MILLIMAN CLIENT REPORT

CY 2023 HealthChoice Illinois Medicaid Managed Care Medical Loss Ratio Calculations – MCO Results

State of Illinois

Department of Healthcare and Family Services

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Background

Milliman, Inc. (Milliman) has been retained by the State of Illinois, Department of Healthcare and Family Services (HFS) to assist HFS in complying with the Medical Loss Ratio (MLR) reporting requirements for calendar year (CY) 2023 for the HealthChoice Illinois Medicaid Managed Care Program (HealthChoice). The MLR reporting requirements are outlined in the final *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, published May 6, 2016. The Final Rule requires that all Medicaid managed care programs ensure that each managed care organization (MCO) calculate and report an MLR in accordance with 42 CFR §438.8, "Medical loss ratio standards", for rating periods starting on or after July 1, 2017. The Centers for Medicare & Medicaid Services (CMS) posted an informational bulletin, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, dated May 15, 2019, which provided further clarification of the regulations outlined in 42 CFR §438.8. An update to the Final Rule in CMS-2408-F, published November 13, 2020, made technical clarification to 42 CFR §438.8. On May 10, 2024, CMS-2439-F, *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, was published to codify regulatory clarifications for 42 CFR §430, §438, and §457 with effective dates on or after July 9, 2024. Collectively, these regulations will be referred to as the "Final Rule" throughout the remainder of this report.

The Medicaid MLR calculation as documented in this report provides our interpretation of the MLR guidance presented by CMS in the Final Rule and written guidance following a CMS technical assistance call on November 19, 2024. In general, the MLR calculation is defined as the sum of incurred claims and quality improvement expenses divided by premium revenue that is reduced by taxes and regulatory fees. Additionally, on May 10, 2024, regulatory updates clarified that incurred claims and premium revenue must include the separate payment term (SPT) state directed payments (SDP) described in 42 CFS CFR §438.6(c) and §438.8(e)(2)(iii)(C). It has been HFS's operational understanding that the SPT SDPs would be excluded from the MLR remittance calculation due to the non-risk bearing nature of the transactions with the MCOs when the remittance calculation methodology was developed for the CY 2023 rating period. After discussions with CMS during a technical assistance call on November 19, 2024, CMS provided written guidance to HFS that the medical loss ratio remittance calculation methodology cannot be modified after the start of the rating period. Therefore, the CY 2023 remittance calculation methodology should reflect the Medicaid MLR regulations that were in effect at the time the risk sharing arrangement was developed. Furthermore, based on CMS guidance the regulatory changes effective July 9, 2024, do not apply to medical loss ratio remittance calculations developed for rating periods prior to the effective date of the final rule as the state is prohibited from modifying the calculation under 42 CFR 438.6(b)(1). Based on CMS guidance and MLR regulations in effect at the time of the remittance methodology development, the SPT SDPs have been excluded from the numerator and denominator for the CY 2023 remittance calculation. Finally, a credibility adjustment is applied to this formula to account for random statistical variations related to the number of enrollees in an MCO. If an MCO does not meet the minimum size requirement for full credibility, then their MLR will be increased by a credibility adjustment published by CMS.

HFS has chosen to require the MCOs to report the MLR in composite across all populations covered under the HealthChoice and YouthCare Medicaid managed care populations. This includes the institutions for mental disease (IMD) population consisting of individuals aged 21 to 64 residing in an IMD with a length of stay greater than 15 days in a calendar month. The population is limited to individuals who would otherwise be in the other populations to the extent IMD stays were fifteen days or less in a given month. All individuals in the IMD population are in either the MLTSS or Other IMD rate cells, which are not eligible for federal financial participation (FFP). The MLR reports are collected in the Encounter Utilization Monitoring reporting templates. HFS requires the MCOs to maintain a minimum MLR of eighty-eight percent (88%) for CY 2023. If the calculated MLR falls below the minimum threshold, the MCOs are required to return 100% of the capitation equal to the difference between the calculated MLR and the minimum MLR multiplied by the CY 2023 revenue.

Introduction

The CMS Final Rule does not set the methodology for calculating remittances and defers the calculation methodology to each State to determine if a remittance is required under 42 CFR §438.8(j). The MCO contracts for the HealthChoice program require that the MCOs maintain a minimum MLR of eighty-eight percent (88%). HFS's remittance methodology excludes SPT SDPs, reflects eighteen months of run-out, and includes the IMD population in the numerator and denominator of the remittance calculation. This will be referred to as the "remittance MLR" throughout the remainder of this report.

The purpose of this report is to document development of the remittance MLR. The remittance MLR is the contractually required CY 2023 MLR calculation to be used to develop the remittance with eighteen months of run-out. This report provides MLR results with and without SPT SDPs and the IMD population using data from the CY 2025 Evaluation Period 3 Encounter Utilization Monitoring (EUM) templates, which includes claims data run out through June 30, 2025 (the remittance MLR and an updated version of the reporting MLR with 18 months of run-out). A separate report dated February 13, 2025, documents the CMS reporting MLR calculation, which included nine months of run-out, and was calculated using data submitted by the MCOs to HFS within twelve months of the end of the MLR reporting year.

