

NWX-HHS-AOA-1

Moderator: Lauren Solkowski
June 25, 2015
1:30 pm CT

Coordinator: Welcome and thank you for standing by. All participants will be able to listen only until the question and answer portion of today's conference. To ask a question, please star 1.

Today's conference is being recorded. If you have any objections, please disconnect at this time. I would now like to turn the conference over to Ms. Lauren Solkowski. Miss, you may begin.

Lauren Solkowski: Thank you so much in good afternoon everyone and thank you for joining us today for the administration for community living's business acumen webinar on medical loss ratio.

As the operator mentioned, this is Lauren Solkowski with ACL and I will be facilitating our Webinar. So for today, we have invited (Tim McNeil), who is going to review and also explained the medical loss ratio and go - and discuss how it could impact your discussions with potential payers.

So before we start with his presentation, I have a few housekeeping announcements. Starting with one, if you have not done so, if you could use

the link that was included in your calendar appointment to get onto WebEx so that you can follow along with the slides as we go through them, but also you can ask your questions or comments, if you have, through the chat function.

If you do not have access to the link that I emailed you, you can also go on to www.WebEx.com and click on the attend a meeting button that's at the top of the page and then enter the meeting number.

So for today, our meeting number is 664376475. That's 664376475. If you have any problems getting into WebEx, please call the WebEx technical support number and that is 1-866-229-3239. Again that's 1-866-229-3239.

As the operator has mentioned, all of our participants are in -- excuse me -- a listen only mode. However, we do welcome your questions throughout the course of the Webinar. There are two ways you can ask your questions, the first of which is through the chat function in WebEx.

You can enter your questions and comments there, located on the right-hand side of the screen. And then the other is - the other way to ask questions, it will be through the audio line.

So when that time comes, the operator will give us instructions as to how to queue up to ask your questions. If there are any questions that we do not get to during the course of this Webinar, we will be sure to follow them up - follow up with you to get them answered.

If you have any questions, you can email them to me and I will enter my email address in the chat box here for everyone's reference before the end of the Webinar.

Also, at the operator has mentioned, we are recording the Webinar and we will be posting the recording, the slides and (Tim)'s presentation as well as a transcript of the Webinar online for your reference.

So with that, I would like to welcome and introduce our speaker for today who is (Tim McNeil). (Tim) is an independent healthcare consultant specializing in health program development and sustainability. (Tim), I just wanted to thank you again for being with us today and with that, I will turn it over to you.

(Tim McNeil): Great. Thank you. So the topic for today is the medical loss ratio, some going to go through a series of slides and I'm also going to be working with Lauren to show you actually how to look at a medical loss ratio and interpreted.

And so hopefully these tools can help you to prepare as you move toward your contracts and pursuits to obtain opportunities and leverage the information that you can obtain publicly about the medical loss ratio performance of health plans in your marketplace and part of your contracting strategy.

Next slide. So I'm going to go through a few things. What is the medical loss ratio? Who does it apply to? How to analyze those reports and how to use that data in a - as part of an overall contracting strategy.

Next slide. So what is the medical loss ratio? The Affordable Care Act requires health insurers to submit data on the proportion of revenue spent on clinical services and quality improvement.

And this ratio of health insurance plan income as compared to expenses is the medical loss ratio. So you may remember back when the Affordable Care Act

was being passed and debated, there was a lot of discussion about health plans reaping lots of profit and then denying claims for services.

And so there was a perception that some health plans were a little bit disingenuous in the fact that they had a profit motive to deny claims to increase their profitability.

And so it came about was that they mandated the implementation of the medical loss ratio so now that it requires all health plans to spend a certain percentage of their total income or the revenue towards direct services for the beneficiaries.

So the Affordable Care Act requires all health plans to issue rebates to enrollees if they did not meet that minimum medical loss ratio standard. So the medical loss ratio standard is 80% or 85%, depending on the size and the type of the plan.

A little bit later we'll actually show you how that figure is created and then show you how you can look up a health plan's medical loss ratio and then based on that figure, how you can adjust your contract capture strategy with that plan.

Next slide. So the medical loss ratio applies to all commercial health insurance plans, and just beginning last year, it was added in and now applies to all Medicare Advantage plans and it applies to all Medicare Part D plans.

So on the first slide, I said that there was - some plans have to meet the 80% medical loss ratio requirements and some plans have to meet the 85% medical loss ratio requirement.

