

MILLIMAN REPORT

HEALTHII Quality Performance Measures Technical Guide – FFY 2027

Commissioned by the Arizona Health Care Cost Containment
System

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Summary

BACKGROUND

The Arizona Health Care Cost Containment System (AHCCCS) engaged Milliman, Inc. (Milliman) to support quality performance measures for the “Hospital Enhanced Access Leading to Health Improvements Initiative” (**HEALTHII**) program to be developed during federal fiscal year (FFY) 2027 (the sixth year of this program). This guide provides the technical specifications and submission requirements for providers to submit historical quality performance data from FFY 2025 (October 1, 2024 – September 30, 2025). This guide focuses on the quality measures based on **hospital self-reported data**, as measures based on Medicaid claims data will be collected directly from AHCCCS. No measures have been introduced to or retired from the program relative to FFY 2026.

In response to 2020 HB 2668 (“Hospitals; unreimbursed costs; assessment; fund”)¹, AHCCCS established the Health Care Investment Fund (HCIF) that expanded the existing inpatient and outpatient hospital assessment under Arizona Final Rule R9-22-731². As required under HB 2668, since October 1, 2020, HCIF has funded the non-federal share of a \$438.6(c) state directed payment for hospitals under Medicaid managed care, called the **“HEALTHII” payment program**. State directed payment arrangements are a commonly used approach for states to set parameters on how expenditures under managed care contracts are made by managed care plans to assist states in achieving their overall objectives for delivery system and payment reform and performance improvement. These programs are made permissible under 42 CFR §438.6(c) and have specific Centers for Medicare and Medicaid Services (CMS) requirements, including a requirement for annual approval by CMS³. Additional background regarding Arizona’s HEALTHII payment program can be found on the AHCCCS website⁴. As of this writing, the FFY 2027 HEALTHII SDP⁵ renewal “preprint” application is under review by CMS and is subject to federal approval.

As part of the HEALTHII payment program, AHCCCS establishes a separate quality incentive payment pool to reward hospitals for reporting on specific quality measures outlined in this guide. Hospitals that meet AHCCCS’ reporting requirements are eligible for additional payments from this pool.

This payment arrangement is designed to advance the goals and objectives in the AHCCCS Quality Strategy, including improving quality of services to AHCCCS members and member health outcomes⁶. It is also a key component to receive written approval from CMS through their annual \$438.6(c) preprint process, which requires states to show that each state-directed payment arrangement supports at least one goal or objective in their Quality Strategy.

Currently, hospitals earn incentive payments for reporting on targeted measures (“pay for reporting”). In the future, AHCCCS may consider adding “pay-for-performance” (P4P) measures, where hospitals could earn incentive payments based on their actual performance or scores on targeted measures.

¹ <https://www.azleg.gov/legtext/54leg/2R/laws/0046.pdf>.

² State of Arizona Final Rule, Title 9. Health Services, Chapter 22. Arizona Health Care Cost Containment System – Administration, Section 731. <https://www.azahcccs.gov/shared/Downloads/Reporting/UnpublishedRules/NOFER11012020.pdf>.

³ For more background see MACPAC’s October 2024 Issue Brief “Directed Payments in Medicaid Managed Care.” <https://www.macpac.gov/publication/directed-payments-in-medicaid-managed-care/>.

⁴ Arizona Health Care Cost Containment System, Hospital Assessment. <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/HospitalAssessment.html>.

⁵ The reporting period for the FFY 2027 HEALTHII SDP program year is FFY 2025 (October 1, 2024 through September 30, 2025).

⁶ Arizona Health Care Cost Containment System, Quality Strategy. July 1, 2024. <https://www.azahcccs.gov/PlansProviders/Downloads/QualityStrategyJuly2024Final.pdf>

FFY 2027 HEALTHII MEASURES

State directed payments such as HEALTHII are subject to an annual approval process by CMS, which involves submission of a “Section 438.6(c) Preprint” application and includes a requirement for an “Evaluation Measures, Baseline and Performance Targets.” We understand AHCCCS developed these quality measures over a multi-year process in coordination with multiple hospital stakeholder sessions.

