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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 SelectHealth, 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 and state 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 October 21, 2024

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	Re	eported Amounts	Adju	stment Amounts	A	djusted Amounts
1.	Medical Loss Ratio Numerator						
1.1	Incurred Claims	\$	510,884,863	\$	(24,623,287)	\$	486,261,57
1.2	Activities that Improve Health Care Quality	\$	3,592,206	\$	374,381	\$	3,966,58
1.3	MLR Numerator	\$	514,477,068	\$	(24,248,906)	\$	490,228,16
1.4	Non-Claims Costs (Not Included in Numerator)	\$	33,421,288	\$	(3,635,817)	\$	29,785,47
2.	Medical Loss Ratio Denominator						
2.1	Premium Revenue	\$	557,325,556	\$	(5,644,750)	\$	551,680,80
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	\$	43,611	\$	-	\$	43,61
2.3	MLR Denominator	\$	557,281,946	\$	(5,644,750)	\$	551,637,19
3.	MLR Calculation						
3.1	Member Months		1,499,228		-		1,499,22
3.2	Unadjusted MLR		92.3%		-3.4%		88.
3.3	Credibility Adjustment		0.0%		0.0%		0.0
3.4	Adjusted MLR		92.3%		-3.4%		88.9
4.	Remittance						
4.2	State Minimum MLR Requirement		85.0%				85.0
4.6.2	Adjusted MLR						88.9
4.6.3	Meets MLR Standard		Yes				Ye

^{*}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 withholds 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 transactions with the pharmacies reflected amounts withheld from the payments to the pharmacies that were 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 withheld from the pharmacies 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	\$(60,402)		

Adjustment #2 - To adjust IBNR to supporting documentation

The health plan submitted more current claim lag tables for the incurred but not reported (IBNR) estimate that reflected material differences in IBNR by population to the original estimate. An adjustment was proposed to increase IBNR to the appropriate amount per supporting information. The IBNR and 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	\$2,557,397	

Adjustment #3 – To remove unsupported care coordination expenses

The health plan reported sub-capitated expense on the MLR Report. Based on the information submitted, the per-member-per month expenses represented care coordination services paid to providers for a restricted program intended to manage the care of the members. Care coordination services are considered health care quality improvement (HCQI) expenses. Documentation supporting the amount of allowable HCQI costs incurred by the providers was not provided. An adjustment has been proposed to remove the unsupported amounts. The medical and HCQI expenses reporting requirements are addressed in the Medicaid Managed Care Final Rule §§ 42 CFR 438.8(e)(2) and 438.8(e)(3).

Proposed Adjustment				
Line # Line Description		Amount		
1.1	Incurred Claims	(\$271,680)		

Adjustment #4 – To remove non-qualifying provider incentive payments

The health plan included provider incentive payments in the MLR Report that are based on a shared savings arrangement with IHC Health Services, Inc. Intermountain Health Care, Inc. is the sole corporate member of both the health plan and IHC Health Services, which owns and manages hospitals, clinics and other health-related operations. Based on the testing performed, it was determined that not all amounts in the shared savings program are paid out to providers as a substantial portion of the shared savings is retained by IHC Health Services. Additionally, based on review of the contract and supporting documentation, a significant portion of the payments paid to providers were not tied to quality metrics, and therefore, were solely shared savings payments. The contract between the health plan and state prohibits payments based on shared savings or profit sharing arrangements from inclusion as medical costs in the MLR calculation. An adjustment was proposed to remove the portion of the shared savings retained by the IHC Health Services, and to remove the payments paid to providers from the calendar year 2021 and 2022 listings that were not tied to quality metrics. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), 45 CFR § 158.140(b)(2)(iii), and the Utah Medicaid Managed Care Contract, Amendment 7, Attachment B, Section 12.5.2(H).

Proposed Adjustment				
Line #	Line Description	Amount		
1.1	Incurred Claims	\$(26,848,602)		

Adjustment #5 - To adjust HCQI expenses to amount per supporting documentation

The health plan reported HCQI expense on the MLR Report. Based on updated cost study information submitted, the amount reported per the template was lower than supporting information. An adjustment is proposed to increase the allowable amount included per supporting documentation. The HCQI expenses 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	\$374,381		

Adjustment #6 – 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, directed 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	\$(5,644,750)		

Adjustment #7 - 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 #	Amount		
1.4	Non-Claims Costs (Not Included in Numerator)	\$(3,635,817)	