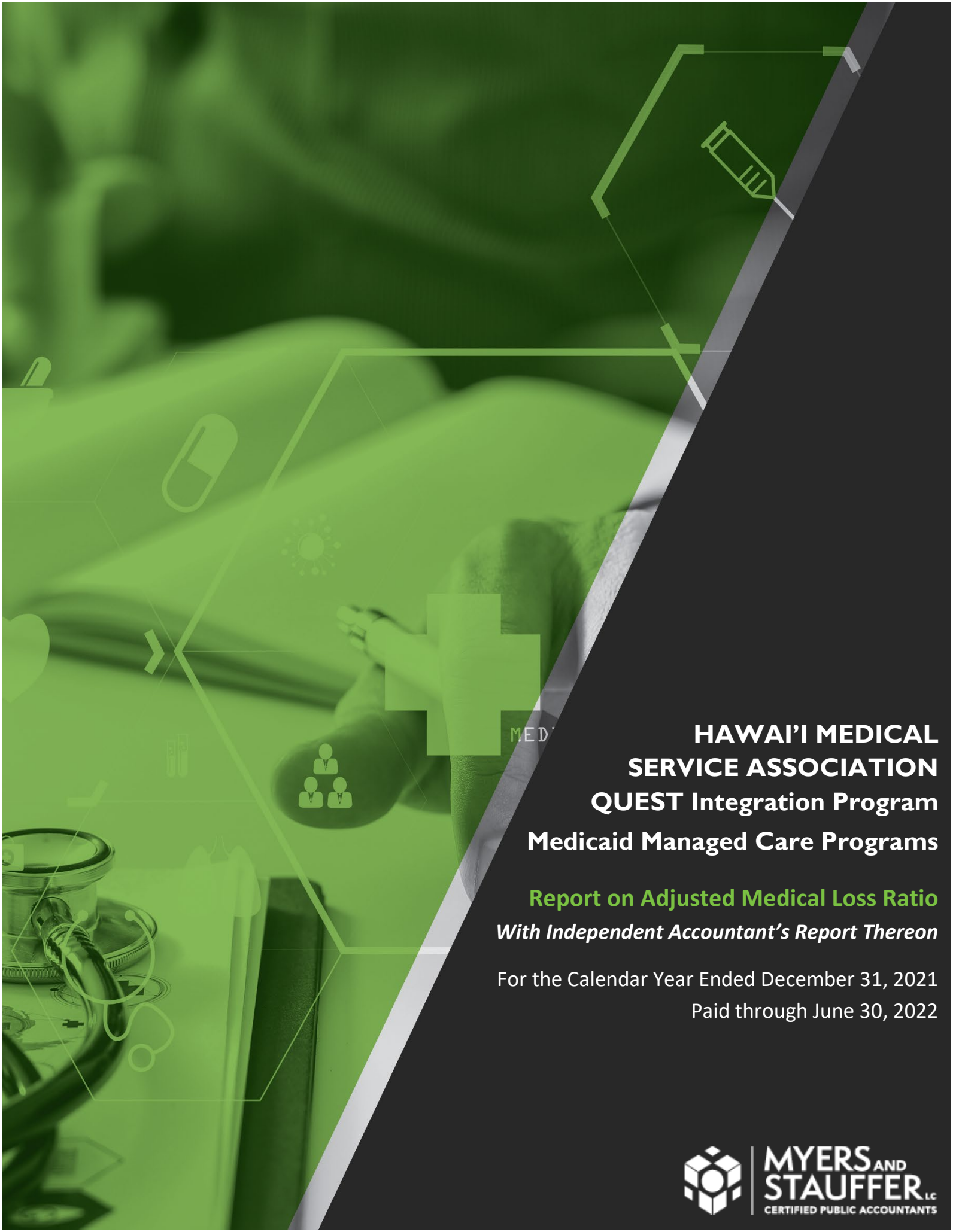

HAWAI'I MEDICAL SERVICE ASSOCIATION

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 Hawai'i Medical Service Association (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	$ 887,566,387	$ (20,655,594)	$ 866,910,793
1.2	Activities that Improve Health Care Quality	$ 8,829,023	$ (8,829,023)	$ -
1.3	MLR Numerator	$ 896,395,410	$ (29,484,617)	$ 866,910,793
1.4	Non-Claims Costs (Not Included in Numerator)	$ -	$ 36,438,484	$ 36,438,484
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 1,029,903,733	$ (11,597,454)	$ 1,018,306,279
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 4,246,352	$ (887,401)	$ 3,358,951
2.3	MLR Denominator	$ 1,025,657,381	$ (10,710,053)	$ 1,014,947,328
3.	**MLR Calculation**			
3.1	Member Months	2,412,571	-	2,412,571
3.2	Unadjusted MLR	87.4%	-2.0%	85.4%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	87.4%	-2.0%	85.4%
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	87.4%	-2.0%	85.4%
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, and accordingly, we express no opinion on it. However, any adjustments identified during the course of the examination procedures directly affecting the line, will be properly reflected within the adjustment totals.*

Schedule of Adjustments and Comments for the Calendar Year Ended December 31, 2021

During our examination, we identified the following adjustments:

Adjustment #1 – To remove pharmacy spread pricing

The health plan reported pharmacy incurred claims based on amounts the health plan paid to the pharmacy benefit manager (PBM), CaremarkPCS Health, LLC. It was determined spread pricing was the variance between amounts paid to pharmacies compared to payments reflected in the health plan's data. This margin charged to the health plan is considered PBM profit and is a non-allowable incurred claims expense. An adjustment was proposed to remove the identified spread pricing to report actual pharmacy medical expenditures and reclassify it to non-claims costs. The incurred claims and third party reporting requirements related to spread pricing 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	($26,178,187)
1.4	Non-Claims Costs (Not Included in Numerator)	$26,178,187

Adjustment #2 – To adjust incurred claims to final net payments to pharmacies

The health plan reported pharmacy incurred claims based on internal data which only reflected the 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 PBM. An adjustment was proposed to reduce incurred claims by the amount related to transaction fees in order to reflect the final amount paid 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	($543,873)
1.4	Non-Claims Costs (Not Included in Numerator)	$543,873

Adjustment #3 – To remove COVID vaccine expense carved out of capitation rate development per state data

The health plan reported COVID vaccine expenses within incurred claims expense. 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	($4,034,861)

Adjustment #4 – To remove expenses inaccurately allocated to the QUEST program

The health plan included telehealth program expenses that were inaccurately allocated to the QUEST program. An adjustment was proposed to remove the amounts attributable to other lines of business. 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	($1,846,114)

Adjustment #5 – To adjust provider incentive payments per supporting documentation

The health plan reported provider incentive payments that did not reconcile to supporting documentation. An adjustment was proposed to reduce provider incentive payments based on 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	($385,465)

Adjustment #6 – To adjust capitated provider payments per supporting documentation

The health plan reported third party capitated provider payments that did not reconcile to supporting documentation. The overall payments reported varied significantly to the recalculation utilizing the contract rate and appropriate membership for the MLR reporting period. An adjustment was proposed to reduce capitated provider payments per 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	($222,941)

Adjustment #7 – To adjust fraud recoveries per supporting documentation

The health plan incorrectly reported claims payments recovered through fraud reduction efforts within the expenses related to fraud recovery activities line. Additionally, due to a template formula error, the fraud recoveries were included within total incurred claims. It was determined based on health plan submitted supporting documentation there were expenses related to fraud recoveries. An adjustment was proposed to properly reflect fraud recoveries, limited to the amount of expense. 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	($76,408)

Adjustment #8 – To adjust understated incurred claims per supporting documentation

The health plan reported paid claims based on the specified runout period, including estimated incurred but not reported (IBNR) for the MLR reporting period. It was determined the majority of the variance was due to reprocessing claims after the MLR reporting period, along with advance payments to providers for claims not yet processed, which were both not factored into the IBNR estimate. Therefore, a current claims lag table was requested, paid through April 30, 2023. An adjustment was proposed to align with the more current and appropriate paid claims lag table amounts. 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	$12,233,859

Adjustment #9 – To adjust premium revenue and incurred claims for state directed payments

The health plan reported state directed nursing facility pay-for-performance (P4P) 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 P4P expense and payments in agreement with the state's data. The state directed payments 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	$509,349
2.1	Premium Revenue	$509,349

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

The health plan did not reduce incurred claims for the Medicaid spend down obligation collected directly from its members 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 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	($110,953)

Adjustment #11 – To remove non-qualifying HCQI/ HIT expense and reconcile per supporting documentation

The health plan reported health care quality improvement (HCQI)/ health information technology (HIT) expense related to salaries and benefits, as well as overhead costs. It was determined the health plan included non-qualifying and unsupported HCQI expenses based on federal guidance. An adjustment was proposed to remove non-qualifying salaries and benefits, amounts paid to vendors, and overhead and reclassify it to non-claims costs. The HCQI/ HIT 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	($8,829,023)
1.4	Non-Claims Costs (Not Included in Numerator)	$8,829,023

Adjustment #12 – 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	($2,746,504)

Adjustment #13 – 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	($2,848,785)

Adjustment #14 – To adjust revenues to remove spend down

The health plan reported spend down within 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 premium revenue. 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	($7,324,323)

Adjustment #15 – To adjust income taxes per audited financial statement information

The health plan reported income taxes that included amounts related to investment income. Per regulations, taxes related to investment income should be excluded from taxes reported for MLR purposes. Additionally, the change in deferred tax assets noted in the audited financial statements was not captured in the reporting of taxes. An adjustment was proposed to decrease taxes to the appropriate amount per supporting documentation and reclassify it to non-claims costs. The tax 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.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	($242,290)
1.4	Non-Claims Costs (Not Included in Numerator)	$242,290

Adjustment #16 – To remove non-qualifying CBE and taxes

The health plan reported community benefit expenditures (CBE) and real estate tax. Since the health plan is not exempt from federal income taxes, CBE is not allowable. The health plan also reported real estate taxes, which based on regulatory guidance do not qualify as an allowable tax for MLR reporting purposes. An adjustment was proposed to remove non-qualifying CBE and real estate taxes and reclassify the amount to non-claims costs. The tax and CBE reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	($645,111)
1.4	Non-Claims Costs (Not Included in Numerator)	$645,111

Adjustment #17 – To adjust premium revenues 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	$812,809