AHCCCS’ selected quality measures for collection and analysis during FFY 2027, along with the measure type and applicable provider types, are listed in Figure 1 below, which is unchanged from FFY 2026..

FIGURE 1: FFY 2027 HEALTHII PERFORMANCE MEASURES

MEASURE	TYPE OF MEASURE	MEASURE DESCRIPTION	MEASURE BASIS	APPLICABLE PROVIDER TYPES
AHCCCS-02	Claims based	Patient Safety Indicators 90 (PSI 90) Patient Safety and Adverse Events Composite	CBE # 0531	General Acute Care Hospitals
AHCCCS-04	Self-reported	Hours of Seclusion Use	CBE # 0641	Psychiatric Hospitals
AHCCCS-05	Self-reported	Percent of Residents Experiencing One or More Falls with Major Injury	CBE #0674	Freestanding Rehabilitation Hospitals & Long Term Acute Care Hospitals
AHCCCS-06	Self-reported	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure	CBE #1717	General Acute & Children's Hospitals
AHCCCS-07	Claims based	30-Day Hospital-Wide All-Cause Unplanned Readmission Measure	CBE # 1789	Short Stay Hospitals
AHCCCS-12	Self-reported	Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients	CBE# 0496	Critical Access Hospitals

Reporting Process

SELF-REPORTED DATA SUBMISSION TEMPLATE

All participating hospitals will collect, calculate, and submit the performance metrics for the applicable self-reported performance measures via the self-reported performance measure submission template ("the template"). The template requires submission of aggregate numerator and denominator data only.

Each participating hospital should download and save a copy of the required Submission Template and update with the required data on each tab.

- The template "Data Submission Template FFY2027" is available on AHCCCS's website:
 - <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/hospitalassessment.html>
- Submit the completed Submission Template to AZ-HEALTHII@milliman.com using the following subject line:
 - *HEALTHII - [Hospital Name] - [AHCCCS Provider ID]*
 - *Example: HEALTHII – Arizona Medicaid Hospital - 123456*

HIGH LEVEL TIMELINE AND DUE DATES

Activity	Timeline
Self-Reported Data Submission Template Available	No later than Thursday, September 17, 2026
Hospitals notified if selected for submission of a complete data log for self-reported measures	No later than Friday, September 18, 2026
Self-Reported Data Submission Template Due to Milliman	No later than Friday November 13 th , 2026
Data log for self-reported measures due	No later than Friday November 13 th , 2026

DATA LOG SUBMISSION REQUIREMENTS

All hospitals must maintain a data log showing the complete set of data inputs used to determine the resulting measure metrics. **A subset of hospitals will be selected to submit a data log subject to a secondary review process.**

Hospitals do not need to follow a specific data log format for HEALTHII measures, but the data log should include all relevant information needed to determine the reported rate. The data log must be an Excel file and may use the facility's prescribed file layout. However, the layout should be clear so that AHCCCS or AHCCCS's vendor can review it with minimal questions. The Excel file should contain sufficient documentation to identify members, events and how the measure numerator/denominator were tallied. Facilities may use the file layout provided for measures in prior years, but this is not required.

POLICIES ON SUBMISSION OF PHI

Hospitals should not include any patient health information (PHI) in the Submission Template. Hospitals selected to submit a completed data log will be required to submit data, including PHI. Hospitals must restrict the data log to the minimum necessary PHI to perform the calculation or analysis. Data log files will be submitted via a secure Milliman FTP site. Hospitals selected to submit data logs will receive instructions on how to submit files via the secure Milliman FTP.

