MILLIMAN CLIENT REPORT

CY 2018 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 2018 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* (Final Rule), 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.

The Medicaid MLR calculation as documented in this report provides our interpretation of the MLR guidance presented by CMS in the Final Rule. 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, 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. None of the MCOs participating in the HealthChoice program required a credibility adjustment.

HFS has chosen to require the MCOs to report the MLR in composite across all populations covered under the HealthChoice program and require the MCOs to maintain a minimum MLR of eighty-five percent (85%). Additionally, if the calculated MLR falls below the minimum threshold, the MCOs are required to return the portion of the capitation equal to the difference between the calculated MLR and the minimum MLR multiplied by the CY 2018 revenue.

Introduction

As part of the MCO contract, HFS requires plans to submit, within twelve months of the end of the MLR reporting year, a report containing the necessary information to calculate the MLR in accordance with the Final Rule. To assist with this requirement, Milliman prepared an MLR reporting template within the quarterly cost reports also required to be completed by the MCOs. This cost reporting template, also known as the Encounter Utilization Monitoring (EUM) templates, 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. We provided a report to HFS dated February 5, 2020 to meet the CMS Final Rule requirement for the calendar year 2018 MLR report.

The purpose of this report is to calculate the remittance required under each MCO's contract for CY 2018. The CMS Final Rule does not set the methodology for calculating remittances and leaves it up to each State to determine if a remittance is required. The MCO contracts for the HealthChoice program require that the MCO's maintain a minimum MLR of eight five percent (85%). HFS has elected to use the methodology defined by 42 CFR 438.8 with certain differences, such as including eighteen months of run-out rather than the shorter timeframe required by CMS. This report documents the MLR remittance calculation with the additional run-out.

The review outlined in this report is intended to provide a reasonableness review of the MCO-submitted MLR values. A limited set of reconciliation exercises was performed between the CY 2020 EUM Evaluation Period 3 MCO submission and various other data sources noted below, and it is possible additional items may be uncovered with a systematic comparison of the MLR reports to other information provided to HFS. We have made some adjustments to the values reported in the EUM submissions. It is our expectation that this correspondence, the MCO specific results, and the MCO adjustments will be shared with each MCO. 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.

Results

Appendix 1 includes the final medical loss ratio calculation for calendar year 2018 for the plans participating in the HealthChoice program. In general, the Final Rule defines the MLR as incurred claims plus healthcare quality improvement expenses divided by premium revenue less taxes, fees and assessments multiplied by a creditability factor, if applicable.

Each MCO reported their initial calculation of the MLR in their CY 2020 Encounter Utilization Monitoring (EUM) Evaluation Period 3 submission finalized on October 9, 2020. We reviewed the calculations for reasonableness by comparing the data to other data sources provided by HFS and the MCOs. Some data, such as the CY 2018 Health Insurer Provider Fee (HIF) assessment, was reported by the MCOs in the year it was paid (CY 2018) rather than the data year used for the calculation (CY 2017). Since the capitation rates for CY 2017 were amended to reimburse the MCOs for the HIF, the revenue and non-benefit expense reported by the MCOs in CY 2018 was excluded. Other adjustments were also required, which have been shared with the individual MCOs impacted.

Within Appendix 1, each MCO has an exhibit noting the line items of the EUM Evaluation Period 3 templates that were used to calculate the totals.

Methodology

The data used in this calculation is from the CY 2020 Encounter Utilization Monitoring (EUM) Evaluation Period 3 reports submitted and finalized on October 9, 2020, which includes calendar year 2018 incurred periods paid through June 30, 2020. We reviewed the calculations for reasonableness by comparing the data to other data sources provided by HFS and the MCOs. Additionally, the allocation methodology for various expenses and revenues is included in the EUM Evaluation Period 3 reports. The reported methodology was reviewed by Milliman for reasonableness and discussed with the MCOs as necessary.

The table below describes the items included in each value in the MLR formula.

