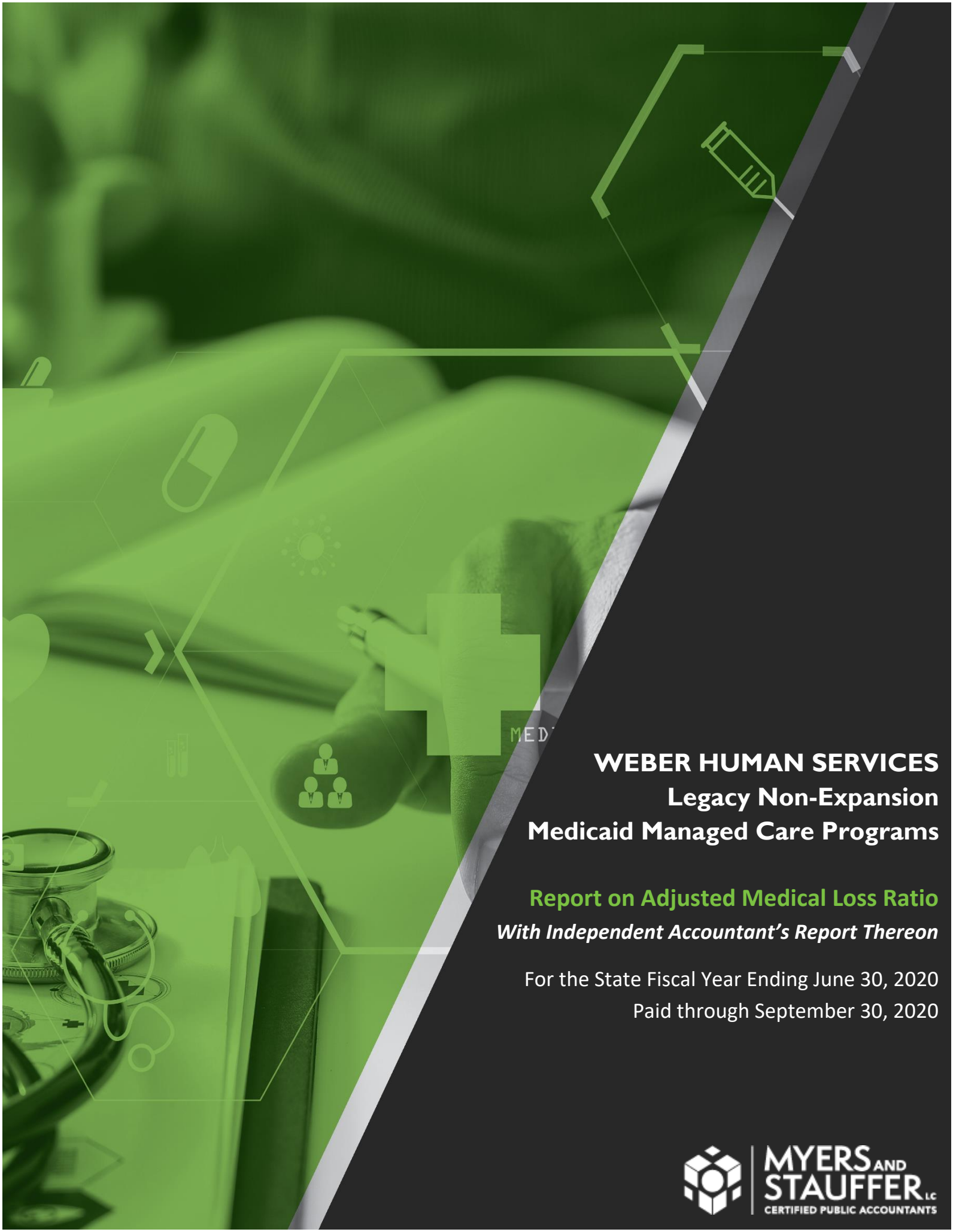

WEBER HUMAN SERVICES
Legacy Non-Expansion Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ending June 30, 2020
Paid through September 30, 2020

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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State of Utah
Department of Health, Division of Medicaid and Health Financing
Salt Lake City, Utah

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio of Weber Human Services Prepaid Mental Health Plan for the state fiscal year ending June 30, 2020. Weber Human Services management is responsible for presenting the Medical Loss Ratio (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.

The accompanying Adjusted Medical Loss Ratio was prepared 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 above referenced accompanying Adjusted Medical Loss Ratio is presented in accordance with the above referenced criteria, in all material respects, and the Adjusted Medical Loss Ratio Percentages Achieved for both the Mental Health and Substance Abuse populations do not exceed the Centers for Medicare & Medicaid Services (CMS) requirement of eighty-five percent (85%) for the state fiscal year ending June 30, 2020.

