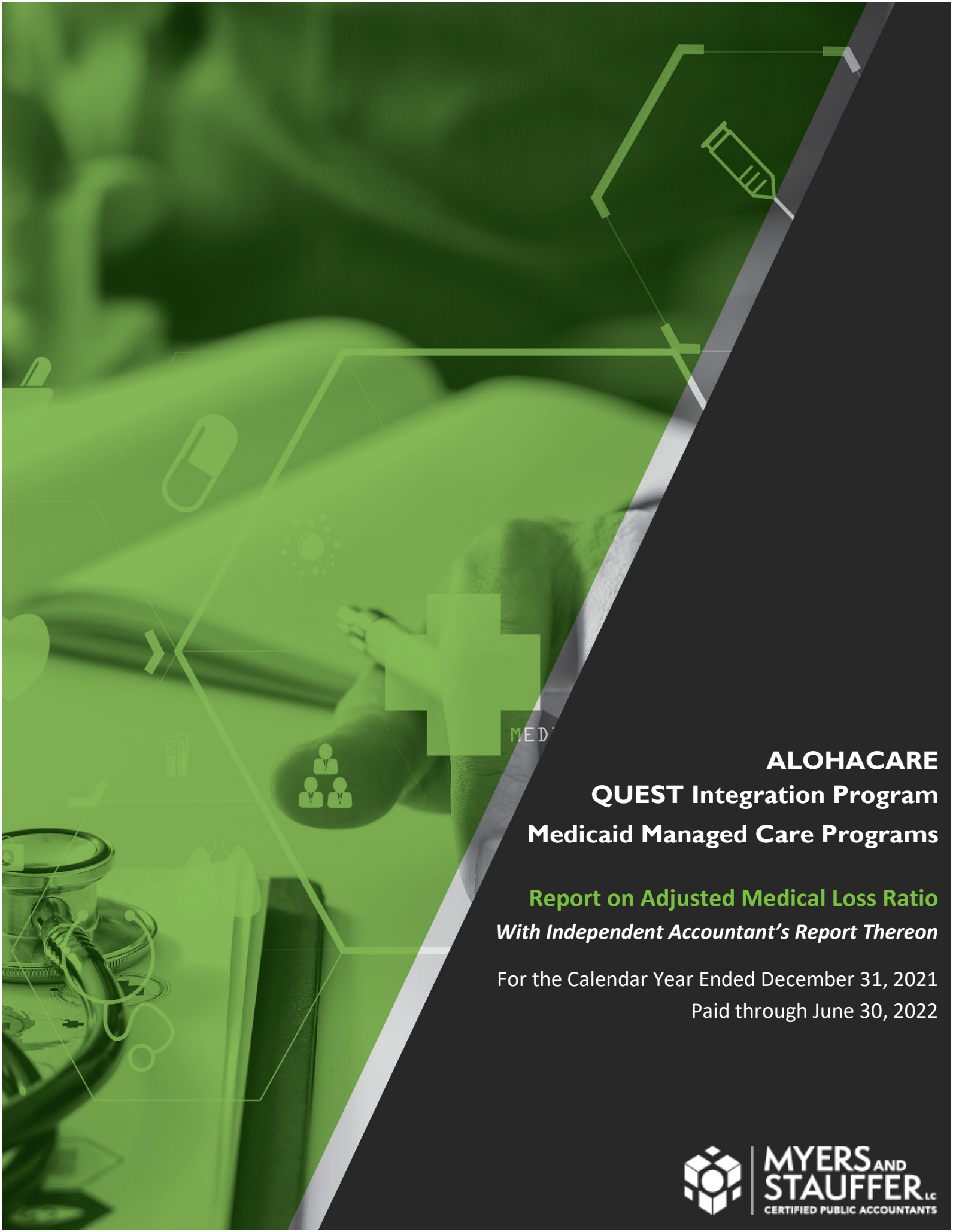

ALOHACARE
QUEST Integration Program
Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the Calendar Year Ended December 31, 2021

Paid through June 30, 2022

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

State of Hawaii
Department of Human Services, Med-QUEST Division
Kapolei, Hawaii

Independent Accountant's Report

We have examined the Medical Loss Ratio Report (MLR) Report of AlohaCare (health plan) for the calendar year ended December 31, 2021. The health plan's management is responsible for presenting information contained in the MLR 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 MLR 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 calendar year ended December 31, 2021.