To assist with calculating the MLR values and any required remittances in accordance with the MCO Contract, we developed an MLR reporting template included within the set of quarterly cost reports required to be completed by the MCOs. This quarterly cost reporting template, also known as the Encounter Utilization Monitoring (EUM) reporting template, collects the necessary eligibility, revenue, medical expense, medical expense adjustments, estimated unpaid claim liabilities, quality improvement expenses, operating expenses, and MCO assessments and taxes required to calculate the MLR. The MLR calculations provided by the MCOs in the CY 2025 EUM Evaluation Period 3 template serve as the starting point for the final calculations.

The review outlined in this report is intended to provide an assessment of the reasonableness of the MCO-submitted values used to calculate the MLR. A limited set of reconciliation exercises were performed between the CY 2025 EUM Evaluation Period 3 MCO submissions and various other data sources noted below. It is possible that additional data reporting issues may be uncovered with a systematic comparison of the MLR reports to other information provided to HFS. We have adjusted the reported values in the EUM submissions and will require the MCOs to review and confirm the treatment. It is our expectation that this report, the MCO specific results, and the MCO adjustments will be shared with each MCO and that each MCO will carefully review the adjustments made to the reported amounts.

It is ultimately the responsibility of the contracted MCOs to ensure the information submitted to HFS in the MLR reports complies with 42 CFR §438.8 and the MCO contract. HFS expects that each MCO will confirm, object, or modify the adjustments of the calculated MLR amounts in writing within thirty (30) days of receipt of this report. Upon receipt of written objections or adjustment notifications, HFS and Milliman will review the MCO's responses or adjustments, if any, for reasonableness. For any additional agreed upon adjustment made, we will update this report to document the final MLR calculations and then request the affected MCOs to sign and date a new attestation. If there are no objections to the MLR calculation report within 30 days of receipt, this report will be considered final.

Results

Each MCO reported their final calculation of the CY 2023 MLR in their CY 2025 EUM Evaluation Period 3 submission finalized on September 15, 2025. We reviewed the calculations for reasonableness by comparing the data to other data sources provided by HFS and the MCOs. Adjustments to reported values were required for the incurred claims, capitation premium revenue, earned withhold amounts, and the transfer payments for the CY 2023 final maternity risk pool. These adjustments are explained in more detail in the Methodology section of this report.

- Appendix 1.1 includes the corresponding CMS reporting medical loss ratio calculation for CY 2023 including the SPT SDPs and excluding the IMD population for the plans participating in the HealthChoice and YouthCare programs updated with 18 months of run out.
- Appendix 1.2 includes the final medical loss ratio used in the state remittance calculation for CY 2023 excluding SPT SDPs and including the IMD population for the plans participating in the HealthChoice and YouthCare programs.
- Appendix 1.1 and Appendix 1.2 detail the MLR calculation and information on the adjustments that require MCO review and possible correction of the MLR reporting template.
- HFS expects the MCOs to review the adjusted calculations included in this report and confirm, object, or modify the adjustments to ensure the MLR calculation is consistent with 42 CFR §438.8 within thirty (30) days of receiving this report. If no responses are received within the time limit, the report and calculations for the CY 2023 medical loss ratios will be considered final.

Methodology

The primary data used in this calculation is from the CY 2025 EUM Evaluation Period 3 reporting templates submitted and finalized on September 15, 2025, which included CY 2023 incurred periods paid through June 30, 2025. We reviewed the calculations for reasonableness by comparing the data to other data sources provided by HFS and the MCOs. Additionally, the MCOs were required to prepare a reconciliation between the MCO reported data requested from the CY 2024 Evaluation Period 2 EUM reporting templates received as of June 17, 2024, and the MCOs' annual CY 2023 NAIC financial statements. A reconciliation for each MCO's CY 2023 NAIC financial statements is included in Appendix 2 and was previously reported in the CMS reporting MLR calculation interim report, *CY 2023 HealthChoice Illinois Medicaid Managed Care Medical Loss Ratio Calculation – MCO Results, dated February 13, 2025*. Please note, one MCO does not prepare NAIC statements, and the data request has been reconciled to their audited financial statements.

The allocation methodologies for corporate expenses, claims reserve liabilities, non-benefit expenses (including healthcare quality improvement expenses) and revenue were requested as part of the CY 2025 EUM Evaluation Period 3 submissions. The MCO reported allocation methodologies were reviewed for reasonableness and inquiries made with the MCOs, as necessary. A summary of the allocation methodologies for each MCO is available in Appendix 3.

