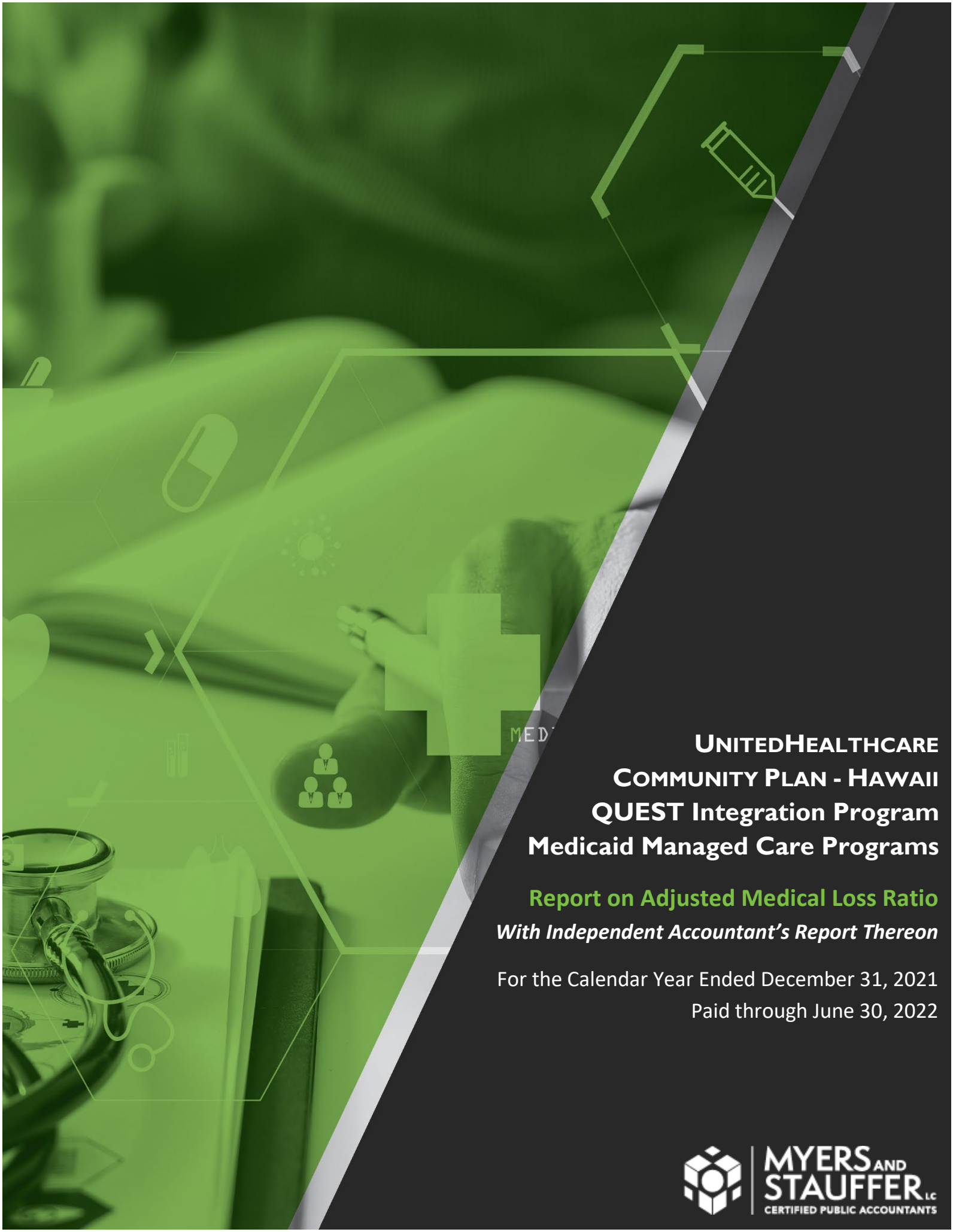

UnitedHealthcare Community Plan - Hawaii QUEST Integration Program Medicaid Managed Care Programs