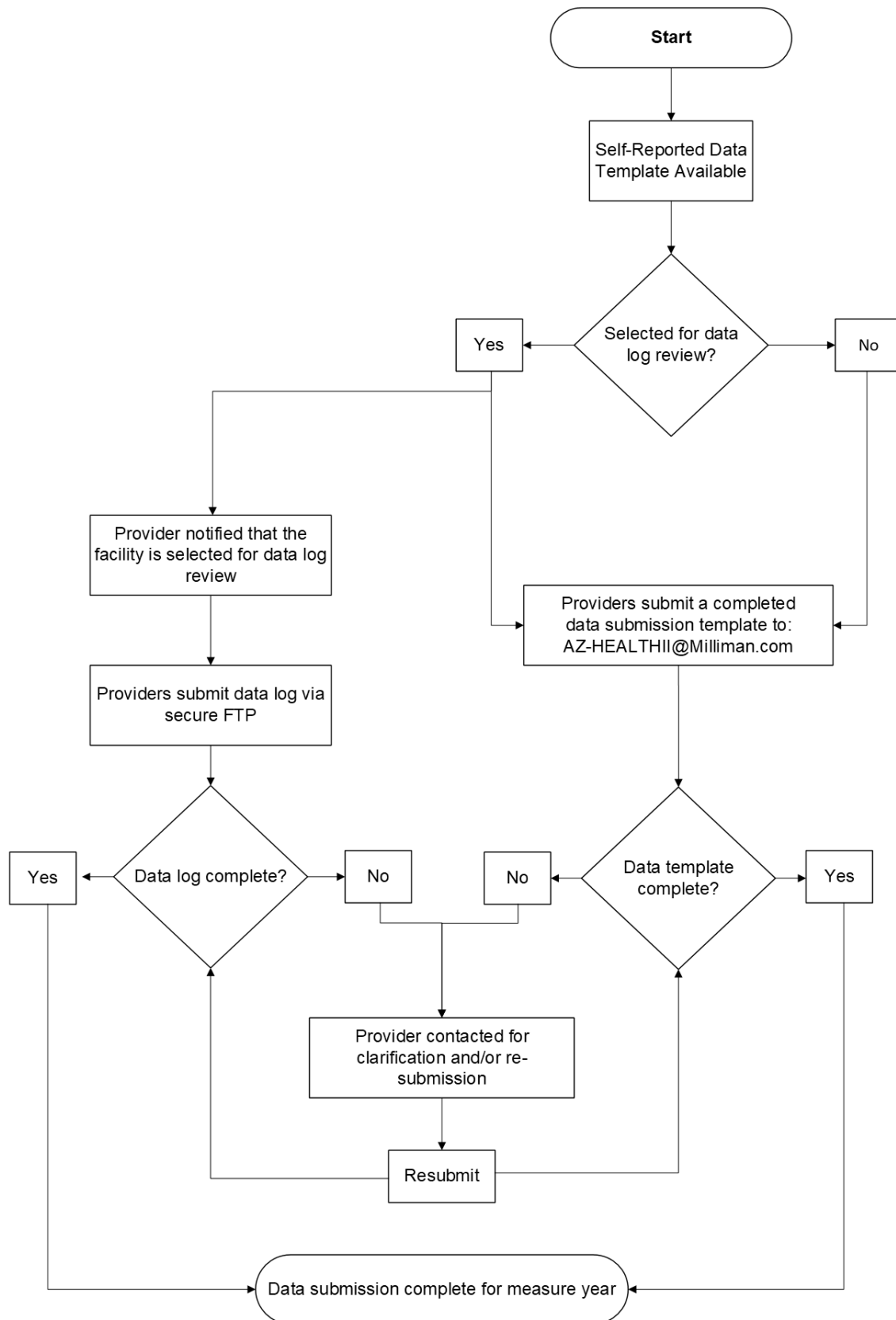
POST SUBMISSION EXPECTATIONS

Hospitals will receive email confirmation that their Submission Template was received and complete within two business days of submission.

All hospitals, including those not selected for data log submission, are required to retain data logs and AHCCCS reserves the right to require additional verification of any data, related documentation, and compliance with all program requirements, and to audit data from participating hospitals at any time.

SELF-REPORTED DATA SUBMISSION FLOW CHART

Below is an illustration of the process for hospitals to submit self-reported data for HEALTHII FFY 2027.



Technical Reporting Guidance

The Self-Reported Measure Specifications sections below describe each measure in detail, including:

- Hospital Type
- Description
- Reporting Period
- Measure Basis
- Specifications Source
- Measure Modifications
- Detailed Specifications Summary

Milliman is available to support organizations who have additional questions that are not addressed in this technical guide. Participating hospitals may contact Milliman via email at AZ-HEALTHII@milliman.com.