This report is intended solely for the information and use of the Department of Health, Milliman, and Weber Human Services 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
March 10, 2022

Adjusted Mental Health Medical Loss Ratio for the State Fiscal Year Ending June 30, 2020 Paid Through September 30, 2020

Adjusted Mental Health Medical Loss Ratio for the State Fiscal Year Ending June 30, 2020 Paid Through September 30, 2020				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1. Numerator				
1.1	Incurred Claims	$ 9,970,567	$ 30,214	$ 10,000,781
1.2	Quality Improvement	$ 123,441	$ (123,441)	$ -
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 10,094,008	$ (93,227)	$ 10,000,781
2. Denominator				
2.1	Premium Revenue	$ 15,430,168	$ (230,469)	$ 15,199,699
2.2	Taxes and Fees	$ 916,668	$ (649,135)	$ 267,533
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 14,513,500	$ 418,666	$ 14,932,166
3. Credibility Adjustment				
3.1	Member Months	295,260	2,482	297,742
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.23%	0.0%	1.2%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	69.55%	-2.6%	67.0%
4.2	Credibility Adjustment	1.23%	0.0%	1.2%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	70.78%	-2.6%	68.2%
5. Remittance Calculation				
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes
5.2	MLR Standard	85.00%		85.0%
5.3	Adjusted MLR	70.78%		68.2%
5.4	Meets MLR Standard	No		No

Adjusted Substance Abuse Medical Loss Ratio for the State Fiscal Year Ending June 30, 2020 Paid Through September 30, 2020

Adjusted Substance Abuse Medical Loss Ratio for the State Fiscal Year Ending June 30, 2020 Paid Through September 30, 2020				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1. Numerator				
1.1	Incurred Claims	$ 889,547	$ (79,529)	$ 810,018
1.2	Quality Improvement	$ 10,200	$ (10,200)	$ -
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 899,747	$ (89,729)	$ 810,018
2. Denominator				
2.1	Premium Revenue	$ 1,274,945	$ (113,688)	$ 1,161,257
2.2	Taxes and Fees	$ 79,906	$ (31,759)	$ 48,147
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 1,195,039	$ (81,929)	$ 1,113,110
3. Credibility Adjustment				
3.1	Member Months	295,260	(3,847)	291,413
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.23%	0.0%	1.2%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	75.29%	-2.5%	72.8%
4.2	Credibility Adjustment*	1.23%	0.0%	1.2%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	76.52%	-2.5%	74.0%
5. Remittance Calculation				
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes
5.2	MLR Standard	85.00%		85.0%
5.3	Adjusted MLR	76.52%		74.0%
5.4	Meets MLR Standard	No		No

**Note 1: The Credibility Adjustment formula as-submited template referenced Mental Health member months in the calculation of the Substance Abuse credibility adjustment. The Substance Abuse Credibility Adjustment formula was updated to reference Substance Abuse member months.*

Mental Health Schedule of Adjustments and Comments for the State Fiscal Year Ending June 30, 2020

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust capitation revenues per state data

The health plan reported revenue amounts that did not reflect all 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 the state 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	($230,469)

Adjustment #2 – To adjust member months per state data

The health plan reported member month amounts that did not reflect the total member months per the state data for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the member months per the state data. The member months reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(1)(xiii).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.1	Member Months	2,482

Adjustment #3 – To adjust health care quality improvement expenses reported as 0.8 percent of premium revenues

The health plan reported health care quality improvement (HCQI) expenses utilizing 0.8% of premium revenues instead of actual cost. This election of reporting HCQI expenses was outlined in 45 CFR § 158.221 for the calculation of the MLR under the Affordable Care Act, but is not referenced in the calculation of the MLR per 42 CFR § 483.8 of the Medicaid Managed Care Final Rule. Actual HCQI costs were requested to support the expenses based on the health plans records. However, the health plan did not provide actual HCQI expense. Therefore, an adjustment was proposed to remove the HCQI expenses from the MLR Report. The HCQI 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	($123,441)

Adjustment #4 – To items that do not qualify as examination fees, state premium taxes, local taxes and assessments

The health plan reported the PMHP administrative charge as a local tax on the MLR Report. This is part of an intergovernmental transfer (IGT) between the health plan and Utah Department of Health (DOH). After discussions with the DOH, it was determined that the administrative charge does not meet the definition of an allowable tax per the federal guidance. An adjustment was proposed to remove the administrative charge from the MLR calculation. The qualifying tax 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	Taxes and Fees	($152,875)

