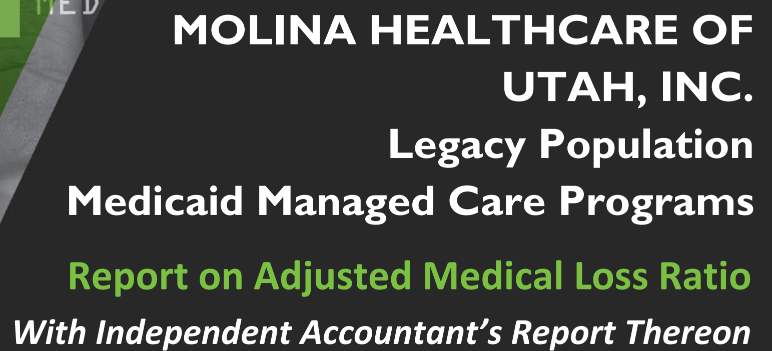

MOLINA HEALTHCARE OF UTAH, INC.
Legacy Population
Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2021
Paid through September 30, 2021

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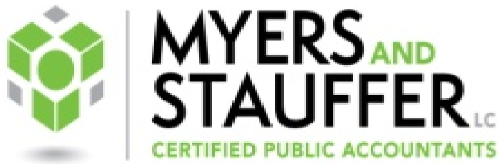

State of Utah
Department of Health and Human Services
Salt Lake City, Utah

Independent Accountant's Report

We have examined the Medical Loss Ratio Report of Molina Healthcare of Utah, Inc. (health plan) Accountable Care Organization 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 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.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio Report 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 Centers for Medicare & Medicaid Services (CMS) requirement of eighty-five percent (85%) for the state fiscal year ended June 30, 2021.

This report is intended solely for the information and use of the Utah Department of Health and Human Services, Milliman, 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
March 11, 2024

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

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2021 Paid Through September 30, 2021				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1. Numerator				
1.1	Incurred Claims	$ 143,643,702	$ 95,902,188	$ 239,545,890
1.2	Quality Improvement	$ 3,206,747	$ (858,920)	$ 2,347,827
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 146,850,449	$ 95,043,268	$ 241,893,717
2. Denominator				
2.1	Premium Revenue	$ 184,772,107	$ 102,824,145	$ 287,596,252
2.2	Taxes and Fees	$ 4,891,407	$ 1,983,078	$ 6,874,485
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 179,880,700	$ 100,841,067	$ 280,721,767
3. Credibility Adjustment				
3.1	Member Months	777,743	-	777,743
3.2	Credibility	Fully Credible		Fully Credible
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	81.6%	4.6%	86.2%
4.2	Credibility Adjustment	0.0%	0.0%	0.0%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	81.6%	4.6%	86.2%
5. Remittance Calculation				
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes
5.2	MLR Standard	85.0%		85.0%
5.3	Adjusted MLR	81.6%		86.2%
5.4	Meets MLR Standard	No		Yes

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 premium revenue per 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 Medical Loss Ratio (MLR) reporting period. An adjustment was proposed to report the revenues per state data for capitation payments, maternity payments, Health Insurer Fee (HIF) payments, and other settlement 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	$6,814,661

Adjustment #2 – To adjust HIF expenses per state data

The HIF 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 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)(3), and the CMS Health Insurance Providers Fee for Medicaid Managed Care Plans FAQ dated October 2014.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Taxes and Fees	$1,582,500

Adjustment #3 – To adjust premium revenues and incurred claims for directed payments

The health plan did not report directed payments and associated expense amounts received for its members applicable to the MLR reporting period. An adjustment was proposed to report the directed 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(e)(2), § 438.8(f)(2), and § 438.6(c).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$96,009,484
2.1	Premium Revenue	$96,009,484