FIGURE 1: LISTING OF ITEMS INCLUDED IN MLR CALCULATION

INCURRED CLAIMS	HEALTHCARE QUALITY IMPROVEMENT EXPENSE	PREMIUM REVENUE	TAXES, FEES AND ASSESSMENTS
Direct paid claims and Subcapitated proxy paid claims	Expenses to improve health outcomes	Capitation payments paid through June 2020	Premium tax payments
Lump sum provider settlements, provider incentives and provider withholds	Expenses to reduce or prevent hospital readmission	Government provider risk pool receipts and payments as calculated in January 13, 2020 report	Income taxes
Direct and subcapitated proxy paid reserves and settlements	Expenses to improve patient safety and reduce medical errors	Includes expenses related to waived member cost-sharing	Other taxes, fees and assessments
Less recoveries such as retail pharmacy rebates and third-party liability recoveries	Expenses to promote wellness and health activities	Excludes MCAP, CCHHS access fees	Excludes Health Insurer Provider Fee (HIF)
Less pharmacy spread administrative expense included in incurred claims	Expenses for health information technology for healthcare quality improvement	Excludes Health Insurer Provider Fee (HIF)	

The MCOs submitted premium revenue was adjusted to the net capitation payments paid to the MCOs through June 30, 2020. We also included the reported revenue received or paid for the Government Provider Risk Pool settlement and transfer payments provided in a separate report to HFS on January 13, 2020.

As part of the EUM Evaluation Period 3 submission, several MCO's reported the Health Insurer Fee (HIF) paid in CY 2018 (fee year) for the calendar year 2017 (data year) incurred period as revenue received in calendar year 2018. The MCOs also reported the amount paid in calendar year 2018 as a non-benefit expense in calendar year 2018. We have made adjustments in these MCOs calculation exhibits to exclude these amounts from both the revenue and non-benefit expense and request that the MCO confirm our understanding or provide an adjustment to the MCO MLR calculation.

Premium revenue does not include the Cook County Health and Hospitals System (CCHHS) access fees or Managed Care Access Payments (MCAP) because these payments are not part of the effective MCO rate. The medical loss ratio is to be expressed as a percentage, rounded to the nearest second decimal point.

Per the Final Rule, unpaid cost-sharing amounts the MCO could have collected from enrollees under the contract are to be included in the premium revenue calculation. If a MCO makes a reasonable effort to collect the cost-sharing amounts, but those efforts were unsuccessful, the cost-share can be excluded. In CY 2018, all but one MCO waived the member cost-sharing requirements of the State Plan. The full amount of the claim payment is included in the numerator of the MLR calculation. Accordingly, we are including the waived cost-sharing amounts in the denominator of the MLR calculation.

Because HFS amended the state plan to no longer require members to pay cost-sharing for services they receive in CY 2020, we no longer required the MCOs to report the waived cost-sharing on their quarterly EUM submissions. Therefore, we included the waived cost-sharing amount reported in the final CY 2019 Evaluation Period 4 template that was finalized in December 2019.

Per CMS guidance published on May 15, 2019, the MCOs reported the amount of administrative costs included in the incurred claims in EUM Evaluation Period 3 submission associated with the MCO's PBM's spread pricing arrangement and any PBM-retained rebates. The amount reported was excluded from the incurred claims.

The calculated MLR was compared against the minimum MLR threshold of eighty-five percent (85%). 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 by the CY 2018 revenue.

Limitations and Qualifications

The services provided for this project were performed under the contract between Milliman and HFS dated April 9, 2019.

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 estimates of 2018 medical loss ratio calculations for each MCO for the HealthChoice Illinois Medicaid Managed Care Program (HealthChoice) in accordance with 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* (Final Rule), published May 6, 2016. It is our expectation that this correspondence, 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. 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 approved third parties, the correspondence should be distributed in its entirety. 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 estimate the MCOs' 2018 MLR and remittance, 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 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 and assignment of enrollees to rate cells. 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
(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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