SELF-REPORTED MEASURE REPORTING TEMPLATE INSTRUCTIONS

The template is an Excel workbook with multiple tabs for data entry. The template also includes important attestations regarding the submission, including that the submission **does not contain PHI** or personally identifying information. Individual level data is not required for completion or submission of the template. Submissions with PHI or individual level data included in the workbooks will be identified as a privacy violation and reported through appropriate security incident reporting channels. As such, workbooks with privacy violations will not be considered complete or valid submissions, and the hospital must resubmit to participate in the HEALTHII program.

The template is organized using the following format.

- **Instructions:** Written instructions on how to complete the template.
- **FAQs:** Frequently Asked Questions regarding the program, submission process, and reporting requirements.
- **Hospital Information:** Documentation of who submitted the data, a series of acknowledgements, hospital information, and a key for the corresponding tabs on hospital types.
- **Hospital Type:** Series of tabs organized in the following order. As described above, data will be entered in these workbook tabs.
 - Children's
 - Critical Access
 - General Acute
 - Long Term
 - Psychiatric
 - Rehabilitation

Instructions as Shown on the Template

Download the template "Data Submission Template FFY2027" from AHCCCS's website:
<https://www.azahcccs.gov/PlansProviders/RatesAndBilling/hospitalassessment.html>

Step 1: Complete "Hospital Information" Tab

Populate contact information for the appropriate person completing and submitting HEALTHII performance data and select your hospital from the drop down.

Step 2: Complete Data Entry in Corresponding Hospital Type Tab

Please enter measure-specific data as applicable for your facility.

Note: Completion of the template does not require Protected Health Information (PHI). PHI should not be included in the workbook or in any email transmittal to Milliman.

Step 3: Submit Data Entry Template via Email

Once all data elements have been entered and saved, please submit via email to Milliman using the program email address below. Should you have any questions, please submit using the same program email address below.

AZ-HEALTHII@milliman.com

Note: The HEALTHII program is displayed using a capital i – healthii

See additional information on submission requirements below.

The following figures outline the data entry required for each measure. Data shall be entered into the green "Numerator" and "Denominator" cells.

FIGURE 2: DATA ENTRY TAB: CHILDRENS & GENERAL ACUTE

Data Entry - Medicaid Managed Care Population Only		
See 2027 HEALTHII Technical Manual for numerator and denominator calculation requirements		
Numerator:	CDI Events	
Denominator:	Admissions	
Calculation		
Rate:		= [CDI Events] ÷ [Admissions]

FIGURE 3: DATA ENTRY TAB: CRITICAL ACCESS

Data Entry - Medicaid Managed Care Population Only		
See 2027 HEALTHII Technical Manual for calculation requirements		
Numerator:	Median Time (Minutes)	
		<i>This is the calculated measure, matching Median Time in white box below.</i>
ED Visits:	Number of Visits	
Calculation		
Median Time:	0	= [Median Time (Minutes)]

FIGURE 4: DATA ENTRY TABS: LONG TERM & REHABILITATION

Data Entry - Medicaid Managed Care Population Only	
<i>See 2027 HEALTHII Technical Manual for numerator and denominator calculation requirements</i>	
Numerator:	Falls With Major Injury
Denominator:	Long Stay Patients
Calculation	
Rate:	0 = [Falls With Major Injury] ÷ [Long Stay Patients]

FIGURE 5: DATA ENTRY TAB: PSYCHIATRIC

Data Entry - Medicaid Managed Care Population Only	
<i>See 2027 HEALTHII Technical Manual for numerator and denominator calculation requirements</i>	
Numerator:	Minutes of Seclusion
Denominator:	Patient Days
Calculation	
Hours of Seclusion:	0.00 = [Minutes of Seclusion] ÷ 60
Rate:	0 = ([Hours of Seclusion] × [1,000]) ÷ ([Total Patient Days] × [24 Hours])

SELF-REPORTED MEASURE SPECIFICATIONS**AHCCCS-04: Hours of Seclusion Use**

- **Hospital Type:** Psychiatric
- **Description:** The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion (Overall rate)
- **Reporting Period:** 10/01/2024 - 09/30/2025
- **Measure Basis:** [CBE #0641](#)
- **Specifications Source:** Reporting may align with The Joint Commission's specifications for the Medicare Inpatient Psychiatric Facility Quality Reporting Program, HBIPS-3a Hours of Seclusion, Overall Rate.
 - Link: [Specifications Manual for Joint Commission National Quality Measures \(v2025B\)](#)
- **Measure Modifications:** Denominator and numerator limited to AHCCCS Medicaid managed care population

Detailed Specifications Summary (See specifications source for logic):

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the **number of minutes** to ensure a more accurate calculation of the measure.

