

MILLIMAN CLIENT REPORT

SFY 2024 Behavioral Health PIHP Medical Loss Ratio Calculation

State of Michigan, Department of Health and Human Services

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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 template for the calculation and assessment of the MLR standards set forth in the October 1, 2023 through September 30, 2024 (SFY 2024) behavioral health managed care contract with the prepaid inpatient health plans (PIHPs).

The final Medicaid and Children's Health Insurance Program rule (Final Rule)¹, released on May 6, 2016, and updated on November 13, 2020, and May 10, 2024,² requires 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 Medical Loss Ratio (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. CMS has also indicated MLR reporting standards result in responsible fiscal stewardship of total Medicaid expenditures, ensuring states have insight and understanding into how capitation payments made for enrollees in managed care programs are being expended.³

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 populations).
- 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,
- The 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 2024 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 and posted on the Medicaid.gov website.⁴ 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 template will be used to calculate the PIHP's Medicaid MLR.

Fraud prevention activities are currently excluded from the numerator of the Medicaid MLR calculation. As stated in 42 CFR § 438.8(e)(4), allowable fraud prevention activities are described as follows: "expenditures on activities

¹ Source: CMS. Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care; available at: <https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicare-and-childrens-health-insurance-program-chip-managed-care>

² Source: CMS. 2024 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule, published May 10, 2024; full text available at: <https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf>

³ 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-medicare-managed-care-chip-delivered>

⁴ Source: Medicaid.gov. Medical Loss Ratio Guidance; available at: <https://www.medicare.gov/medicaid/managed-care/guidance/medical-loss-ratio/index.html>

related to fraud prevention consistent with regulations adopted for the private market at 45 CFR part 158". At this time, the private market does not incorporate fraud prevention activities in the MLR calculation. If the 45 CFR part 158 regulation defining fraud prevention activities are amended in the future, we will review the Medicaid MLR calculation for incorporation of fraud prevention activities, as appropriate. However, until that time, please note that fraud prevention activities have been included in this Medicaid MLR template for reporting purposes only.

The Medicaid MLR reporting instructions are to be used in completing and submitting the MLR template for all PIHPs participating in the MDHHS' behavioral health managed care program in SFY 2024. MDHHS and Milliman will rely on the accuracy and completeness of the submitted Michigan Medicaid MLR template 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 template.

This Medicaid MLR template 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 of the Final Rule.

II. General Instructions

This section outlines the general instructions for PIHPs to complete the requested information in the accompanying Excel-based Medicaid MLR template. The SFY 2024 Medicaid MLR as defined in Section I will be calculated for each PIHP based on plan-submitted data. It is expected each PIHP will submit a completed version of the Excel template to MDHHS by July 31, 2025. Please note that the MLR is being calculated specifically to the behavioral health managed care program. Given the behavioral and opioid health homes are excluded from the capitation rates, these revenues and expenses should be excluded from this template.

The Medicaid MLR Reporting template contains the following tabs:

- Attestation
- Data Collection
- Allocation Methodology
- Summary

PIHPs are requested to populate the Attestation and Data Collection tabs. The Summary 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 to confirm 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 PIHPs must attest that provider incentives payments that are included in the numerator are in compliance with 42 CFR 438.8(e)(2)(iii)(A), and that the templates include a separate attachment that compares the plan's audited financial statement to the information provided in the template. 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 used to collect the data needed to calculate the SFY 2024 Behavioral Health PIHP medical loss ratio. 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 template 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 2023 – September 2024, paid through January 31, 2025

Line 1.1 should reflect total SFY 2024 net paid and incurred claims, with claims run out through January 31, 2025, consistent with the inclusion and exclusion lists provided below. Please note most of the items excluded from Line 1.1 are specifically requested to be quantified in a subsequent line item in Section 1.

Include:

- Direct paid claims to providers, including all CCBHC claims for SMI/SED encounters, and any non-encounterable payments for services covered under the managed care contract during SFY 2024.
- Sub-capitation paid attributed to services provided.

- Claims expenditures for non-state plan services that the PIHP voluntarily provides through the Medicaid managed care program.
- Direct care worker wage increases to providers.