This report is intended solely for the information and use of the Med-QUEST Division, 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

Myers and Stauffer LC
Kansas City, Missouri
January 17, 2024

Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2021 Paid Through June 30, 2022

Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2021 Paid Through June 30, 2022				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 378,582,734	$ 27,133,889	$ 405,716,623
1.2	Activities that Improve Health Care Quality	$ 3,223,001	$ (776,482)	$ 2,446,519
1.3	**MLR Numerator**	$ 381,805,735	$ 26,357,407	$ 408,163,142
1.4	Non-Claims Costs (Not Included in Numerator)	$ -	$ 4,605,473	$ 4,605,473
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 423,017,643	$ 31,653,127	$ 454,670,770
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ -	$ -	$ -
2.3	MLR Denominator	$ 423,017,643	$ 31,653,127	$ 454,670,770
3.	**MLR Calculation**			
3.1	Member Months	922,299	-	922,299
3.2	Unadjusted MLR	90.3%	-0.5%	89.8%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	90.3%	-0.5%	89.8%
4.	**Remittance**			
4.1	Contract Includes Remittance Requirement	Yes		Yes
4.2	State Minimum MLR Requirement	85.0%		85.0%
4.5	Calculated MLR for Remittance Purposes	90.3%	-0.5%	89.8%
4.6.1	Remittance Dollar Amount Owed for MLR Reporting Period	$ -	$ -	$ -

**The Non-Claims Costs line has not been 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 Calendar Year Ended December 31, 2021

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust incurred claims to remove expenses related to fraud recoveries

The health plan reported fraud recovery expense but did not report an amount for claims payments recovered through fraud reduction efforts. Due to a template formula error, the fraud recovery expenses were included within total incurred claims. An adjustment was proposed to remove the reported fraud recovery expenses from incurred claims. The incurred claims 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	($216,046)

Adjustment #2 – To adjust incurred claims and premium revenue to remove spend down

The health plan reported amounts related to spend down within incurred claims cost and premium revenue. As a component of the state's section 1115 waiver with the Centers for Medicare and Medicaid Services, the health plan is expected to collect the spend down amounts for members with a spend down obligation directly from members or providers through a reduction in provider reimbursement or direct payment from members. The state capitation payments made to the health plan were net of member spend down amounts the health plan was expected to collect. An adjustment was proposed to remove the impact of the spend down payment arrangement from incurred claims cost and premium revenue. The incurred claims and revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2) and 438.8(f)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($4,712,997)
2.1	Premium Revenue	($4,690,960)

Adjustment #3 – To adjust incurred claims to remove non-qualifying expenses

The health plan reported capitated provider payments and other medical expenses, outside of paid claims, within incurred claims. It was determined the health plan included non-qualifying expenses for cost containment. An adjustment was proposed to remove the non-qualifying amounts from incurred claims and reclassify it to non-claims costs. The incurred claims 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	($1,125,159)
1.4	Non-Claims Cost (Not Included in Numerator)	$1,125,159

Adjustment #4 – To adjust dental vendor expenses per supporting documentation

The health plan reported dental incurred claims in excess of the amounts paid to providers by third party dental vendor, Hawaii Dental Service. A certified statement was submitted by the vendor for actual claims payments incurred for dental services during the MLR reporting period. An adjustment was proposed to reduce dental expenses to the certified statement and reclassify the remaining dental expense to non-claims costs. 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	($41,004)
1.4	Non-Claims Cost (Not Included in Numerator)	$41,004

Adjustment #5 – To remove unsupported incurred claims per supporting documentation

The health plan reported incurred claims in excess of amounts per supporting documentation. An adjustment was proposed to remove the unsupported amount from incurred claims. The incurred claims 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	($213,048)

Adjustment #6 – To remove physician enhancement state directed payments included within incurred claims

The health plan reported incurred claims for physician enhancement state directed payments that were also reflected within the paid claim lag tables. An adjustment was proposed to remove the duplicated amount from incurred claims. The incurred claims 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	($2,500,756)

