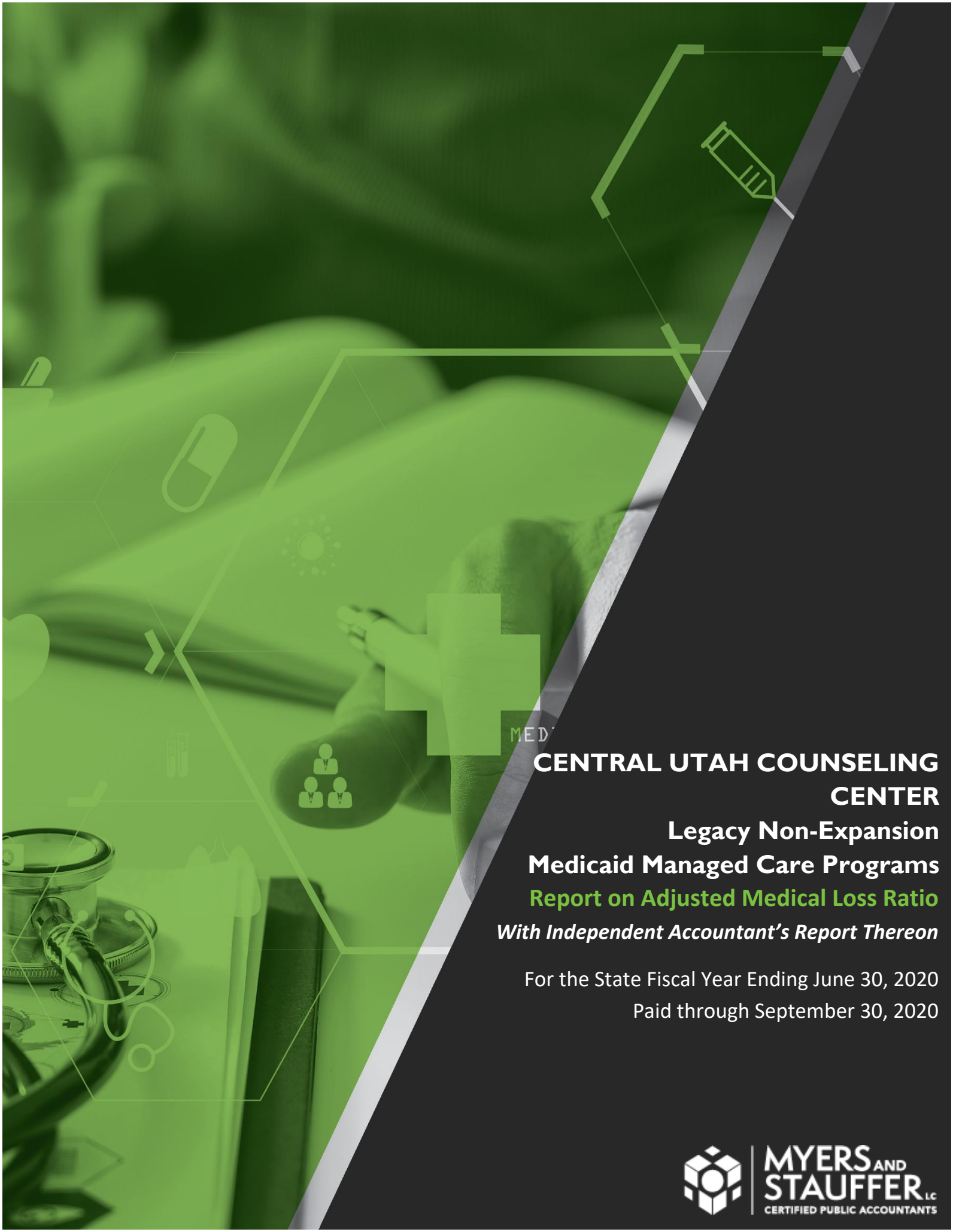

CENTRAL UTAH COUNSELING CENTER

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 Central Utah Counseling Center's (Central) Prepaid Mental Health Plan for the state fiscal year ending June 30, 2020. Central's 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 Percentage Achieved for the Substance Abuse population exceeds the Centers for Medicare & Medicaid Services (CMS) requirement of eighty-five percent (85%) for the state fiscal year ending June 30, 2020; however, the Mental Health population does not exceed the requirement 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 Central 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 18, 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	$ 3,684,544	$ (476,940)	$ 3,207,604
1.2	Quality Improvement	$ 30,916	$ 108,492	$ 139,407
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 3,715,460	$ (368,448)	$ 3,347,012
2. Denominator				
2.1	Premium Revenue	$ 4,389,571	$ -	$ 4,389,571
2.2	Taxes and Fees	$ 176,386	$ (176,386)	$ (0)
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 4,213,185	$ 176,386	$ 4,389,571
3. Credibility Adjustment				
3.1	Member Months	104,106	-	104,106
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.96%	0.0%	2.0%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	88.19%	-12.0%	76.2%
4.2	Credibility Adjustment	1.96%	0.0%	2.0%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	90.15%	-12.0%	78.2%
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	90.15%		78.2%
5.4	Meets MLR Standard	Yes		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	$ 370,224	$ (63,360)	$ 306,864
1.2	Quality Improvement	$ 2,003	$ 16,175	$ 18,178
1.3	Total Numerator [Incurred Claims + Quality Improvement]	$ 372,227	$ (47,185)	$ 325,042
2. Denominator				
2.1	Premium Revenue	$ 383,420	$ -	$ 383,420
2.2	Taxes and Fees	$ 20,344	$ (20,344)	$ (0)
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	$ 363,076	$ 20,344	$ 383,420
3. Credibility Adjustment				
3.1	Member Months	100,981	-	100,981
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.96%	0.0%	2.0%
4. MLR Calculation				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	102.52%	-17.7%	84.8%
4.2	Credibility Adjustment*	1.96%	0.0%	2.0%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	104.48%	-17.7%	86.8%
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	104.48%		86.8%
5.4	Meets MLR Standard	Yes		Yes

**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 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:

- To reclassify non-allowable pass-through expense to non-covered costs on Schedule 5.
- To recategorize cost without units associated to allow the cost to be allocated through cost center allocation rather than being assigned to a CPT code without units on Schedule 5.
- To adjust units reported on Schedule 4 based on minutes to units recalculation.
- Reconcile third party liability collections to support provided by the health plan.
- To adjust hours on Schedule 6 to agree with support provided by the health plan.
- To exclude non-cash portion of post-employment health benefits.
- To eliminate employee direct hours on Schedule 6 counted twice in the two tracking systems used by the health plan.
- To correct employee compensation on Schedule 6.
- To reclassify healthcare quality improvement and health plan administrative non-claims cost on Schedule 6.

These adjustments to the PMHP report then impacted the incurred claims cost reported on the MLR. 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	($476,940)