Exclude:

- Health home expenses as these are not covered in the capitation rates.
- 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.
- Psych Hospital Rate Adjuster payments made.
- Fraud recoveries and expenses related to fraud recovery activities.
- CCBHC expenditures for mild-to-moderate claims.

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 covered Medicaid services provided to an enrollee during SFY 2024 as these amounts will not be used in the MLR calculation. Amounts should also be reported in line 2.1 Managed Care Administrative costs.

Line 1.3 – Unpaid Claim Liabilities

Unpaid claim liabilities reflect the estimated outstanding liabilities for all behavioral health services for SFY 2024. This includes items such as incurred but not reported (IBNR) claims, claims in the course of settlement (ICOS), and claims that are adjudicated but not yet paid. Additionally, include all accruals for non-encounterable payments to providers (i.e., lump sum settlements). Provide the total reserve balance held on January 31, 2025, for the SFY 2024 incurred period. The 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

Payments for incentives, bonuses, withholds, and other settlement amounts to participating providers specific to the SFY 2024 incurred period. For payments that have not yet been measured and paid out, PIHPs should provide the accrued payment amount.

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. This should include the amounts already recovered and an estimate of any future Coordination of Benefits recoveries expected to be received. This amount should be entered as a negative.

Line 1.6 – Overpayment Recoveries Received from Network Providers

Recoveries received because of overpayments to network providers. This amount should be entered as a negative.

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 2024. We are not aware of any state-mandated solvency funds for purposes of SFY 2024.

Line 1.8 – Hospital Reimbursement Assessment (HRA) Psych Hospital Rate Adjuster

Include the HRA 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 3.8.

Line 1.9 – Allowable Claims Recovered Through Fraud Reduction Efforts

Fraudulent claim payments recovered because of fraud reduction efforts.

Line 1.9a – Total Fraud Recoveries Expense

Conducting fraud recovery activities including any expenditures to recover fraudulent provider payments consistent with 42 CFR 438.8(e)(2)(iii)(B).

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.

Line 1.9c – Total Fraud Recoveries Added Back to Incurred Claims

Fraud recoveries up to total fraud recoveries expense as reported in Line 1.9.a are included in the incurred claims calculation.

Line 1.10 – Fraud Prevention Activities

PIHP expenditures on activities related to detection and prevention of fraudulent payments, excluding expenses for fraud reduction efforts in Line 1.9a.

Line 1.11 – CCBHC Mild-to-Moderate claims

Claim payments made for individuals identified as mild-to-moderate severity.

Non-Claims Costs

Although administrative expenses (under subsection 2.1) are not used in the MLR calculation, CMS requires PIHPs to report all non-claims costs in the MLR calculation. Non-claims costs are expenses for administrative services that are not defined as Incurred Claims, Healthcare Quality Improvement Activity expenditures, licensing and regulatory fees, or Federal and State taxes. The Final Rule provides the following examples of non-claims costs that must be excluded from other areas of the medical loss ratio calculation.

- Amounts paid to third party vendors for secondary network savings.
- Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
- Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.
- Fines and penalties assessed by regulatory authorities.
- Specific exclusions from healthcare quality improvement activity expenditures as described below.

Line 2.1 – Incurred non-claims expenses (including managed care administrative costs delegated to the CMHSPs and other sub-capitated entities)

We would like 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. 1915(c) Waiver (CWP, HSW, SED) Admin
- e. Other Admin

It should be noted that “CCBHC Admin Attributable to Behavioral Health Managed Care Program” expenses are not listed as a distinct item under Line 2.1. CCBHC-only administrative costs should be included under the “Other Admin” item.

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 2024

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.

Specific exclusions from healthcare quality improvement activity expenditures are detailed below:

- Expenditures are designed primarily to control or contain costs.
- Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from premium revenue.
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
- The portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
- All retrospective and concurrent utilization reviews.
- Fraud prevention activities.
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
- Provider credentialing.
- Marketing expenses.
- Costs associated with calculating and administering individual enrollee or employee incentives.
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.
- Any function or activity not expressly included in 45 CFR § 158.150(a) and (b), unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this part or otherwise support monitoring, measuring or reporting health care quality improvement.