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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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 UnitedHealthcare Community Plan - Hawaii (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
April 4, 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	$ 377,209,965	$ 21,797,626	$ 399,007,591
1.2	Activities that Improve Health Care Quality	$ 18,832,567	$ (7,114,898)	$ 11,717,669
1.3	MLR Numerator	$ 396,042,533	$ 14,682,728	$ 410,725,261
1.4	Non-Claims Costs (Not Included in Numerator)	$ -	$ 11,426,128	$ 11,426,128
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 481,819,859	$ 15,207,170	$ 497,027,029
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 28,681,734	$ 690,976	$ 29,372,710
2.3	MLR Denominator	$ 453,138,125	$ 14,516,194	$ 467,654,319
3.	**MLR Calculation**			
3.1	Member Months	701,639	-	701,639
3.2	Unadjusted MLR	87.4%	0.4%	87.8%
3.3	Credibility Adjustment	0.0%	0.0%	0.0%
3.4	Adjusted MLR	87.4%	0.4%	87.8%
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	87.4%	0.4%	87.8%
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, 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 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 Medical Loss Ratio (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	$40,043,312
2.1	Premium Revenue	$40,043,312

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. 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	($176,287)

Adjustment #3 – To adjust paid claims per supporting documentation

The health plan under reported paid claims when comparing amounts per the health plan paid claims lag tables. An adjustment was proposed to include the paid claims amount per health plan 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	$1,315,190

Adjustment #4 – 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	($13,104,728)
2.1	Premium Revenue	($14,381,185)

Adjustment #5 – To adjust fraud recoveries per supporting documentation

The health plan reported an amount for claims payments recovered through fraud reduction efforts but did not report an amount for fraud recovery expense. 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 that there were no expenses incurred 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	($49,380)

Adjustment #6 – To adjust related party vendor per supporting documentation

The health plan reported services for related party vendor, United Behavioral Health based on a per-member per-month (PMPM) arrangement. Paid claims lag tables were submitted for actual claim 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 claims lag tables and reclassify the amount to non-claims costs. The incurred claims and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), Center for Medicaid and CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019, CMS Publication 15-1, Chapter 10.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($618,254)
1.4	Non-Claims Cost (Not Included in Numerator)	$618,254

Adjustment #7 – To adjust third party vendor expenses per supporting documentation

The health plan reported services for third party vendor, Modivcare based on a per-member per-month (PMPM) arrangement. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the MLR reporting period. An adjustment was proposed to remove the administrative and profit components of the PMPM amount from incurred claims. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), 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	($3,409,435)
1.4	Non-Claims Cost (Not Included in Numerator)	$3,409,435

Adjustment #8 – 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	($238,541)
1.4	Non-Claims Cost (Not Included in Numerator)	$283,541

Adjustment #9 – To remove non-qualifying HCQI expenses and to reclassify non-qualifying HCQI expenses to non-claims costs

The health plan reported health care quality improvement/health information technology (HCQI/HIT) expense based on salaries, benefits, and overhead costs for departments performing HCQI/HIT activities. It was determined the health plan included non-qualifying expenses per federal regulations. An adjustment was proposed to remove non-qualifying salaries and benefits, and overhead expense and reclassify it to non-claims costs. The HCQI/HIT 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	Health Care Quality Improvement (HCQI)	($7,114,898)
1.4	Non-Claims Cost (Not Included in Numerator)	$7,114,898

Adjustment #10 – 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 Revenues	($405,263)

Adjustment #11 – 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	($9,694,586)

Adjustment #12 – To adjust premium taxes per recalculation to adjusted premium revenue

The health plan reported premium taxes that reconciled to the original supporting documentation. However, after determining that an incorrect amount of revenue was reported per state data, changes were applied to the premium tax calculation to recalculate based on the adjusted premium revenue. An adjustment was proposed to increase taxes to the appropriate amount per the recalculation. 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	$690,976

Adjustment #13 – 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	($355,108)

Adjustment #14 – To adjust settlement claims reserve per supporting documentation

The health plan reported estimated expense to establish a reserve for anticipated provider claim settlements. In lieu of re-adjudicating claims related to claim disputes or multiple claim payment errors, the health plan may negotiate settlement agreements with providers. Based on information provided by the health plan the reserve was overestimated. An adjustment was proposed to remove the unused reserve. 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	($1,919,251)