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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



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	R	eported Amounts	Ac	djustment Amounts	P	Preliminary Adjusted Amounts	Risk Corridor Cost Settlement	Α	djusted Amounts
1.	Medical Loss Ratio Numerator									
1.1	Incurred Claims	\$	72,698,408	\$	320,431	\$	73,018,839		\$	73,018,839
1.2	Activities that Improve Health Care Quality	\$	1,454,254	\$	(152,740)	(\$	1,301,514		\$	1,301,514
1.3	MLR Numerator	\$	74,152,662	\$	167,691	\$	74,320,353		\$	74,320,353
1.4	Non-Claims Costs (Not Included in Numerator)	\$	13,735,505	\$	(4,244,138)) \$	9,491,367		\$	9,491,367
2.	Medical Loss Ratio Denominator									
2.1	Premium Revenue	\$	113,488,130	\$	13,837	\$	113,501,967	\$ (21,628,213)	\$	91,873,754
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$	2,789,884	\$	-	\$	2,789,884		\$	2,789,884
2.3	MLR Denominator	\$	110,698,246	\$	13,837	\$	110,712,083	\$ (21,628,213)	\$	89,083,870
3.	MLR Calculation									
3.1	Member Months		178,060		-		178,060			178,060
3.2	Unadjusted MLR		67.0%		0.1%	S	67.1%			83.4%
3.3	Credibility Adjustment		1.6%		0.0%	5	1.6%			1.6%
3.4	Adjusted MLR		68.6%		0.1%	5	68.7%			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		68.6%				68.7%			68.7%
4.6.1	Risk Corridor Cost Settlement Due to Department							\$ (21,628,213)	\$	(21,628,213)
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.

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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	(\$13,134)

Adjustment #2 - 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 amount removed from the MLR Report to ensure reinsurance is excluded. The reporting requirement for reinsurance recoveries is addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment					
Line #	Line Description	Amount			
1.1	Incurred Claims	\$426,771			

Adjustment #3 – 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	(\$49,123)		

Adjustment #4 - 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 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	(\$44,083)		

Adjustment #5 – To remove non-qualifying HCQI expenses

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 nonqualifying 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	(\$152,740)		

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).



Proposed Adjustment				
Line #	Line Description	Amount		
2.1	Premium Revenue	\$13,837		

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)	(\$4,244,138)		