

The background of the cover is a blurred photograph of a medical professional, likely a nurse, wearing a white coat and gloves, attending to a patient. A large, semi-transparent green overlay covers the left and center portions of the image. Overlaid on this green area are several white line-art icons: a syringe in the upper right, a pill in the middle left, a virus particle in the center, a large medical cross in the center, and a group of three stylized human figures in the lower center. A network of thin white lines connects these icons and other points across the green area. The right side of the cover is a solid dark grey triangle.

HEALTH CHOICE 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, 2022
Paid through September 30, 2022



**MYERS AND
STAUFFER** L.C.
CERTIFIED PUBLIC ACCOUNTANTS



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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 Health Choice Utah, Inc. (health plan) Accountable Care Organization 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 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, 2022.

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
April 23, 2024



HEALTH CHOICE UTAH, INC.
ADJUSTED MEDICAL LOSS RATIO
LEGACY POPULATION

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

Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through September 30, 2022				
Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
1. Medical Loss Ratio Numerator				
1.1	Incurred Claims	\$ 102,119,395	\$ (7,391,675)	\$ 94,727,719
1.2	Activities that Improve Health Care Quality	\$ 2,038,718	\$ (1,581,323)	\$ 457,395
1.3	MLR Numerator	\$ 104,158,113	\$ (8,972,998)	\$ 95,185,114
1.4	Non-Claims Costs (Not Included in Numerator)	\$ 3,094,348	\$ (3,094,348)	\$ (0)
2. Medical Loss Ratio Denominator				
2.1	Premium Revenue	\$ 115,872,413	\$ (3,155,825)	\$ 112,716,588
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$ -	\$ 1,739,840	\$ 1,739,840
2.3	MLR Denominator	\$ 115,872,413	\$ (4,895,665)	\$ 110,976,748
3. MLR Calculation				
3.1	Member Months	321,093	-	321,093
3.2	Unadjusted MLR	89.9%	-4.1%	85.8%
3.3	Credibility Adjustment	1.2%	0.0%	1.2%
3.4	Adjusted MLR	91.1%	-4.1%	87.0%
4. Remittance				
4.2	State Minimum MLR Requirement	85.0%		85.0%
4.6.2	Adjusted MLR			87.0%
4.6.3	Meets MLR Standard	Yes		Yes

**The Non-Claims Costs line has not be subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. This includes adjustments identified during the course of the examination directly affecting the Non-Claims Costs line. 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 premium revenues and incurred claims for directed payments

The health plan reported directed payments and associated expense amounts that did not reflect payments received for its members applicable to the Medical Loss Ratio (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	(\$2,244,297)
2.1	Premium Revenue	(\$2,244,297)

Adjustment #2 – To adjust IBNR per supporting documentation

The health plan reported significantly higher incurred but not reported (IBNR) expense compared to prior year on the MLR report. After discussion with the health plan, a revised IBNR model was submitted. The revised IBNR model more closely aligned with paid claims, and appeared reasonable compared to prior year. An adjustment was proposed to reduce IBNR to reflect amounts per the revised IBNR model provided by the health plan. 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	(\$4,177,679)

Adjustment #3 – 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



SCHEDULE OF ADJUSTMENTS AND COMMENTS

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	(\$776,632)

Adjustment #4 – To adjust transmission fee included in pharmacy claims

The health plan included pharmacy paid claims based on the amounts the health plan paid its PBM. During testing of the paid claims, it was determined the PBM was charging a transmission fee to the pharmacies that was not included as a reduction to the paid amounts reported by the health plan. An adjustment was proposed to reduce incurred claims for the amount of transmission fees per the PBM supporting documentation. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) 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	(\$26,568)

Adjustment #5 – 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 understated per support provided by the PBMs for the applicable period. An adjustment was proposed to increase the prescription drug rebates to reconcile to the supporting documentation submitted by the PBMs. Pharmacy rebates are a reduction to incurred claims cost in the MLR calculation, therefore, the increase in pharmacy rebates results in a negative adjustment to incurred claims. 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).



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	(\$166,499)

Adjustment #6 – To remove non-allowable HCQI expenses

The health plan reported health care quality improvement (HCQI) expenses utilizing vendor data as well as salaries and benefits data. The health plan did not provide sufficient supporting documentation to determine whether corporate Health Information Technology (HIT) expense qualified to be included in HCQI. Additionally, salaries and benefits for non-qualifying HCQI activities and vendor costs incurred outside of the MLR reporting period were noted. An adjustment was proposed to remove non-qualifying expense, unsupported expense, and expense outside the MLR period. The HCQI reporting requirements are addressed in Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	Line Description	Amount
1.1	Incurred Claims	(\$1,581,323)

Adjustment #7 – To adjust premium revenue 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, maternity payments, and risk score settlements. 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	(\$911,528)

Adjustment #8 – To include qualifying taxes per supporting documentation

The health plan did not report income taxes on the correct line of the MLR Report. An adjustment was proposed to include the tax amount based on the audited financial statements, excluding investment income and including the change in deferred tax, and to apportion the expense to each population based on adjusted net revenue after the risk corridor adjustment. The taxes and fees 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.



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Proposed Adjustment		
Line #	Line Description	Amount
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$1,739,840

Adjustment #9 – To correct a formula error on the as-submitted medical loss ratio template

The UDHHS MLR Report contains a formula error in the calculation of the Non-Claims Costs. The Non-Claims Cost total is linked to Non-Benefit Expenses. The Non-Benefit Expenses total includes a formula that is linked to the total taxes and HCQI lines, resulting in total Taxes and Fees and HCQI being duplicated in the Non-Claims Costs in the MLR Report. An adjustment was proposed to remove reported Taxes and Fees & HCQI from Non-Claims Costs. The Non-Claims Costs reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	Line Description	Amount
1.4	Non-Claims Costs (Not Included in Numerator)	(\$3,094,348)