Plans that have to meet the 80% medical loss ratio requirements our health plans that have - that are small plans, so plans that have 100 or fewer members. Any plan with greater than 100 members have to meet the 85% medical loss ratio requirement and all Medicare Advantage plans, regardless of size, have to meet the 85% requirement.

And this also applies to Part D. So you may have a Medicare Advantage plan in a particular state and they may only have 75 members in that particular state. They still have to meet the 85% medical loss ratio requirement because for Medicare Advantage plans, that mandate covers them regardless of the size of the plan.

Next slide. So just to make sure we're all speaking on the same terms, the Medicare Advantage plan, sometimes called Part C, or (in their plan) - Medicare Advantage plans have to cover all services that are covered under Medicare Part A and Part B.

And so when a beneficiary likes Medicare Part C or Medicare Advantage, and they have elected to have their Part A and Part B benefits managed by a private health insurance plan is approved by CMS, so the medical loss ratio applies to all of those plans.

It does not apply to someone that is in traditional or original Medicare or Medicare fee-for-service. The medical loss ratio also does not apply to ACOs, because ACOs manager population that is in original Medicare. When a beneficiary ops to participate in Medicare Advantage, then they are moved from an ACO's attribution must.

Next slide. So the key concept is the four parts of Medicare. Part A is all in patient care. Part B is all outpatient. Part C is Medicare Advantage. And Part D is the prescription benefit.

So you might be thinking right off the bat, it's the Part D plan that manages the prescription benefit for a beneficiary, it's very interesting that they also have to meet this 85% medical loss ratio.

So if their members are not getting more prescriptions or if the prescription costs are not at that 85% threshold, some of the things that a Medicare Part D plan can do is to increase their cost in the area of quality improvement activities.

And quality improvement activities can be things like a comprehensive medication review and paying for the services allows the health plans to have that cost included in the medical loss ratio.

Next slide. So Medicare Advantage enrollment, when looking at the medical loss ratio and assessing how plans in your market performing as it relates to the medical loss ratio, it's important to know what is the penetration of the Medicare Advantage plans and your marketplace?

So a Kaiser (Family) Foundation report from January 2015 shows that about 30% of all Medicare beneficiaries are in a Medicare Advantage plan. And so this does vary by market because this is the average across the entire United States.

A lot of times, when I have had the opportunity to visit a market, they often feel that 90% to 100% of the population of Medicare beneficiaries are in a Medicare Advantage plan, but very rarely do you see a market where - I mean,

if you have a market where you're at 40%, 50%, you're above the average. If you're at 60%, you're very high.

And so not many markets have a Medicare Advantage penetration rate much higher than that. Next slide. This is the map from the Kaiser Family Foundation report from January 2015. And the orange areas have the highest penetration of Medicare Advantage plans.

Dark blue areas have the lowest penetration. You see Alaska has 0% penetration of Medicare Advantage and Minnesota does have a high penetration with 52% - or 51%.

Next slide. So you can determine the Medicare Advantage enrollment in your area. I just want to remind everyone that the Administration for Community Living Center for Disability and Aging Policy, there are two tip sheets there that can walk you through exactly how to look up the number of Medicare beneficiaries that are in original Medicare and the number that enrolled in a Medicare Advantage plan in each county and some territories in the United States.

The tip sheets walk you through how to look it up by state and then it breaks it down for every county in the United States. And it will be listed there. And those tips, the data is provided by CMS. The tip sheet will walk you through how to access the data through the CMS Web site.

And CMS updates those tables every single month. And so the data that is there is good as of the end of the prior month for which you are looking. So if you pulled it up now, you would be seeing they are that's good as of May 31st.

Then once you have that data, then looking up the medical loss ratio for those particular plans that have high penetration in your market, it provides you with in-depth knowledge towards how the plan is performing as it relates to cost.

The medical loss ratio does not speak at all to quality. Quality is something that is tracked according to something called (HETIS) measures and we'll have - we're going to be having some additional information provided to everyone at a later time around (HETIS) measures.

But the medical loss ratio, along with the (HETIS) measure's quality performance and performance of the plan really gives you information about how that plan is performing (and through) (costs) in the medical loss ratio, you can begin to craft your strategy to work with the health plan to be a value added person because - or a value-added vendor because now you can begin to determine their points of pain.

You can address those points of pain based on the knowledge you have about how they're performing as it relates to cost and quality. Next slide. So Medicare Advantage plans, so that we're all clear again, is that they're capitated plans.

They provide all Part A and Part B benefits. And Medicare does have - Part D plans are separate for medication, and then under the Balanced Budget Act of 1997, Medicare pays 95% of the average traditional Medicare costs in the county.