Line 2.2.a – Improve Health Outcomes

Expenses for direct interaction of the PIHP (including those services delegated by contract for which the PIHP retains ultimate responsibility under the contract), providers and the enrollee or the enrollee's representatives (e.g., face-to-face, telephone, web-based interactions, or other means of communication) to improve health outcomes. These activities must meet the following requirements:

- The activity must be designed to:
 - Improve health quality.
 - Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
 - Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage if no additional costs are incurred due to the non-enrollees.
 - Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.
- The activity must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
 - Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
 - Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.
 - Identifying and addressing ethnic, cultural, or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
 - Quality reporting and documentation of care in non-electronic format.
 - Health information technology to support these activities.
 - Accreditation fees directly related to quality of care activities.
 - Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

Line 2.2.b – Activities to Prevent Hospital Readmission

Expenses to prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

- Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) to help assure appropriate care that will, likely, avoid re-admission to the hospital.
- Patient-centered education and counseling.
- Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
- Health information technology to support these activities.

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

Expenses for implementing activities to improve patient safety and reduce medical errors. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

- The appropriate identification and use of best clinical practices to avoid harm.
- Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
- Activities to lower the risk of facility-acquired infections.
- Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
- Health information technology to support these activities.

Line 2.2.d – Wellness and Health Promotion Activities

Expenses to implement, promote, and increase wellness and health activities. Examples include:

- Wellness assessments.
- Wellness/lifestyle coaching programs are designed to achieve specific and measurable improvements.
- Coaching programs are designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition.
- Public health education campaigns that are performed in conjunction with State or local health departments.
- Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims, to the extent permitted by section 2705 of the PHS Act.
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities.
- Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity).
- Health information technology to support these activities.

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 Medicaid meaningful use requirements and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible. Specific examples of these types of expenses are described in 45 CFR 158.151(a).⁵

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 and performed in the 12 months preceding the preceding finalization of the annual report. Mandatory activities include validation of performance improvement projects, validation of PIHP performance measures, a review conducted within the previous 3-year period to determine compliance with PIHP standards, and validation of PIHP network adequacy. Optional activities include validation of encounter data reported, administration or validation of consumer or provider surveys of quality of care, calculations of performance measures, conduct of performance improvement projects, conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services, assist with quality rating of PIHP, and assist with required evaluations pertaining to outcomes, quality, or access to healthcare services.

Line 2.2.g – 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 all expenses included in this line.

Premium Revenue

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

Line 3.1 – Total State Capitation Payments during SFY 2024

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

⁵ [https://www.ecfr.gov/current/title-45/part-158/section-158.151#p-158.151\(a\)](https://www.ecfr.gov/current/title-45/part-158/section-158.151#p-158.151(a))

Include:

- Risk-adjusted capitation payment revenue for the Michigan Specialty Services and Support Waiver and Healthy Michigan Plan behavioral health programs for the SFY 2024 contract year including taxes and fees.
- Direct care worker wage increases funding.

Exclude

- The portion of the capitation rate related to the quality withhold and bonus program.
- The portion of the capitation rate related to Psych Hospital Rate Adjuster Payments.
- Revenues related to the behavioral and opioid health homes.
- Incentive payments for the DHIP program.
- Risk Corridor Settlements.
- CCBHC Supplemental Payments for Mild-to-Moderate services.

Line 3.2 – PIHP Withhold Earned Back – Related to October 2023 - September 2024

The amount of the quality withhold earned back based on quality indices established by MDHHS for the SFY 2024 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 2023 - September 2024

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 2024 contract period. This line should reflect any amounts received that were above and beyond the actual withhold amount. 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 from the DHIP program

Incentive payments received or accrued from the DHIP program for the SFY 2024 contract period.

Line 3.5 – Net Payments from Risk Corridor

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 – CCBHC Supplemental Payments for Mild-to-Moderate Services

Revenue through the CCBHC program for supplemental reconciliations related to Mild-to-Moderate CCBHC services.

