

The background features a blurred image of a person lying in a hospital bed, overlaid with a semi-transparent green layer. Various medical icons are scattered across the green area, including a syringe, a pill, a stethoscope, a microscope, a group of people, and a cross. A large, semi-transparent cross is centered over the person's chest. The word 'MEDICAL' is partially visible in the background. A dark grey diagonal shape on the right side contains the main text.

**VALLEY BEHAVIORAL HEALTH**  
**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**<sub>LC</sub>  
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 Valley Behavioral Health Prepaid Mental Health Plan for the state fiscal year ending June 30, 2020. Valley Behavioral Health'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 Percentages Achieved for the Mental Health 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 Substance Abuse 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 Valley Behavioral Health and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC  
Kansas City, Missouri  
September 8, 2021



## 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
<b>1. Numerator</b>				
1.1	Incurred Claims	\$ 3,017,808	\$ 247,507	\$ 3,265,315
1.2	Quality Improvement	\$ 30,291	\$ (30,291)	\$ 0
1.3	Total Numerator [Incurred Claims + Quality Improvement]	\$ 3,048,099	\$ 217,216	\$ 3,265,315
<b>2. Denominator</b>				
2.1	Premium Revenue	\$ 3,786,376	\$ -	\$ 3,786,376
2.2	Taxes and Fees	\$ 157,159	\$ (157,159)	\$ 0
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	\$ 3,629,217	\$ 157,159	\$ 3,786,376
<b>3. Credibility Adjustment</b>				
3.1	Member Months	72,701	-	72,701
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	2.44%	0.0%	2.4%
<b>4. MLR Calculation</b>				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	83.99%	2.3%	86.2%
4.2	Credibility Adjustment	2.44%	0.0%	2.4%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	86.43%	2.3%	88.7%
<b>5. Remittance Calculation</b>				
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes
5.2	MLR Standard	85.00%		85.0%
5.3	Adjusted MLR	86.43%		88.7%
5.4	Meets MLR Standard	Yes		Yes



**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
<b>1. Numerator</b>				
1.1	Incurred Claims	\$ 161,378	\$ (42,431)	\$ 118,947
1.2	Quality Improvement	\$ 2,395	\$ (2,395)	\$ (0)
1.3	Total Numerator [Incurred Claims + Quality Improvement]	\$ 163,773	\$ (44,826)	\$ 118,947
<b>2. Denominator</b>				
2.1	Premium Revenue	\$ 299,367	\$ -	\$ 299,367
2.2	Taxes and Fees	\$ 19,536	\$ (19,536)	\$ (0)
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	\$ 279,831	\$ 19,536	\$ 299,367
<b>3. Credibility Adjustment</b>				
3.1	Member Months	70,695	(830)	69,865
3.2	Credibility	Partially Credible		Partially Credible
3.3	Credibility Adjustment	2.44%	0.1%	2.5%
<b>4. MLR Calculation</b>				
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	58.53%	-18.8%	39.7%
4.2	Credibility Adjustment*	2.44%	0.1%	2.5%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	60.97%	-18.8%	42.2%
<b>5. Remittance Calculation</b>				
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes
5.2	MLR Standard	85.00%		85.0%
5.3	Adjusted MLR	60.97%		42.2%
5.4	Meets MLR Standard	No		No

\*Note 1: The Credibility Adjustment formula as-submitted 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:

- Remove non-allowable charitable donation expense included on Schedule 5
- Reclassify incorrect hours placement on Schedule 6
- Remove Medicaid units on Schedule 3MH, 3SA, and 4 without any identified cost
- Adjust total units on Schedule 4 to agree to revised health plan support
- Adjust Medicaid units on Schedule 3MH, 3SA, and 4 that varied from state encounter data significantly
- Include total inpatient cost from Schedule 4A after reduction of direct employee expense for time spent performing utilization review

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	\$247,507

## **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 is 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	(\$30,291)

**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	(\$43,568)

**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	(\$113,591)



# 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:

- Remove non-allowable charitable donation expense included on Schedule 5
- Reclassify incorrect hours placement on Schedule 6
- Remove Medicaid units on Schedule 3MH, 3SA, and 4 without any cost
- Adjust total units on Schedule 4 to agree to revised plan support
- Adjust Medicaid units on Schedule 3MH, 3SA, and 4 that varied from state encounter data significantly

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	(\$42,431)

## **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 is 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	(\$2,395)

**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	(\$10,555)

**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	(\$8,981)



**Adjustment #5 – To adjust member months to 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. 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	(830)