

MILLIMAN CLIENT REPORT

# SFY 2019 Behavioral Health PIHP Medical Loss Ratio Calculation

State of Michigan, Department of Health and Human Services  
Draft and Confidential

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## I. Background

Milliman, Inc. (Milliman) has been retained by the State of Michigan, Department of Health and Human Services (MDHHS) to develop a medical loss ratio (MLR) reporting tool for the calculation and assessment of the MLR standards set forth in the October 2018 through September 2019 (SFY 2019) behavioral health managed care contract with the prepaid inpatient health plans (PIHPs).

The final Medicaid and Children's Health Insurance Program rule (Final Rule), released on May 6, 2016 requires that all Medicaid managed care programs ensure, through contracts for rating periods starting on or after July 1, 2017, that each PIHP calculate and report a MLR in accordance with 42 CFR 438.8, medical loss ratio standards.

In 42 CFR 438.4(b)(9), CMS has proposed that the MLR for PIHPs as calculated and reported under §438.8 be used in the development of actuarially sound capitation rates effective for rating periods starting on or after July 1, 2019. The MLR is used to assess whether capitation rates are appropriately set by generally illustrating how these funds are spent on claims and quality improvement activities as compared to administrative expenses, demonstrating that adequate amounts under the capitation payments are spent on services for enrollees.<sup>1</sup> CMS has also indicated that MLR reporting standards result in responsible fiscal stewardship of total Medicaid expenditures, ensuring that states have insight and understanding into how capitation payments made for enrollees in managed care programs are being expended.

The reporting requirements and MLR formula for Medicaid managed care programs as set forth in the Final Rule are generally consistent with previously established MLR formulas in the Medicare Advantage (MA) and commercial health insurance market, with a few key notable exceptions (among others):

- States are **not required** to collect capitation rate refunds when PIHP MLRs are below a minimum requirement;
- States can choose the level of aggregation for calculating the MLR (e.g., population level stratifications vs. composite across all population);
- States are given flexibility to determine the minimum MLR requirement, as long as the minimum MLR percentage is **at least as** high as the CMS guidelines of 85%; and,
- Commercial MLR reporting period is a rolling 3-year period, while the MA and Medicaid MLR reporting period is aligned with a single contract year.

The contract between MDHHS and the PIHPs does not include a remittance amount for the SFY 2019 contract if the MLR is below 85%. Instead, the contract employs and outlines the risk corridor arrangement.

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 a PIHP. If a PIHP does not meet the minimum size requirement for full credibility, then their MLR will be increased by a credibility adjustment published by CMS. Plan-reported data as submitted in the Medicaid MLR reporting tool will be used to calculate the PIHP's Medicaid MLR.

The Medicaid MLR reporting instructions are to be used in completing and submitting the MLR Tool for all PIHPs participating in the MDHHS' Specialty Services and Supports Waiver and Healthy Michigan Plan programs in SFY 2019. MDHHS and Milliman will rely on the accuracy and completeness of the submitted Michigan Medicaid MLR tool for each PIHP based on the attestation of the PIHP executive signing off on this request. During the review and data validation process, we may request additional information or documentation supporting the data on an as-needed basis to gain clarification on any information provided in the Medicaid MLR Tool.

This Medicaid MLR Tool should be completed in accordance with 42 CFR 438.8, medical loss ratio standards. Additional information regarding how to treat program specific items in the Medicaid MLR formula is outlined in the contract between MDHHS and the PIHPs. Complete documentation on the CMS regulation establishing the Medicaid MLR guidance can be found in § 438.8 at the following link: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-healthinsurance-program-chip-programs-medicaid-managed-care-chip-delivered>.

<sup>1</sup> Source: CMS. Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; available at: <https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>

## II. General Instructions

This section outlines the general instructions for PIHPs to complete the requested information in the accompanying Excel-based Medicaid MLR Tool. The SFY 2019 Medicaid MLR as defined in Section I will be calculated for each PIHP based on plan-submitted data. It is expected that each PIHP will submit a completed version of the Excel template to MDHHS.

The Medicaid MLR Reporting Tool contains the following tabs:

- Attestation
- Data Collection
- Summary Calculation

PIHPs are requested to populate the Attestation and Data Collection tabs. The Summary Calculation tab is populated from the PIHP-submitted data and calculates the PIHP-specific Medicaid MLR.