Included Populations:

- Patients for whom at least one seclusion event is reported during the month

Excluded Populations: None

Denominator Statement: Number of psychiatric inpatient days

Denominator Basis: per 1,000 hours

Included Populations:

- All psychiatric inpatient days

Excluded Populations:

- Total leave days

AHCCCS-05: Percent of Residents Experiencing One or More Falls with Major Injury

- **Hospital Type:** Rehabilitation and Long Term Hospitals
- **Description:**
Long Term Hospital: Percentage of LTCH patients who experience one or more falls with major injury during their LTCH stay
Rehabilitation Hospital: The percentage of IRF stays in which patients experience one or more falls with major injury during the IRF stay.
- **Reporting Period:** 10/01/2024 - 09/30/2025
- **Measure Basis:** [CBE #0674](#)
- **Specifications Source:** Reporting may align with Medicare Inpatient Rehab Facility Quality Reporting and Long-Term Care Hospital Quality Reporting, limited to AHCCCS members.
 - Link: [Inpatient Rehabilitation Facility Quality Reporting Program Measure Calculations and Reporting User's Manual](#)
 - Link: [Long-Term Care Hospital Quality Reporting Program Measure Calculations and Reporting User's Manual](#)
- **Measure Modifications:** Denominator and numerator limited to AHCCCS Medicaid managed care population

Detailed Specifications Summary (See specifications source for logic):**Rehabilitation Hospitals**

Numerator
Total number of IRF stays in the denominator during the selected time window that experienced one or more falls that resulted in major injury: J1900C = [1] or [2].
Denominator
The total number of IRF stays with a discharge date in the measure target period, which do not meet the exclusion criteria
Exclusions
An IRF stay is excluded if the number of falls with major injury was not coded at discharge: ▪ J1900C (Falls with Major Injury) = [-]

Long Term Hospitals

Numerator
Numerator Total number of LTCH stays in the denominator with planned or unplanned Discharge assessment or Expired Record during the selected time window that experienced one or more falls that resulted in major injury: J1900C = [1] or [2].
Denominator
The total number of LTCH stays with a planned or unplanned Discharge assessment or Expired Record (A0250 = [10, 11, 12]) in the measure target period, which do not meet the exclusion criteria.
Exclusions
An LTCH stay is excluded if the number of falls with major injury was not coded: J1900C (Falls with Major Injury) = [-].

AHCCCS-06: NHCN Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure

- **Hospital Type:** Children's and General Acute Hospitals
- **Description:** Hospital-onset CDI Laboratory-identified events (LabID events) among all inpatients in the facility, excluding well-baby nurseries and neonatal intensive care units (NICUs).
- **Reporting Period:** 10/01/2024 - 09/30/2025
- **Measure Basis:** [CBE #1717](#)
- **Specifications Source:** Hospitals will use their own medical record data to calculate an observed rate (no standardized infection ratio will be calculated). Because no SIR is calculated, specifications will not align with Medicare programs.
 - Link: [Measure Calculation Guidance](#)
- **Measure Modifications:** Denominator and numerator limited to AHCCCS Medicaid managed care population
 - Hospitals will report one rate for all inpatient locations monitored during the twelve-month period
 - Hospitals will report one rate for the twelve-month reporting period

Detailed Specifications Summary (See specifications source for logic):