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

The health plan included heath care quality improvement (HCQI) expenses on the MLR Report. Based on supporting documentation, it was determined HCQI expenses included certain non-qualifying positions and/or duties based on federal guidance. Additionally, subsequent to the submission of the MLR Report, the health plan updated its HCQI methodology which reallocated the expenses between populations. Therefore, an adjustment was proposed to remove the non-qualifying salaries and benefits from HCQI expenses and appropriately allocate between populations. 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	($858,920)

Adjustment #5 – To adjust reinsurance recoveries reported in incurred claims

The health plan reported reinsurance recoveries as a reduction to incurred claims. Based on review of the state contract, it was determined reinsurance is not mandated and therefore, not to be reported on the MLR Report. An adjustment was proposed to add back the reinsurance recoveries that were reducing the incurred claims expenses. The medical expense 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	$661,710

Adjustment #6 – To adjust income taxes based on audited financial statement information

The health plan reported income taxes that included amounts for investment income. Per federal regulations, investments should be excluded from taxes reported for MLR purposes. Additionally, the change in deferred tax assets noted in the audited financial statements was not considered in the reporting of the taxes. A revised calculation was submitted by the health plan to include all pertinent

items. Therefore, an adjustment was proposed to report taxes per the revised calculation. The tax 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	Taxes and Fees	$400,578

Adjustment #7 – To remove overstated medical expense based on supporting documentation

The health plan reported paid claims on the MLR Report based on the specified runout period, including estimated incurred but not reported (IBNR) for the MLR reporting period. It was determined the submitted claims data included paid dates within 2022, which extended past the MLR Report runout period. The additional runout for the dates of service within the MLR reporting period indicated there were many large negative adjustments not factored into the reported medical expenses. Therefore, a current claims lag table was requested with a runout period through the February 28, 2023. An adjustment was proposed to align with the more current and appropriate paid claims lag table amounts. The medical expense and third party 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	($1,016,538)

Adjustment #8 – To adjust third party vendors to incurred claims cost

The health plan reported vision services as a per-member-per-month (PMPM) on the MLR Report. Based on the supporting certification statement attesting to incurred medical expense from the vision vendor, VSP, it was determined non-claims cost was included in medical expenses. An adjustment was proposed to decrease vision services expense to the incurred paid claims reported on the certification statement. The medical expense and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(v) 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	($74,726)

Adjustment #9 – To adjust pharmacy paid claims to PBM claims data

The health plan included pharmacy incurred claims on the MLR Report that did not reconcile to the PBM claims detail provided. Based on testing performed, it was determined the amount reported was understated. Pharmacy paid claims were tested and determined to be appropriate. An adjustment was proposed to align with the claims data amount. Additionally, it was determined the PBM was charging the pharmacies a transmission fee, which reduced the overall reimbursement to the pharmacy. The transmission fees however, were not reducing incurred claims in the MLR calculation. Therefore, an adjustment was also proposed to reduce incurred claims for the transmission fees noted in the PBM's claims detail data. The medical expense 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	$435,277

Adjustment #10 – To adjust prescription drug rebates received and accrued

The health plan reported prescription drug rebates received and accrued on the MLR Report. It was determined the amount reported was overstated compared to the Pharmacy Benefit Manager (PBM) certification statement. An adjustment was proposed to decrease the prescription drug rebates to reconcile to the certification statement. Pharmacy rebates are a reduction to incurred claims cost in the MLR calculation, therefore, the decrease in pharmacy rebates results in a positive 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**
1.1	Incurred Claims	$210,945

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

The health plan reported provider incentives on the MLR Report that did not agree to the supporting documentation submitted. It was determined reported expenses were understated based on the incentives listing and trial balance. Therefore, an adjustment was proposed to increase the provider

incentive to the 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	$38,475

Adjustment #12 – To adjust incurred claims expense to final net payments to pharmacies

The health plan reported pharmacy incurred claims expense based on internal data. The paid amount within the PBM claims data was only reflecting ingredient cost and dispensing fees. It was determined recoveries were made from the pharmacies by the PBM. An adjustment was proposed to reduce incurred claims expense for the recoveries to reflect the final paid to the pharmacy. 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**
1.1	Incurred Claims	($362,439)