### ATTESTATION

The purpose of the attestation page is to collect company specific data as well as confirmation that the information provided is complete and accurate. On this tab, PIHPs must provide the plan name from the drop down menu, the preparer's name and contact information, and the attesting officer's name and signature. The attesting officer must be designated as a CEO, CFO, or COO of the organization. **Failure to complete the attestation will be considered an incomplete submission and will not be accepted by MDHHS.**

### DATA COLLECTION

The Data Collection tab is separated into the five major data elements of the MLR calculation: Incurred Claims, Quality Improvement Expenses, Premium Revenue, Taxes and Fees, and a Credibility Adjustment. This tab also collects information pertaining to the managed care administrative costs of the programs.

$$MLR Formula = \frac{Incurred Claims + Quality Improvement}{Premium Revenue - Taxes and Fees} + Credibility Adjustment$$

The MLR reporting tool has been developed to stratify the major elements of the MLR formula, with the intent of identifying key components that should be included and excluded to ensure adherence to the MLR guidance established by CMS in the Final Rule. As documented in Section I, CMS provides specific guidance on inclusions and exclusions for each component of the MLR formula. The inputs outlined below are intended to illustrate compliance with the Final Rule by documenting each item specifically identified in the MLR guidance.

#### Incurred Claims

This section provides guidance on the incurred claims portion of the MLR formula.

#### Line 1.1 - Paid Claims to Providers Incurred October 2018 – September 2019, paid through January 31, 2020

Line 1.1a should reflect total SFY 2019 net paid and incurred claims, with claims run-out through January 31, 2020, consistent with the inclusion and exclusion lists provided below. Please note that the majority of the items excluded from Line I are specifically requested to be quantified in a subsequent line item in Section 1.

##### Include

- Non-subcapitated claims paid to providers for services covered under the managed care contract during SFY 2019;
- Sub-capitation paid attributed to services provided; and,
- Claims expenditures for non-state plan services that the PIHP voluntarily provides through the Medicaid managed care program.

Exclude

- Sub-capitation paid related to delegated managed care administrative expenses
- Unpaid claim liabilities (both in process of being adjusted or incurred but not reported)
- Incentives, bonuses, and withholds paid to providers;
- Third party liabilities (coordination of benefits);
- Overpayment recoveries received from network providers;
- Net payments or receipts related to state mandated solvency funds;
- HRA Pass-Through Payments Paid; and,
- Fraud recoveries and expenses related to fraud recovery activities;

**Line 1.2 – Sub-capitation paid related to delegated managed care administrative expenses**

The non-benefit expense portion (generally the administrative amount) of sub-capitated amounts paid to providers that **do not** represent direct compensation for medical services provided to an enrollee during SFY 2019 as these amounts will not be used in the MLR calculation.

**Line 1.3 – Unpaid Claim Liabilities**

Unpaid claim liabilities reflect the estimated outstanding liabilities for all behavioral health services for SFY 2019. This includes items such as incurred but not reported (IBNR) claims, claims in course of settlement (ICOS), and claims that are adjudicated but not yet paid. Provide the total reserve balance held at January 31, 2020 for the SFY 2019 time period. The January 31, 2020 reserve balance for other fiscal years should not be included in this amount.

**Line 1.4 – Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers**

Incentive, bonus, withhold, and other settlement amounts paid to participating providers specific to the SFY 2019 time period. For payments that have not yet been measured and paid out, PIHPs should provide an estimate of the associated payments.

**Line 1.5 – Third Party Liability (Coordination of Benefits) Recoveries**

Recoveries received as a result of determining that another insurance plan has primary payment responsibility.

**Line 1.6 – Overpayment Recoveries Received from Network Providers**

Recoveries received as a result of overpayment to a network provider.

**Line 1.7 – Net Payments (or Receipts) Related to State Mandated Solvency Funds**

Market stabilization payments (or receipts) required by the state to provide protection to members in the event of health plan insolvency specific to SFY 2019 (e.g. contributions to ISF and/or Medicaid Savings). A contribution to ISF would be reported as a positive amount with receipts from ISF reported as negative.

**Line 1.8 – Hospital Reimbursement Assessment (HRA) Pass-Through Payments Paid**

The HRA pass-through payments made to inpatient psychiatric hospital providers. This amount is expected to be exactly equal to the premium revenue for HRA payments as reported in Line 3.7.

**Line 1.9 – Allowable Claims Recovered Through Fraud Reduction Efforts**

Fraudulent claim payments recovered as a result of fraud reduction efforts. Please note that fraud recoveries up to total fraud recoveries expense as reported in Line 1.9.a are included in the incurred claims calculation.

**Line 1.9a – Total Fraud Recoveries Expense**

Costs of Medicaid Verification Teams or Staff performing Provider audits looking at claims for validation.

**Line 1.9b – Total Fraud Recoveries that Reduced Paid Claims in Line 1.1**

Results of paybacks from providers that would offset claims, include Medicaid Verification recoupments.