Figure 1 below describes the items included in each value in the CMS reporting and state remittance MLR formulas (Appendix 1.1 and Appendix 1.2). Additionally, although not included in either MLR calculation, the values are described below in the excluded non-claims costs column as required by 42 CFR 438.8(e)(2)(v)(A). Please note, the IMD rate cell is not included as part of the CMS reporting MLR calculation in Appendix 1.1.

FIGURE 1: LISTING OF ITEMS INCLUDED IN THE CMS REPORTING AND STATE REMITTANCE MLR CALCULATIONS

NUMERATOR INCURRED CLAIMS	NUMERATOR HEALTHCARE QUALITY IMPROVEMENT EXPENSE	NUMERATOR FRAUD REDUCTION EXPENSES	EXCLUDED NON-CLAIMS COSTS	DENOMINATOR PREMIUM REVENUE	DENOMINATOR TAXES, FEES AND ASSESSMENTS
Direct paid claims and subcapitated proxy paid claims	Expenses to improve health outcomes	Expenses related to fraud reduction efforts up to the amount of fraud recoveries received	Administrative costs such as claims processing, network maintenance, etc.	Net capitation revenue received	Premium tax payments
Lump sum provider settlements, provider incentives, provider withholds, and provider value-based payments	Expenses to reduce or prevent hospital readmission		Administrative expenditures for value added services	Earned withhold, as provided by HFS	Federal and State income taxes
Direct and subcapitated proxy paid reserves and settlements	Expenses to improve patient safety and reduce medical errors			Separate payment term state directed payments[1]	Other taxes, fees, and assessments
Expenditures for value added services	Expenses to promote wellness and health activities				
Less recoveries such as third-party liability recoveries	Expenses for health information technology for healthcare quality improvement				
Separate payment term state directed payments[1]					

[1] SPT SDP included only in Appendix 1.1 and based on the SDP Reconciliation Report dated May 15, 2025.

The following adjustments were made to the MCO reported amounts:

- MCO reported premium revenue was adjusted to the net capitation payments paid to the MCOs as of September 30, 2025
- MCO reported earned withhold was adjusted to reflect the amount provided by HFS on December 9, 2024.
- MCO reported MCO Tax revenue and expense were excluded from the calculation.

In Appendix 1.2, premium revenue does not include payments that are not part of the effective MCO rate (i.e., SPT SDPs, pass-through payments, or MCO tax). However, for the CMS reporting MLR in Appendix 1.1, the SPT SDPs have been included in premium revenue. The MLR is expressed as a percentage, rounded to the nearest second decimal point.

Per CMS guidance published on May 15, 2019, administrative costs should be excluded from incurred claims. Based on our review of the MCOs' third party vendor payment information, the MCOs have excluded administrative costs from their incurred claims in CY 2025 EUM Evaluation Period 3 submissions.

The calculated MLR in Appendix 1.2 was compared against the minimum MLR threshold of eighty-eight percent (88%). If the calculated MLR was less than the threshold, a remittance amount was calculated as the difference between the calculated MLR and the minimum threshold multiplied by the CY 2023 MLR denominator. None of the MCOs' calculated MLRs were below the minimum MLR threshold for the remittance calculation.

Limitations and Qualifications

The information contained in this correspondence, including any enclosures, has been prepared for the State of Illinois, Department of Healthcare and Family Services (HFS) and their advisors to provide an estimate of the CY 2023 medical loss ratio calculations for each MCO participating in the HealthChoice Illinois Medicaid Managed Care Program (HealthChoice) and YouthCare program in accordance with the MCO contracts, final *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability* published May 6, 2016, and updated with the *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, published May 10, 2024. It is our expectation that this report, the MCO specific results, and the MCO adjustments will be shared with each MCO and that each MCO will carefully review the adjustments made to the reported amounts. It is ultimately the responsibility of the contracted MCOs to ensure the information submitted to HFS in the MLR reports complies with 42 CFR §438.8 and the MCO contracts. The data and information presented may not be appropriate for any other purpose.

It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this correspondence is provided to any third party, the correspondence should be distributed in its entirety. Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for HFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Milliman does not intend to benefit any third-party recipient of its work product, even if Milliman consents to the release of its work product to such third party.

Milliman has developed certain models to estimate the values included in this correspondence. The intent of the models was to calculate the MCOs' CY 2023 MLR percentages and final remittances, if any. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by HFS, and on behalf of HFS, for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. Milliman's data and information reliance includes MCO-reported eligibility and financial experience, as well as information related to HFS' eligibility system, assignment of enrollees to rate cells, and accepted encounter data. The models, including all input, calculations, and output may not be appropriate for any other purpose.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report who are actuaries are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

Appendix 1

Medical Loss Ratio Calculations

(Included in Excel)

Appendix 2

Reconciliation to Audited Financials by MCO

(Included in Excel)

Appendix 3

Allocation Methodologies by MCO

(Included in Excel)

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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