard	85.0%		85.0%		85.0%
5.3	Adjusted MLR Prior to Risk Corridor Cost Settlement	99.2%		99.3%		99.3%
5.4	Risk Corridor Cost Settlement Due to Health Plan				$ 2,175,995	$ 2,175,995
5.5	Adjusted MLR					91.0%
5.6	Meets MLR Standard	Yes		Yes		Yes

Schedule of Reporting Caveats

During our examination, the following reporting issues were identified.

Caveat #1 – MLR reporting period does not align with the rating period

The Department of Health had an 18-month rating period of January 1, 2020 through June 30, 2021. The MLR Report was developed by the Department of Health to capture data for the MLR reporting period of January 1, 2020 through June 30, 2020. Per 42 CFR § 438.8, the MLR reporting year should be a period of 12 months consistent with the rating period selected by the state. For purposes of this engagement, the six-month MLR reporting period was examined.

Schedule of Adjustments and Comments for the Six-Month Period Ended June 30, 2020

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust member months to state data

The health plan over reported member months applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the member months per state data. The credibility adjustment requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(h).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.1	Member Months	(374)
3.1a	Annualized Member Months	(748)

Adjustment #2 – To adjust provider reported 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 understated. 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 increase to the actual cost of the entity after removal of 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	$19,878

Adjustment #3 – 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 separation of the expansion

population and the UMIC population 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	($44,434)

Adjustment #4 – 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	($27,498)

Adjustment #5 – To adjust premium revenue to state data

The health plan reported revenue amounts that did not reflect accurate payment amounts 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).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	($192,393)

Adjustment #6 – 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 UMIC 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	($124,994)