## Administrative Costs

Although administrative expenses (under subsection 2.1) are not used in the MLR calculation, we are capturing the managed care administrative expenses in this template because the historical administrative cost reports have been sunset. This information will be reviewed for purposes of developing the non-benefit expense assumptions in the SFY 2021 capitation rate development.

### Line 2.1 – Incurred Expenses for Managed Care Administrative Costs

We would like for the managed care administrative expenses to be broken into the following components. Please include any costs incurred by CMHSPs or other sub-capitated entities for managed care administrative costs delegated to them by the PIHP. These would include expenses reported under Line 1.2.

- a. Mental Health Admin
- b. SUD Admin
- c. Autism Admin
- d. HSW Admin
- e. Other Admin

## Quality Improvement Expenses

This section provides guidance on the quality improvement expenses portion of the MLR formula in accordance with the provisions in 45 CFR 158.150(b) and 42 CFR 438.358(b) and (c).

### Line 2.2 – Incurred Health Care Quality Improvement Expenses during SFY 2019

Consistent with NAIC guidelines, Quality Improvement Expenses are defined as expenses that control or contain cost with the primary purpose of improving health care quality. These expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. These expenses can be objectively measured and must not be billed or allocated as clinical or claims costs.

#### Line 2.2.a – Improve Health Outcomes

Expenses for direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g. face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes.

#### Line 2.2.b – Activities to Prevent Hospital Readmission

Expenses for implementing activities to prevent hospital readmissions (e.g. Continued Stay Reviewers).

#### Line 2.2.c – Improve Patient Safety and Reduce Medical Errors

Expenses for implementing activities to improve patient safety and reduce medical errors.

#### Line 2.2.d – Wellness & Health Promotion Activities

Expenses for programs that provide wellness and health promotion activity (e.g. face-to-face, telephonic, web-based interactions or other means of communication).

#### Line 2.2.e – Health Information Technology Expenses Related to Improving Health Care Quality

Health Information Technology expenses required to accomplish the activities designed for use by health plans, health care providers or enrollees for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements.

**Exclude** costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in Health Information Technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims.

**Line 2.2.f – Activities Related to External Quality Review (EQR)**

Mandatory and optional EQR-related activities as defined in 42 CFR 438.358.

**Line 2.2.f – Other Health Care Quality Improvement Expenses**

All other health care quality improvement expenses that cannot be attributed to the items above. Please include comments for any and all expenses included.

**Premium Revenue**

This section provides guidance on the premium revenue portion of the MLR formula.

**Line 3.1 – Total State Capitation Payments during SFY 2019**

Line 3.1 should reflect total state capitation payments consistent with the inclusions and exclusion lists provided below. Please note that the majority of the items excluded from Line 3.1 are explicitly requested in a subsequent premium revenue line item.

Include

- Risk-adjusted capitation payment revenue for the Michigan Specialty Services and Support Waiver and Healthy Michigan Plan behavioral health programs for the SFY 2019 contract year including taxes and fees.

Exclude

- The portion of the capitation rate related to the quality withhold and bonus program;
- The portion of the capitation rate related to HRA program pass-through payments;
- Incentive payments for the DHIP program; and,
- Risk Corridor Settlements;

**Line 3.2 – PIHP Withhold Earned Back – Related to October 2018 - September 2019**

The amount of the quality withhold earned back based on quality indices established by MDHHS for the SFY 2019 contract period. This includes the performance bonus incentive pool (PBIP). The quality withhold is measured and paid on a state fiscal year basis. For withholds that have not yet been measured and reported by MDHHS, PIHPs should provide an estimated quality withhold payout.

**Line 3.3 – PIHP Bonus Payments Funded from Quality Withhold Arrangement – Related to October 2018 - September 2019**

The amount of the bonus payment funded from the quality withhold program for high-performing PIHPs in the Medicaid managed care program for the SFY 2019 contract period. For quality withhold programs that have not yet been measured and reported by MDHHS, PIHPs should provide an estimated bonus payment.

**Line 3.4 – PIHP Incentive Payments**

Incentive payments received from the DHIP program for the SFY 2019 contract period.

**Line 3.5 – Risk Corridor Settlements**

PIHP settlements paid to or received from the state related to the risk corridor arrangement. Funds released from PIHP ISF and prior year Medicaid/HMP savings should not be included in this amount.

**Line 3.6 – Other Premium Revenue**

All other premium revenue that cannot be categorized into the items above (e.g. changes to unearned premium reserves). Please include detail in the comments if including Other Premium Revenue.



### Line 3.7 – Pass-Through Revenue for the HRA Program

The portion of the total capitation revenue related to HRA payments. This amount is expected to be exactly equal to the claims expense for HRA providers as reported in Line 1.7.

