MILLIMAN CLIENT REPORT

CY 2019 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 2019 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 2019 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.

The purpose of this report is to calculate the MLR using data received within twelve months of the end of the MLR reporting year as required in the CMS Final Rule. However, 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 eighty-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. This report documents the MLR calculation to be used for remittances. A separate report dated March 11, 2021 outlined the results of the CMS-compliant MLR calculation, which included nine months of claims run out. This report was submitted to HFS within twelve months of the end of the MLR reporting year.

The review outlined in this report is intended to provide a reasonableness assessment of the MCO-submitted MLR values. A limited set of reconciliation exercises were performed between the CY 2021 EUM Evaluation Period 3 MCO submissions and various other data sources noted below. It is possible additional data reporting issues may be uncovered with a systematic comparison of the MLR reports to other information provided to HFS. We have made some adjustments to the reported values in the EUM submissions that will require the MCOs to review and confirm their treatment. 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 and correct and explain any changes to those adjustments, as required.

We expect that each MCO will confirm or further adjust the calculated MLR amounts within 30 days of this report. 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. This report is considered final unless any MCO disagrees with the adjustments made to their reported information. If an MCO disagrees with any adjustment, the MCO must notify HFS and provide additional information. If HFS and the MCO agree that any amount in this report should be adjusted, we will update this report to document the final MLR calculations.

Results

Appendix 1 includes the final medical loss ratio calculation for calendar year 2019 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 credibility factor, if applicable.

Each MCO reported their initial calculation of the MLR in their CY 2021 Encounter Utilization Monitoring (EUM) Evaluation Period 3 submission finalized on October 15, 2021. We reviewed the calculations for reasonableness by comparing the data to other data sources provided by HFS and the MCOs. Some adjustments of the reported data were required, such as corrections to the Government Provider Risk Pool (GPRP) transfers, MCO tax, the amount of reported HIF, and reported withhold amounts. These adjustments are discussed in more detail in the Methodology section below.

Within Appendix 1, each MCO also has an exhibit with adjustments that require MCO review and possibly 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. Once the responses are received, Milliman and HFS will review and finalize the reported CY 2019 medical loss ratios for compliance with CMS regulations.

Methodology

The data used in this calculation is from the CY 2021 Encounter Utilization Monitoring (EUM) Evaluation Period 3 reports submitted and finalized on October 15, 2021, which includes calendar year 2019 incurred periods paid through June 30, 2021. We reviewed the calculations for reasonableness by comparing the data to other data sources provided by HFS and the MCOs. These data sources include encounter and eligibility data provided by HFS, prior MCO EUM submissions, and annual and quarterly NAIC regulatory statements accessed through S&P Global Market Intelligence. A summary of the comparison of the reported revenue, benefit expense and administrative expense to the CY 2019 annual NAIC regulatory statement for each MCO is provided in Appendix 2.

The allocation methodology for claims reserve liabilities, non-benefit expenses (including healthcare quality improvement expenses) and revenue was requested as part of the CY 2021 EUM Evaluation Period 3 submissions. The MCO reported allocation methodology was reviewed for reasonableness and discussed with the MCOs as necessary. A summary of the allocation methodologies for each MCO is available in Appendix 3.

The table below describes the items included in each value in the MLR formula. Additionally, although not included in the MLR calculation, the values included in non-claims costs is described below as required by 42 CFR 438.8(e)(2)(v)(A).

FIGURE 1: LISTING OF ITEMS INCLUDED IN MLR CALCULATION

INCURRED CLAIMS	HEALTHCARE QUALITY IMPROVEMENT EXPENSE	FRAUD REDUCTION EXPENSES	NON-CLAIMS COSTS	PREMIUM REVENUE	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	Pharmacy spread administrative expense included in encounter submissions	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 costs such as claims processing, network maintenance, etc.	Government provider risk pool receipts and payments as calculated on March 3, 2021 report to HFS	Federal and State income taxes
Direct and subcapitated proxy paid reserves and settlements	Expenses to improve patient safety and reduce medical errors		Administrative expenditures for Non-State Plan Services	Expenses related to waived member cost-sharing	Other taxes, fees, and assessments
Expenditures for Non-State Plan Services	Expenses to promote wellness and health activities			HFS Provided Earned Withhold	Health Insurer Provider Fee (HIF)
Less recoveries such as retail pharmacy rebates and third-party liability recoveries	Expenses for health information technology for healthcare quality improvement			Health Insurer Provider Fee (HIF) including gross up for income taxes	MCO Tax
Less pharmacy spread administrative expense included in encounter submissions				MCO tax	

Premium revenue does not include the Cook County Health and Hospitals System (CCHHS) directed payments or Managed Care Access Payments (MCAP) directed payments and pass-through payments because these payments are not part of the effective MCO rate.

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 through August 31, 2021.
- MCO reported revenue was adjusted to include the Government Provider Risk Pool settlement and transfer payments provided in a separate report dated March 3, 2021 for one MCO that did not report the amount in their CY 2021 EUM Evaluation Period 3 submission.
- MCO reported earned withhold was adjusted to reflect the amounts provided by HFS on February 17, 2021 for two MCOs that did not report the finalized amounts in their CY 2021 EUM Evaluation Period 3 submissions.
- MCO reported HIF revenue and taxes were adjusted to reflect the October 2019 capitation rate amendment, dated March 10, 2021, due to multiple MCOs reporting the HIF tax in the incorrect year.
- MCO reported MCO Tax revenue was adjusted to match the MCO Tax expense reported by the MCO due to timing differences in payments.
- 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 an MCO makes a reasonable effort to collect the cost-sharing amounts, but those efforts were unsuccessful, the cost-share can be excluded. However, none of the MCOs attempted to collect cost-sharing amounts during 2019. Accordingly, we adjusted the MCO reported revenue to include the waived cost-sharing amounts in the denominator of the MLR calculation. Note that the full amount of the claim payment is included in the numerator of the MLR calculation.

Per CMS guidance published on May 15, 2019, the MCOs reported the amount of administrative costs included in the encounter submissions in CY 2021 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 and the numerator of the MLR calculation.

The medical loss ratio is expressed as a percentage, rounded to the nearest second decimal point. 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 minimum threshold and the calculated MLR multiplied by the by the CY 2019 revenue. No MCOs calculated MLR was below the minimum MLR threshold for CY 2019.

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 2019 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’ 2019 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, 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 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

MLR Schedules by MCO

(Included in Excel)

Appendix 2

Reconciliation to Audited Financials by MCO

(Included in Excel)

Appendix 3

Allocation Methodologies by MCO

(Included in Excel)

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