OHANA HEALTH PLAN, INC.
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

Table of Contents

- Table of Contents..... 1
- Independent Accountant's Report..... 2
- Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2021 Paid Through June 30, 2022..... 3
- Schedule of Adjustments and Comments for the Calendar Year Ended December 31, 2021..... 4

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 Ohana Health Plan, Inc. (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 30, 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	$ 317,161,325	$ 8,952,049	$ 326,113,375
1.2	Activities that Improve Health Care Quality	$ 12,240,756	$ (5,750,430)	$ 6,490,326
1.3	MLR Numerator	$ 329,402,081	$ 3,201,620	$ 332,603,701
1.4	Non-Claims Costs (Not Included in Numerator)	$ -	$ 13,561,115	$ 13,561,115
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 388,136,882	$ 13,133,256	$ 401,270,138
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 21,615,178	$ (1,330,857)	$ 20,284,321
2.3	MLR Denominator	$ 366,521,704	$ 14,464,113	$ 380,985,817
3.	**MLR Calculation**			
3.1	Member Months	464,692	-	464,692
3.2	Unadjusted MLR	89.9%	-2.6%	87.3%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	89.9%	-2.6%	87.3%
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	89.9%	-2.6%	87.3%
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 adjust spend down collected directly from members and providers per supporting documentation (inclusive of bad debt expenses reported).

The health plan reported spend down and bad debt expenses within incurred claim 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 offset of bad debt expense was also removed within the adjustment proposed. 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	($7,820,010)
2.1	Premium Revenue	($8,836,632)

Adjustment #2 – To remove COVID vaccine expenses carved out of capitation rate development per state data

The health plan reported COVID vaccine expenses within incurred claims and the corresponding revenue within premium revenue. 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 and to remove the amount included within 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	($381,783)
2.1	Premium Revenue	($192,000)

Adjustment #3 – To remove IBNR margin per health plan supporting documentation

The health plan reported incurred but not reported (IBNR) expenses that included an amount in excess of the incurred claims contained within the health plan's paid claim lag tables. It was determined the reported amount included a non-allowable reserve margin percentage. An adjustment was proposed to remove margin from IBNR and reclassify it to non-claims costs. The incurred claims and IBNR 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	($550,000)
1.4	Non-Claims Cost (Not Included in Numerator)	$550,000

Adjustment #4 – To remove malpractice and other non-allowable settlement expense

The health plan reported expense related to a malpractice settlement and unsupported vendor costs within IBNR expense. It was determined these expenses were non-allowable in the numerator of the MLR, and an adjustment was proposed to remove the non-allowable amounts and reclassify the amount to non-claims costs. The incurred claims and IBNR 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	($261,724)
1.4	Non-Claims Cost (Not Included in Numerator)	$261,724

Adjustment #5 – To adjust premium revenue and incurred claims for state directed payments

The health plan reported state directed payments and associated expense 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 associated expense in agreement with the state's data. The state directed payment and associated expense reporting requirements are addressed 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	$24,998,093
2.1	Premium Revenue	$24,998,093

Adjustment #6 – To adjust non-allowable administrative fees included within incurred claims

The health plan included expenses related to the Chore Services Program within incurred claims. It was determined administrative fees were included within the total amount reported. An adjustment was proposed to remove non-allowable administrative expenses 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	($51,017)
1.4	Non-Claims Cost (Not Included in Numerator)	$51,017

Adjustment #7 – To adjust vendor expenses per health plan supporting documentation

The health plan reported services for third party vendors based on capitated payment arrangements. Certified statements were submitted by the vendors for actual claims payments incurred during the MLR reporting period, which did not reconcile to the reported amounts by the health plan. An adjustment was proposed to reduce the amounts paid based on the vendor certification statements 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 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	($3,666,387)
1.4	Non-Claims Cost (Not Included in Numerator)	$3,666,387

Adjustment #8 – To remove unsupported incurred claims expense

The health plan included expense described as related to provider settlements, capitated vendor payments, and provider payments processed outside of the claims adjudication system within incurred claims. Based on supporting documentation submitted, there was not enough information regarding the nature of the services performed to determine the allowability of the expense as incurred claims. An adjustment was proposed to remove the expense from incurred claims due to the lack of supporting documentation 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	($1,634,760)
1.4	Non-Claims Cost (Not Included in Numerator)	$1,634,760

Adjustment #9 – To remove non-allowable PBM administrative fees

The health plan reported pharmacy incurred claims for the third party vendor pharmacy benefit manager (PBM), CVS Health, based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims were overstated as it included administrative fees. An adjustment was proposed to remove the non-allowable administrative fees 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	($301,793)
1.4	Non-Claims Cost (Not Included in Numerator)	$301,793

Adjustment #10 – To adjust value added services expenses per health plan supporting documentation

The health plan included value added services expenses that were incurred prior to the state approval effective date of July 1, 2021. An adjustment was proposed to remove the non-allowable expenses from within incurred claims based on health plan supporting documentation 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	($47,864)
1.4	Non-Claims Cost (Not Included in Numerator)	$47,864

Adjustment #11 – To adjust to related party HCQI expenses per health plan supporting documentation

The health plan did not report expenses for a related party vendor, Envolve PeopleCare. An adjustment was proposed to include the vendor's salary and benefit expenses for health care quality improvement

(HCQI) services performed per supporting documentation. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	$16,958

Adjustment #12 – To adjust incurred claims to final net payments to pharmacies

The health plan reported pharmacy incurred claims based on paid claim detail only reflecting 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 pharmacy benefit manager (PBM), CVS Health. 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 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	($72,341)
1.4	Non-Claims Cost (Not Included in Numerator)	$72,341

Adjustment #13 – To adjust PBM vendor rate guarantee calculation per supporting documentation

The health plan reported pharmacy incurred claims for the third party vendor PBM, CVS Health. 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	($1,207,841)
1.4	Non-Claims Cost (Not Included in Numerator)	$1,207,841

Adjustment #14 – To adjust provider incentives payments per health plan 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	($50,523)

Adjustment #15 – To remove non-qualifying HCQI/HIT expenses

The health plan reported health care quality improvement/ health information technology (HCQI/HIT) expenses based on salaries and benefits, and overhead costs for departments performing HCQI/HIT activities. 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, 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	Activities that Improve Health Care Quality	($5,767,388)
1.4	Non-Claims Cost (Not Included in Numerator)	$5,767,388

Adjustment #16 – 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	($848,414)

Adjustment #17 – 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	($2,076,581)

Adjustment #18 – To adjust taxes per health plan supporting documentation

The health plan reported income taxes that included amounts for investment income. In accordance with regulations, income taxes on investment income should be excluded from taxes reported for MLR purposes. An adjustment was proposed to decrease taxes to the appropriate amount per supporting documentation and allocate the tax to the Medicaid line of business. 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	($1,330,857)

Adjustment #19 – To remove reduction of revenue related to reinsurance

The health plan reported a reduction to premium revenue related to reinsurance. The state of Hawaii does not mandate reinsurance, therefore its impact should not be reflected within the MLR calculation. An adjustment was proposed to remove the reduction of revenue for reinsurance. 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	$25,635

Adjustment #20 – 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	$63,155