### Taxes and Fees

Consistent with NAIC guidelines, taxes and fees pertain to amounts a governmental or regulatory body charges the PIHP to perform a service which is allocated to Medicaid business in Michigan. Additionally, all Federal and State taxes and assessments and licensing or regulatory fees should be reported in accordance with the provisions in § 422.2420(c)(2) and § 423.2420(c)(2) of the Medicare Advantage MLR regulations.

### Line 4.1 – Federal Taxes and Federal Assessments

All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Federal Public Health Service Act, including the Health Insurer Fee.

**Exclude** federal income taxes on investment income and capital gains.

### Line 4.2 – HICA Tax

The applicable HICA (or claims tax) that was paid for SFY 2019 claims.

### Line 4.3 – State Insurance, Premium, and Other Taxes

#### Include

- “Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the state directly;
- Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by Michigan;
- Advertising required by law, regulation or ruling, except advertising associated with investments;
- State income, excise and business taxes other than premium taxes;
- State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes; and,
- In lieu of reporting state premium taxes, the reporting entity may choose to report payment for community benefit expenditures (Line V.d) limited to the highest premium tax rate for Michigan, but not both.”

#### Exclude

- “State sales taxes, if company does not exercise the option of including such taxes with the cost of goods and services purchased;
- Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes; and,
- Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.”

### Line 4.4 – Regulatory Authority Licenses and Fees

#### Include

- “Statutory assessments to defray operating expenses of any State or Federal department; and,
- Examination fees in lieu of premium taxes as specified by Michigan state law.”

#### Exclude

- Fines and penalties of regulatory authorities; and,
- Fees for examinations by MDHHS other than as referenced above.

## Credibility Adjustment

This section provides information related to the credibility adjustment in the MLR formula.

On July 31, 2017, CMS published an Information Bulletin, Medical Loss Ratio (MLR) Credibility Adjustments<sup>2</sup>, which provides an overview and methodology for credibility adjustments in the Medicaid MLR formula. The credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:

- **Fully-credible:** Managed care plans with sufficient claims experience, measured in terms of member months, are assumed to experience MLRs that are not subject to random variation as observed in statistically insignificant samples. Such managed care plans will not receive a credibility adjustment for their MLRs.
- **Partially-credible:** Managed care plans with sufficient claims experience, measured in terms of member months, to calculate an MLR with a **reasonable** chance that the difference between the actual and target medical loss ratios is statistically significant. Such managed care plans will receive a partial credibility adjustment to their calculated MLRs.
- **Non-credible:** Managed care plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR. Such plans will not be measured against the MLR standard; managed care plans in this group are presumed to meet or exceed the target MLR standard.

The following table illustrates the Medicaid and CHIP credibility adjustment factors utilized in the MLR formula:

| MLR Credibility Adjustment Table                                      |                                       |
|-----------------------------------------------------------------------|---------------------------------------|
| Credibility Adjustment Table for Medicaid and CHIP Managed Care Plans |                                       |
| Standard Plans Member Months in MLR Reporting Year                    | Standard Plans Credibility Adjustment |
| < 5,400                                                               | Non-credible                          |
| 5,400                                                                 | 8.4%                                  |
| 12,000                                                                | 5.7%                                  |
| 24,000                                                                | 4.0%                                  |
| 48,000                                                                | 2.9%                                  |
| 96,000                                                                | 2.0%                                  |
| 192,000                                                               | 1.5%                                  |
| 380,000                                                               | 1.0%                                  |
| > 380,000                                                             | Fully Credible                        |

### Line 5.1 – Total Member Months for SFY 2019

Include The number of months a group of enrollees is covered by a PIHP for the 12-month reporting period. The MLR tool will populate the appropriate credibility adjustment based on the number of reported member months.

### SUMMARY CALCULATION

The “Summary Calculation” tab calculates the PIHP’s MLR calculation for SFY 2019 based on information reported on the data collection tab. The separate components of the MLR formula are summarized with an unadjusted and adjusted MLR displayed in Section 4 of this tab.

In situations where the PIHP is non-credible based on reported member months, it is assumed that the PIHP meets the minimum MLR Standard. For situations where the PIHP is partially-credible or fully-credible, the Adjusted MLR is compared to the MLR Standard.

<sup>2</sup> CMS Information Bulletin: MLR Credibility Adjustments; available at: <https://www.medicare.gov/federal-policy-guidance/downloads/cib073117.pdf>

### III. Limitations and Data Reliance

The services provided for this project were performed under the signed contract between Milliman and MDHHS approved September 13, 2019.

The information contained in this letter, including the appendices, has been prepared for the State of Michigan, Department of Health and Human Services and their consultants and advisors. It is our understanding that this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for MDHHS 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.

In performing this analysis, we relied on data and other information provided by MDHHS and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

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