Adjustment #5 – To adjust CBE per supporting documentation

The health plan reported community benefit expenditures (CBE) related to a medical clinic for mental health clients, transportation, community outreach team, and advertising. An adjustment was proposed to remove the transportation and advertising expenses from the MLR Report as these are non-covered Medicaid expenses. An adjustment was proposed to apply the mental health capitated percentage to allowable CBE. The CBE reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and 45 CFR § 158.162(c).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Taxes and Fees	($496,260)

Adjustment #6 – To adjust incurred claims cost based on adjustments made to the PMHP cost report

The health plan's incurred claims cost was reported based on the claims cost included in the PMHP financial report. After performing verification procedures on the PMHP report, adjustments were made to the financial report for the following items:

- Adjust capitated percentages of non-coded state plan services to support.
- Adjust reported CPT units to minutes to units calculation.
- Reconcile Schedule 2BMH to submitted support.
- Correct Schedule 5 formula errors where all general ledger accounts were not being included, and Basis 1 for each CPT code where not all cost centers were being included.
- Reconcile Schedule 4A Part 4R to submitted data and remove service year 19 bed days/inpatient cost.
- Adjust cost center 4 telephone expense to support.
- Reconcile retirement liability on cost center 16 to audited financial statements.
- Adjust administrative and non-covered maintenance direct hours to support.
- Provider revised schedule 6 which impacted cost of all other schedules due to linking.

These adjustments to the PMHP report then impacted the incurred claims cost reported on the MLR report. The incurred claims reported 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	$30,214

Substance Abuse Schedule of Adjustments and Comments for the State Fiscal Year Ending June 30, 2020

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust capitation revenues per state data

The health plan reported revenue amounts that did not reflect all 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 the state 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	($113,688)

Adjustment #2 – To adjust member months per state data

The health plan reported member month amounts that did not reflect the total member months per the state data for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the member months per the state data. The member months reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(1)(xiii).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.1	Member Months	(3,847)

Adjustment #3 – To adjust health care quality improvement expenses reported as 0.8 percent of premium revenues

The health plan reported health care quality improvement (HCQI) expenses utilizing 0.8% of premium revenues instead of actual cost. This election of reporting HCQI expenses was outlined in 45 CFR § 158.221 for the calculation of the MLR under the Affordable Care Act, but is not referenced in the calculation of the MLR per 42 CFR § 483.8 of the Medicaid Managed Care Final Rule. Actual HCQI costs were requested to support the expenses based on the health plans records. However, the health plan did not provide actual HCQI expense. Therefore, an adjustment was proposed to remove the HCQI expenses from the MLR Report. The HCQI 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	($10,200)

Adjustment #4 – To items that do not qualify as examination fees, state premium taxes, local taxes and assessments

The health plan reported the PMHP administrative charge as a local tax on the MLR Report. This is part of an intergovernmental transfer (IGT) between the health plan and Utah Department of Health (DOH). After discussions with the DOH, it was determined that the administrative charge does not meet the definition of an allowable tax per the federal guidance. An adjustment was proposed to remove the administrative charge from the MLR calculation. The qualifying tax 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	Taxes and Fees	($29,421)

Adjustment #5 – To adjust CBE per supporting documentation

The health plan reported community benefit expenditures (CBE) related to a medical clinic for mental health clients, transportation, community outreach team, and advertising. An adjustment was proposed to remove the transportation and advertising expenses from the MLR Report as these are non-covered Medicaid expenses. An adjustment was proposed to apply the substance abuse capitated percentage to allowable CBE. The CBE reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and 45 CFR § 158.162(c).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Taxes and Fees	($2,338)

Adjustment #6 – To adjust incurred claims cost based on adjustments made to the PMHP cost report

The health plan's incurred claims cost was reported based on the claims cost included in the PMHP financial report. After performing verification procedures on the PMHP report, adjustments were made to the financial report for the following items:

- Adjust capitated percentages of non-coded state plan services to support.
- Adjust reported CPT units to minutes to units calculation.
- Adjust Schedule 2BSA to reconcile to provider support.
- Correct Schedule 5 formula errors where all general ledger accounts were not being included, and Basis 1 for each CPT code where not all cost centers were being included.
- Adjust cost center 4 telephone expense to support.
- Reconcile retirement liability on cost center 16 to audited financial statements.
- Adjust administrative and non-covered maintenance direct hours to support.
- Provider revised schedule 6 which impacted cost of all other schedules due to linking.

These adjustments to the PMHP report then impacted the incurred claims cost reported on the MLR report. The incurred claims reported 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	($79,529)