

**MOLINA HEALTHCARE OF
UTAH, INC.**
**ACO Expansion 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^{LC}**
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 Molina Healthcare of 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 meets 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
May 30, 2025



MOLINA HEALTHCARE
ADJUSTED MEDICAL LOSS RATIO
ACO EXPANSION 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	Preliminary Adjusted Amounts	Risk Corridor Cost Settlement	Adjusted Amounts
1. Medical Loss Ratio Numerator						
1.1	Incurred Claims	\$ 11,202,752	\$ (17,249)	\$ 11,185,503		\$ 11,185,503
1.2	Activities that Improve Health Care Quality	\$ 273,435	\$ (28,381)	\$ 245,054		\$ 245,054
1.3	MLR Numerator	\$ 11,476,187	\$ (45,630)	\$ 11,430,557		\$ 11,430,557
1.4	Non-Claims Costs (Not Included in Numerator)	\$ 2,750,096	\$ (966,687)	\$ 1,783,409		\$ 1,783,409
2. Medical Loss Ratio Denominator						
2.1	Premium Revenue	\$ 21,338,496	\$ (11,697)	\$ 21,326,799	\$ (6,635,898)	\$ 14,690,901
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$ 693,252	\$ -	\$ 693,252		\$ 693,252
2.3	MLR Denominator	\$ 20,645,244	\$ (11,697)	\$ 20,633,547	\$ (6,635,898)	\$ 13,997,649
3. MLR Calculation						
3.1	Member Months	38,412	-	38,412		38,412
3.2	Unadjusted MLR	55.6%	-0.2%	55.4%		81.7%
3.3	Credibility Adjustment	3.3%	0.0%	3.3%		3.3%
3.4	Adjusted MLR	58.9%	-0.2%	58.7%		85.0%
4. Remittance						
4.2	State Minimum MLR Requirement	85.0%		85.0%		85.0%
4.2.1	Adjusted MLR Prior to Risk Corridor Cost Settlement	58.9%		58.7%		58.7%
4.6.1	Risk Corridor Cost Settlement Due to Department				\$ (6,635,898)	\$ (6,635,898)
4.6.2	Adjusted MLR					85.0%
4.6.3	Meets MLR Standard	No		No		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 direct claims paid to supporting documentation

The health plan reported direct medical claims paid on the Medical Loss Ratio (MLR) Report that did not agree to the health plan's supporting documentation. An adjustment was proposed to report the direct claims paid per 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	(\$5,539)

Adjustment #2 – 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	(\$8,847)

Adjustment #3 – To remove non-allowable transmissions fees from pharmacy paid claims

The health plan included non-allowable transmission fees in pharmacy incurred claims on the MLR Report. Based on testing performed, 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 proposed to reduce incurred claims for the transmission fees noted in the PBM's claims detail



SCHEDULE OF ADJUSTMENTS AND COMMENTS

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	(\$9,863)

Adjustment #4 – To adjust provider incentive payments per supporting documentation

The health plan reported provider incentives on the MLR Report that did not agree to the supporting documentation submitted. An adjustment was proposed to report the provider incentives per 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	\$7,000

Adjustment #5 – To remove non-qualifying HCQI expenses

The health plan included health 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. Therefore, an adjustment was proposed to remove the non-qualifying salaries and benefits from HCQI. 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	Activities that Improve Health Care Quality	(\$28,381)

Adjustment #6 – To adjust premium revenues 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, high cost drug pool, and risk score settlements. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).



SCHEDULE OF ADJUSTMENTS AND COMMENTS

Proposed Adjustment		
Line #	Line Description	Amount
2.1	Premium Revenue	(\$11,697)

Adjustment #7 – To correct a formula error on the as-submitted MLR Report

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)	(\$966,687)