SOUTHWEST BEHAVIORAL HEALTH
Expansion Population
Medicaid Managed Care Programs

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the Six-Month Period Ended 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 Southwest Behavioral Health Prepaid Mental Health Plan for the six-month period ended June 30, 2020. Southwest 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, except for the effect of the item addressed in the Schedule of Reporting Caveats, 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 for the Mental Health and Substance Abuse populations exceeds the Centers for Medicare & Medicaid Services (CMS) requirement of eighty-five percent (85%) for the six-month period ended June 30, 2020.

This report is intended solely for the information and use of the Department of Health, Milliman, and Southwest Behavioral Health 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
June 23, 2022

Adjusted Mental Health Medical Loss Ratio for the Six-Month Period Ended June 30, 2020 Paid Through September 30, 2020

Adjusted Mental Health Medical Loss Ratio for the Six-Month Period Ended June 30, 2020 Paid Through September 30, 2020 Expansion Population						
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Preliminary Adjusted Amounts**	**Risk Corridor Cost Settlement Amount**	**Adjusted Amounts**
1. Numerator						
1.1	Incurred Claims	$ 370,592	$ (10,412)	$ 360,180		$ 360,180
1.2	Quality Improvement	$ 2,901	$ 1,554	$ 4,455		$ 4,455
1.3	Total Numerator [Incurred Claims + Quality Improvement]	**$ 373,493**	**$ (8,858)**	**$ 364,635**		**$ 364,635**
2. Denominator						
2.1	Premium Revenue	$ 362,597	$ 67,713	$ 430,310	$ -	$ 430,310
2.2	Taxes and Fees	$ 13,859	$ (13,859)	$ -		$ -
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	**$ 348,738**	**$ 81,572**	**$ 430,310**	**$ -**	**$ 430,310**
3. Credibility Adjustment						
3.1	Member Months	8,833	1,660	10,493		$ 10,493
3.1a	Annualized Member Months	17,666	3,320	20,986		$ 20,986
3.2	Credibility	Partially Credible		Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.99%	2.4%	4.4%		4.4%
4. MLR Calculation						
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	107.10%	-22.4%	84.7%	0.0%	84.7%
4.2	Credibility Adjustment	1.99%	2.4%	4.4%		4.4%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	**109.09%**	**-20.0%**	**89.1%**	**0.0%**	**89.1%**
5. Remittance Calculation						
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes		Yes
5.2	MLR Standard	85.00%		85.0%		85.0%
5.3	Adjusted MLR Prior to Risk Corridor Cost Settlement	109.09%		89.1%		89.1%
5.4	Risk Corridor Cost Settlement Due to Department				$ -	$ -
5.5	Adjusted MLR					**89.1%**
5.6	Meets MLR Standard	Yes		Yes		Yes

Adjusted Substance Abuse Medical Loss Ratio for the Six-Month Period Ended June 30, 2020 Paid Through September 30, 2020

Adjusted Substance Abuse Medical Loss Ratio for the Six-Month Period Ended June 30, 2020 Paid Through September 30, 2020 Expansion Population						
Line #	Line Description	Reported Amounts	Adjustment Amounts	Preliminary Adjusted Amounts	Risk Corridor Cost Settlement Amount	Adjusted Amounts
1. Numerator						
1.1	Incurred Claims	$ 175,375	$ (3,955)	$ 171,420		$ 171,420
1.2	Quality Improvement	$ 1,080	$ 1,006	$ 2,086		$ 2,086
1.3	Total Numerator [Incurred Claims + Quality Improvement]	**$ 176,455**	**$ (2,949)**	**$ 173,506**		**$ 173,506**
2. Denominator						
2.1	Premium Revenue	$ 135,029	$ 25,219	$ 160,248	$ 40,168	$ 200,416
2.2	Taxes and Fees	$ 5,946	$ (5,946)	$ -		$ -
2.3	Total Denominator [Premium Revenue - Taxes and Fees]	**$ 129,083**	**$ 31,165**	**$ 160,248**	**$ 40,168**	**$ 200,416**
3. Credibility Adjustment						
3.1	Member Months	8,833	1,660	10,493		$ 10,493
3.1a	Annualized Member Months	17,666	3,320	20,986		$ 20,986
3.2	Credibility	Partially Credible		Partially Credible		Partially Credible
3.3	Credibility Adjustment	1.99%	2.4%	4.4%		4.4%
4. MLR Calculation						
4.1	Unadjusted MLR [Total Numerator / Total Denominator]	136.70%	-28.4%	108.3%	-21.7%	86.6%
4.2	Credibility Adjustment	1.99%	2.4%	4.4%		4.4%
4.3	Adjusted MLR [Unadjusted MLR + Credibility Adjustment]	**138.69%**	**-26.0%**	**112.7%**	**-21.7%**	**91.0%**
5. Remittance Calculation						
5.1	Is Plan Membership Above the Minimum Credibility Value?	Yes		Yes		Yes
5.2	MLR Standard	85.00%		85.0%		85.0%
5.3	Adjusted MLR Prior to Risk Corridor Cost Settlement	138.69%		112.7%		112.7%
5.4	Risk Corridor Cost Settlement Due to Health Plan				$ 40,168	$ 40,168
5.5	Adjusted MLR					**91.0%**
5.6	Meets MLR Standard	Yes		Yes		Yes

Schedule of Reporting Caveats

During our examination, the following reporting issues were identified.