Numerator
The number of observed hospital-onset incident CDI LabID events among all inpatients in the facility
Denominator
The number of Medicaid managed care facility admissions
Settings
While two core reporting options exist for reporting C. difficile, this measure is specific to Laboratory Identified "LabID" Events. "LabID" Event reporting must be limited to inpatient events. Surveillance will NOT be performed in NICU, Specialty Care Nurseries, babies in Labor, Delivery, Recovery, and Post-partum (LDRP/PP) units, well-baby nurseries, or well-baby clinics. If LDRP/PP locations are being monitored, baby counts must be removed when compiling total facility counts for line 3 of the facility-wide level for inpatient areas (FacWideIN) denominator submission.
Exclusions
Baby based locations such as, neonatal ICU, special care nursery and well-baby nurseries, are excluded from the denominator count. In LDRP locations, moms and babies must each be counted separately (as two patients). Any locations that predominantly house infants, including NICU, SCN, or well-baby locations (for example, nurseries, babies in LDRP) are excluded.

AHCCCS-12: Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients

- **Hospital Type:** Critical Access Hospitals
- **Description:** Calculates the median time from emergency department arrival to time of departure from the emergency room for patients discharged from the ED
- **Reporting Period:** 10/01/2024 - 09/30/2025
- **Measure Basis:** [CBE #0496](#)
- **Specifications Source:** Reporting may align with the Medicare Hospital Outpatient Quality Reporting Program (OP-18: Median Time from ED Arrival to ED Departure for Discharged ED Patients but limited to AHCCCS members.)
 - Link: [Hospital Outpatient Quality Reporting Specifications Manual](#) (Pages 37-43)
- **Measure Modifications:** Median time calculated based on the AHCCCS Medicaid managed care population only
- **Median Time Calculation (not the same formula as the arithmetic mean):**
 - Collect all visit durations for the patient population
 - For each ED encounter, calculate the difference in **minutes** between the emergency department location departure time and the emergency department location arrival time.
 - Sort the visit durations in ascending order
 - The median is the **middle value**:
 - If the number of ED Visits is odd, the middle value is the median.
 - If the number of ED Visits is even, the median is the average of the two middle values.
 - Link: [eCQI Measure Resource - Median Time from ED Arrival to ED Departure for Discharged ED Patients](#)

Detailed Specifications Summary (See specifications source for logic):

Continuous Variable Statement Time (in minutes) from ED arrival to ED departure for patients discharged from the emergency department.
Included Populations Any ED patient from the facility's emergency department
Excluded Populations Patients who expired in the emergency department

CLAIMS BASED MEASURE SPECIFICATIONS**NOTE: HOSPITALS WILL NOT SUBMIT DATA FOR CLAIMS-BASED MEASURES OR PATIENT HEALTH INFORMATION (PHI)**

Hospitals are not required to submit information for the claims-based performance measures, as those calculations are performed by Milliman on claims obtained directly from AHCCCS. After a review of the data, Milliman and AHCCCS may outreach to providers in the event that a calculation falls significantly outside of the expected results range or a data issue has been identified that impacts the results of the claims-based performance measures.

Hospital quality data submissions should not contain PHI.

Data

Medicaid managed care encounters were obtained from the AHCCCS Medicaid Management Information System (MMIS). The extract consists of approved/adjudicated encounters from 10/1/2024 through 10/31/2025 based on service end date. This extract serves as the basis for claims-based quality measures and subsequent inclusion/exclusion criteria are applied at the individual measure level.

AHCCCS-02: Patient Safety Indicator (PSI) 90 Patient Safety and Adverse Events Composite

- **Hospital Type:** General Acute Care Hospitals
- **Description:** The PSI 90 composite measure summarizes patient safety across multiple indicators. Claims data extracted from the MMIS is used to calculate a PSI 90 composite score. The ten measures included in the composite measure are listed below:
 - PSI 03: Pressure Ulcer Rate
 - PSI 06: Iatrogenic Pneumothorax Rate
 - PSI 08: In-Hospital Fall-Associated Fracture Rate
 - PSI 09: Postoperative Hemorrhage or Hematoma Rate
 - PSI 10: Postoperative Acute Kidney Injury Requiring Dialysis Rate
 - PSI 11: Postoperative Respiratory Failure Rate
 - PSI 12: Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
 - PSI 13: Postoperative Sepsis Rate
 - PSI 14: Postoperative Wound Dehiscence Rate
 - PSI 15: Abdominopelvic Accidental Puncture or Laceration Rate
- **Reporting Period:** 10/01/2024 - 09/30/2025
- **Measure Basis:** [CBE #0531](#)
- **Specifications Source:** Facilities can download PSI software via CMS. To request the free software, visit: https://cmsqualitysupport.servicenowservices.com/qnet_qa
 - Select, "Ask a Question"
 - Choose "Inpatient Claims-Based Measures" in the program list,
 - In the "Patient Safety Indicators (PSI)" Topic List category, select "PSI 90 Software"
 - Complete the form as requested and submit
 - Software is provided as a SAS program with supporting reference tables
- **Measure Modifications:** Denominator and numerator limited to AHCCCS Medicaid managed care population.