Line 3.7 – 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 column if any amounts are reported in this line.

Line 3.8 – Psych Hospital Rate Adjuster (HRA) Payments Received

The portion of the total capitation revenue related to HRA payments. This amount is expected to be exactly equal to the claims expenses for HRA providers as reported in Line 1.8. If amounts are not exactly equal, please provide an explanation in the comments column.

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 42 CFR 438.8(f)(3). Tax exempt entities may report community benefit expenditures in compliance with 42 CFR 438.8(f)(3)(v).

Line 4.1 – Federal Taxes and Federal Assessments

All federal taxes and assessments incurred by the PIHP during SFY 2024 allocable to the Medicaid line of business. Exclude federal income taxes on investment income and capital gains.

Line 4.2 – IPA

The applicable insurance provider assessment (IPA) that was paid for SFY 2024 claims.

Line 4.3 – State Insurance, Premium, and Other Taxes

Include:

- State income, excise, business, and other taxes, allocated to the Medicaid line of business for SFY 2024
- 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 (excluding IPA reported above).
- 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:

- Fines, penalties, and fees for examinations by any State departments.
- State employment taxes and assessments (such as State unemployment / reemployment insurance, employment training, and other similar taxes and assessments).
- State sales taxes, if the PIHP 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.
- 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.
- Examination fees in lieu of premium taxes as specified by Michigan State Law.

Exclude:

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

Line 5.1 – Total Member Months for SFY 2024

Include the total number of months a group of enrollees is covered by a PIHP for SFY 2024. The MLR template will populate the appropriate credibility adjustment based on the number of reported member months.

Credibility Adjustment

This section provides information related to the credibility adjustment in the 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 is determined by the total number of SFY 2024 Medicaid member months by program and in aggregate. 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. If the Adjusted MLR is greater than or equal to the MLR Standard, then the PIHP meets the MLR Standard. If the Adjusted MLR is less than the MLR standard, then the PIHP does not meet the MLR Standard.

The credibility adjustment factors can be found in the July 31, 2017, CMS Informational Bulletin, Medical Loss Ratio (MLR) Credibility Adjustments.⁶

SUMMARY

The Summary tab calculates the PIHP's MLR calculation for SFY 2024 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.

ALLOCATION METHODOLOGY

This tab requests free form information on the allocations and assumptions utilized in the development of the allocation and types of expenses reported for the MLR elements of incurred claims, healthcare quality improvement expenses, taxes (federal and state) and fees (licensing or regulatory), and other non-claims costs, as described above.

A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

- Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the PIHP should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.
- Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.
- Any basis adopted to apportion expenses must be the basis expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios, or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

The PIHP may insert additional rows if necessary. If additional explanation is needed, the notes section at the bottom of the tab can be used to describe any other relevant information on section questions.

⁶ CMS Information Bulletin: MLR Credibility Adjustments; available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf>

III. Limitations and Data Reliance

The Medicaid MLR template and these instructions have been prepared for the internal use of MDHHS along with the intended PIHP recipients. No portion of this communication may be provided to or relied upon by any other party without Milliman's prior written consent. Any user of these materials must possess a certain level of expertise in actuarial science and health care modeling that will allow appropriate use of the instructions and corresponding Medicaid MLR template. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. Likewise, third parties are instructed that they are to place no reliance upon this template 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.

Milliman has developed this template to collect information that will assist MDHHS in calculation and assessment of the SFY 2024 Behavioral Health PIHP Medicaid MLR in accordance with the PIHP contracts and 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, 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 and the SFY 2024 Behavioral Health PIHP MLR Template will be shared with each PIHP. It is ultimately the responsibility of the contracted PIHPs to ensure the information submitted to MDHSS in the MLR reports complies with 42 CFR §438.8 and the PIHP contracts. The template may not be appropriate for any other purpose.

Milliman has developed certain models to estimate the values included in this correspondence. The intent of the models was to estimate the PIHP's SFY 2024 Behavioral Health PIHP MLR percentages. 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 MDHHS 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 PIHP contracts. 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.

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.