Caveat #1 – MLR reporting period does not align with the rating period

The Department of Health had an 18-month rating period of January 1, 2020 through June 30, 2021. The MLR Report was developed by the Department of Health to capture data for the MLR reporting period of January 1, 2020 through June 30, 2020. Per 42 CFR § 438.8, the MLR reporting year should be a period of 12 months consistent with the rating period selected by the state. For purposes of this engagement, the six-month MLR reporting period was examined.

Mental Health Schedule of Adjustments and Comments for the Six-Month Period Ended 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 financial 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 move employee cost on Schedule 6 "CCtr 7" from CPT code "Covered Managed Care" to "Disallowed MLR Admin".
- To included units that were originally determined as duplicated but found out later by the health plan they were not true duplicates.
- To move employee cost from Schedule 6 "CCtr 6" to "LOCAL" to be included in Admin spread for Case Management program.
- To move employee cost and hours from Schedule 6 "CCtr 12" to "LOCAL" to be included in Admin spread for Case Management program.
- Adjust direct hours on Schedule 6 "CCtr 2" for CPT codes 96130 & 96131 to the health plan's submitted support.
- To adjust direct hours to health plan's submitted support for CPT code H0006 at Schedule 6"CCtr 6".
- To remove prior year Inpatient cost and units from the PMHP Cost Report.
- To directly assign non-allowable cost to CPT Code "Non-covered Fundraiser and Pass-Thru".
- To remove FFS Claims, Claims not found in State Data or outside FY20, and include Estimated Accrual all pertaining to Subcontractor Cost.

These adjustments to the PMHP report impact the incurred claims cost reported on the MLR. 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	($10,413)

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. An adjustment was proposed to remove reported HCQI expenses from the MLR Report and to add actual HCQI expense per supporting documentation. 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	$1,554

Adjustment #3 – 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	$67,713

Adjustment #4 – To remove non-qualifying 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	$(2,981)

Adjustment #5 – 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	$(10,878)

Adjustment #6 – To adjust member months per state data.

The health plan reported member month amounts that did not reflect the total member months for its members, per the state data, 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	1,660

Adjustment #7 – To correct a formula error on the as-submitted medical loss ratio template regarding the calculation of the expansion population credibility adjustment.

The DOH MLR Report contains a formula error in the calculation of the credibility adjustment for the expansion populations. The formula is referencing member months for the legacy population instead of annualized member months for the expansion population. An adjustment was proposed

to update the report formula to correctly reference expansion population member months on the MLR Report. The credibility adjustment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(h) and the Medical Loss Ratio Credibility Adjustment CMCS Informational Bulletin dated July 31, 2017.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.3	Credibility Adjustment	2.4%

Substance Abuse Schedule of Adjustments and Comments for the Six-Month Period Ended 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 financial 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 move employee cost on Schedule 6 "CCtr 7" from CPT code "Covered Managed Care" to "Disallowed MLR Admin".
- To included units that were originally determined as duplicated but found out later by the health plan they were not true duplicates.
- To move employee cost from Schedule 6 "CCtr 6" to "LOCAL" to be included in Admin spread for Case Management program.
- To move employee cost and hours from Schedule 6 "CCtr 12" to "LOCAL" to be included in Admin spread for Case Management program.
- Adjust direct hours on Schedule 6 "CCtr 2" for CPT codes 96130 & 96131 to the health plan's submitted support.
- To adjust direct hours to health plan's submitted support for CPT code H0006 at Schedule 6"CCtr 6".
- To remove prior year Inpatient cost and units from the PMHP Cost Report.
- To directly assign non-allowable cost to CPT Code "Non-covered Fundraiser and Pass-Thru".
- To remove FFS Claims, Claims not found in State Data or outside FY20, and include Estimated Accrual all pertaining to Subcontractor Cost.

These adjustments to the PMHP report impact the incurred claims cost reported on the MLR. 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	($3,955)

Adjustment #1 – 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. An adjustment was proposed to remove reported HCQI expenses from the MLR Report and to add actual HCQI expense per supporting documentation. 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	$1,006

Adjustment #2 – 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	$25,219

Adjustment #3 – To remove non-qualifying 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	$(1,895)

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	$(4,051)

Adjustment #5 – To adjust member months per state data.

The health plan reported member month amounts that did not reflect the total member months for its members, per the state data, 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	1,660

Adjustment #6 – To correct a formula error on the as-submitted medical loss ratio template regarding the calculation of the expansion population credibility adjustment.

The DOH MLR Report contains a formula error in the calculation of the credibility adjustment for the expansion populations. The formula is referencing member months for the legacy population instead of annualized member months for the expansion population. An adjustment was proposed

to update the report formula to correctly reference expansion population member months on the MLR Report. The credibility adjustment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(h) and the Medical Loss Ratio Credibility Adjustment CMCS Informational Bulletin dated July 31, 2017.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3.3	Credibility Adjustment	2.4%