Measure Description: Measure reports a hospital level weighted average of the indicators listed in the measure description for AHCCCS Medicaid managed care admissions

Note: Numerators, denominators, and exclusions are defined separately for each measure included in the composite. Please refer to [Partnership for Quality Measurement](#) for more detail.

AHCCCS-07: 30-Day Hospital Wide All-Cause Readmission Rate

- **Hospital Type:** Short Stay Hospitals
- **Description:** 30-Day Hospital-Wide All-Cause Unplanned Readmission Measure (Observed rate)
- **Reporting Period:** Reporting Period: 10/01/2024 - 09/30/2025
- **Measure Basis:** [CBE #1789](#)
- **Specifications Source:** [2024 Hospital-Wide Readmission Measure Updates and Specifications](#)
- **Measure Modifications:** Denominator and numerator limited to AHCCCS Medicaid managed care population

Numerator: Number of index admissions with one or more readmission within 30 days

The outcome is 30-day readmission defined as an inpatient admission for any cause, except for certain planned readmissions, within 30 days from the date of discharge from an eligible index admission. If a patient has more than one unplanned admission (for any reason) within 30 days after discharge from the index admission, only one is counted as a readmission.

Denominator: Total number of index admissions

Admissions for Medicaid MCO beneficiaries who are 65 years and older and are discharged from Arizona short stay hospitals with a complete claims history for the 12 months prior to admission.

Exclusions:

Exclude index admissions for patients:

1. Admitted to Prospective Payment System (PPS)-exempt cancer hospitals;
2. Without at least 30 days post-discharge enrollment in Medicaid MCO;
3. Discharged against medical advice;
4. Admitted for primary psychiatric diagnoses;
5. Admitted for rehabilitation; or
6. Admitted for medical treatment of cancer.

Limitations

The information contained in this document is prepared solely for the business use of the Arizona Health Care Cost Containment System (AHCCCS) for the purpose of providing technical specifications for hospitals to report quality measures selected by AHCCCS, and is not appropriate for other purposes. Any user of the information in this document must possess a certain level of expertise in hospital quality measurement that will allow appropriate use of the information presented.

We understand AHCCCS will share this document with Arizona Medicaid hospital stakeholders. To the extent that the information contained in this document is provided to any approved third parties, the document should be distributed in its entirety.

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Milliman has not advocated for, recommended, or endorsed any particular Arizona hospital quality measure program or Arizona Medicaid hospital quality incentive payments design. Implementation of Arizona hospital quality program design and requirements into Arizona Medicaid hospital quality incentive payments are subject to approval by AHCCCS and CMS. All final policy decisions regarding the design, modeling methodology, parameters, assumptions, and requirements of the Arizona hospital quality measures and Arizona Medicaid hospital quality incentive payments are the responsibility of AHCCCS.

For technical questions or questions related to the submission process please contact:

AZ-HEALTHII@milliman.com

For questions related to hospital assessments or HEALTHII directed payments please contact:

HospitalAssessmentProject@azahcccs.gov

For more information about Milliman,
please visit us at: milliman.com

Solutions for a world at risk™

Milliman leverages deep expertise, actuarial rigor, and advanced technology to develop solutions for a world at risk. We help clients in the public and private sectors navigate urgent, complex challenges—from extreme weather and market volatility to financial insecurity and rising health costs—so they can meet their business, financial, and social objectives. Our solutions encompass insurance, financial services, healthcare, life sciences, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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