Adjustment #7 – To adjust unsupported case management expense

The health plan reported case management expense, provided by external agencies, within incurred claims. Based on federal guidance, case management expense should be reported as health care quality improvement expense and should reflect the external party's cost to provide the services. Supporting documentation of the external party's cost was not submitted by the health plan. An adjustment was proposed to remove the case management expense from incurred claims. The incurred claims and health care quality improvement (HCQI) 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	($835,609)
1.4	Non-Claims Costs (Not Included in Numerator)	$835,609

Adjustment #8 – To adjust premium revenue and incurred claims for state directed payments

The health plan reported state directed payments and associated expense amounts as pass-through revenue and expense, respectively, resulting in the exclusion of the amounts from the MLR calculation. An adjustment was proposed to report the state directed payments and the associated expense in agreement with the state's data. The state directed payment and associated expense reporting requirements are addressed in the 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	$39,726,267
2.1	Premium Revenue	$39,726,267

Adjustment #9 – To remove COVID vaccine expense carved out of capitation rate development per state data

The health plan reported COVID vaccine expenses within incurred claims. Expenses related to administering COVID vaccines was reimbursed outside of the capitation payments. An adjustment was proposed to remove COVID vaccine expenses from incurred claims per state data. The incurred claims 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	($1,051,116)

Adjustment #10 – To adjust spend down collected directly from members and providers per supporting documentation

The health plan did not reduce incurred claims for the Medicaid spend down obligation collected directly from its members and providers in situations where the amount could not be applied to the cost of care. An adjustment was proposed to reduce incurred claims for the amount directly collected per the health plan's supporting documentation. The incurred claims 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	($69,424)

Adjustment #11 – To adjust incurred claims to final net payments to pharmacies

The health plan reported pharmacy incurred claims based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims expense was overstated due to excluding the transaction fees assessed to the pharmacies by the pharmacy benefit managers (PBM), Express Scripts, Inc (January-June 2021) and IngenioRx (July-December 2021). An adjustment was proposed to reduce incurred claims by the amount related to transaction fees in order to reflect the final paid amount to the pharmacy and reclassify it to non-claims costs. The incurred claims and 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	($122,739)
1.4	Non-Claims Costs (Not Included in Numerator)	$122,739

Adjustment #12 – To adjust PBM vendor rate guarantee calculation per supporting documentation

The health plan reported pharmacy incurred claims for the third party vendor PBM, IngenioRx. It was determined contracted rate guarantee calculations were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact for the Medicaid line of business was a reduction in reimbursement to pharmacies. An adjustment was proposed to remove the Medicaid calculated amount for the MLR reporting period from incurred claims and reclassify it to non-claims costs. The incurred claims and 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	($1,704,480)
1.4	Non-Claims Costs (Not Included in Numerator)	$1,704,480

Adjustment #13 – To remove non-qualifying HCQI expense and adjust allocation statistics per supporting documentation

The health plan reported HCQI/ health information technology (HIT) external quality review (EQR) based on salaries, benefits, and overhead or fees for departments performing HCQI/ HIT/ EQR activities. It was determined the health plan included non-qualifying expenses per federal regulation. Additionally, the amount allocated to the Medicaid line of business was adjusted based on revised statistics. An adjustment was proposed to remove non-qualifying expenses and reclassify it to non-claims costs, and adjust allocation statistics per the health plan's supporting documentation. The HCQI/ HIT/ EQR expense 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 (HCQI)	($776,482)
1.4	Non-Claims Costs (Not Included in Numerator)	$776,482

Adjustment #14 – To adjust withhold payments per state data

The health plan reported withhold revenues that did not reflect the total payments earned, per state data, applicable to the MLR reporting period. An adjustment was proposed to report the earned withhold revenues in agreement with the state's data. 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	($399,587)

Adjustment #15 – To adjust risk share settlements per state data

A risk corridor was contractually in effect for the MLR reporting period. The health plan reported risk share payments that did not reflect the final settlement amounts, per state data, applicable to the MLR reporting period. An adjustment was proposed to report the risk share settlements in agreement with the state's data. 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	($3,420,517)

Adjustment #16 – To adjust premium revenue per state data

The health plan reported premium 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. 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	$437,924