Adjustment #2 – 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. The health plan submitted support for HCQI and the costs activities were compared to the HCQI guidance. Activities that were deemed allowable were included in 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	$108,492

Adjustment #3 – To remove 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	($44,698)

Adjustment #4 – To correct a formula error on the as-submitted medical loss ratio template regarding the calculation of allowable Community Benefit Expenditures

The DOH's MLR Report contains a formula error in the calculation of maximum allowable community benefit expenditures (CBE) for tax exempt health plans. The formula includes the lesser of three percent of premium revenues or actual CBE expense in the MLR calculation. Because the health plan submitted the MLR Report with a blank value rather than a zero value for CBE expense, the lesser of logic included three percent of premium revenue in the MLR calculation rather than zero. As a result, the MLR calculation was overstated. An adjustment was proposed to update the report formula to correctly calculate CBE on the MLR Report. 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	($131,688)

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 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:

- To reclassify non-allowable pass-through expense to non-covered costs on Schedule 5.
- To recategorize cost without units associated to allow the cost to be allocated through cost center allocation rather than being assigned to a CPT code without units on Schedule 5.
- To adjust units reported on Schedule 4 based on minutes to units recalculation.
- Reconcile third party liability collections to support provided by the health plan.
- To adjust hours on Schedule 6 to agree with support provided by the health plan.
- To exclude non-cash portion of post-employment health benefits.
- To eliminate employee direct hours on Schedule 6 counted twice in the two tracking systems used by the health plan.
- To correct employee compensation on Schedule 6.
- To reclassify healthcare quality improvement and health plan administrative non-claims cost on Schedule 6.

These adjustments to the PMHP report then impacted the incurred claims cost reported on the MLR. 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	($63,360)

Adjustment #2 – 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. The health plan submitted support for HCQI and the costs activities were compared to the HCQI guidance. Activities that were deemed allowable were included in 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	$16,175

Adjustment #3 – To remove 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	($8,841)

Adjustment #4 – To correct a formula error on the as-submitted medical loss ratio template regarding the calculation of allowable Community Benefit Expenditures

The DOH's MLR Report contains a formula error in the calculation of maximum allowable community benefit expenditures (CBE) for tax exempt health plans. The formula includes the lesser of three percent of premium revenues or actual CBE expense in the MLR calculation. Because the health plan submitted the MLR Report with a blank value rather than a zero value for CBE expense, the lesser of logic included three percent of premium revenue in the MLR calculation rather than zero. As a result, the MLR calculation was overstated. An adjustment was proposed to update the report formula to correctly calculate CBE on the MLR Report. 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	($11,503)