Next slide. Part C plan premiums a risk-adjusted, so all Medicare Advantage plan receives a risk-adjusted capitated payment. And what that essentially means is that health plans get a per member per month payment to provide all

of the services for Medicare Advantage, all Part A and Part B services that are required for the population.

That's per me- per patient, per person per month payment is risk-adjusted so they can get a higher capitated amount based on the level of health and complexity of the population that they're serving.

So if the health plan is able to provide information to CMS that shows that they have a population that has higher health costs and multiple chronic conditions, then they're able to get a higher payment because it's a risk-adjusted capitated payment amount. That's what that means.

So your ability as a CBO to be working with a health plan and identifying all of the conditions and complications that a consumer has, provided information to the health plan, the health plan, if they did not already have that information in hand and have not already shared that information with CMS, once they do share that information, they're able to risk-adjusted to a higher capitated amount if they're able to accurately demonstrate the level of health and complexity of the population they serve.

Next slide. These hierarchal condition category ATC, when talking to (health centers), you may come across this so I just want to make sure that you know this.

And the reason this is important for the medical loss ratio is because once you know how that health plan is performing, once you're able to provide assistance to that plan, the information that they're able to obtain and talk about submitting their information to CMS, this is what they're submitting it on.

So the hierarchal condition categories, the methodology that incorporates both diseases and demographic factors for the population, based on the clinical diagnostic information that's gathered, the Medicare it Advantage plan submits that data to CMS and then they give you the appropriate risk (adjustment).

So there - if they fail to properly document the need for services or the need to - the level of the burden of disease of the population that they are serving, then they are essentially going to not get the risk-adjusted payments and they could be getting less money than they actually require or should be getting because they did not report this.

Next slide. So the medical loss ratio applies to all commercial plans after the passage of the Affordable Care Act, but it did not apply to all Medicare Advantage plans or Part D plans immediately after the passage of the Affordable Care Act.

There was a period of time that allowed the Medicare Advantage plans to prepare for the implementation of the medical loss ratio, and so the medical loss ratio requirement to not apply to them until January 1, 2014.

Next slide. So that medical loss ratio calculation occurs in - the medical loss ratio numerator includes all the healthcare paid claims, along with any quality improvement activities.

And the quality improvement activity, I believe, is an area where many community-based organizations can really excel and be a very positive contributor to the health plan by, one, helping to improve the population and allowing the costs that are spent towards reimbursement of the community-based organization, if it can be applied to the numerator, i.e., the quality

improvement activity in the numerator line, then that helps improve the medical loss ratio.

That - the healthcare paid claims plus quality improvement activity divided by the premium, which is the per person, per month that's collected, minus allowable deductions it was the medical loss ratio. Allowable deductions are things like taxes that the health plan has to pay.

Next slide. So what are quality improvement activities? Quality improvement activities, the things that can be included in the medical loss ratio numerator calculation, they must stand up to audit.

They must be designed to improve health quality and designed to increase the likelihood of desired health outcomes. So it sounds like the poster child for evidence-based programs because they're designed to improve health care quality. They're designed to increase the likelihood of positive health outcomes.

And when a health plan spends any of their premium dollars towards quality improvement activities, it's added to the numerator and then helps to meet the 85% medical loss ratio requirement.

Next slide. Specifically in the final rule that CMS provided, they listed some quality improvement activities as examples. So some that were specifically listed in the final rule, including medication therapy management, things that improve health outcomes, including those that increased the likelihood, including desired outcomes, things that reduce health disparities, preventing hospital admissions, things that help improve patient safety like reducing medical errors are lowering infection rates, programs designed to increase wellness and promote health activities.

These things, verbatim, came out of the final rule for CMS that said all of these are examples of quality improvement activities that health plan can use towards the medical loss ratio requirement.

And this is - this counts for all commercial or applies to all commercial plans as well as all Medicare Advantage plans and now even Part D plans can use any of these activities to count towards the 85% requirement.

Next slide. So the requirements for individual small group plans as 80% which are small plans that have 1 to 100 beneficiaries. If a plan - the commercial plan has 101 or more beneficiaries in the plan, then it is - it must meet the 85%.

Medicare Advantage plans, beginning January 1, 2014, 85% was the medical loss ratio requirement regardless of size in the same thing for Part D plans which also began January 1, 2014.

So this is the first reporting year for Medicare Advantage plans and Part D plans because they have to report in June for the prior year. So this month, all Medicare Advantage plans and Part D plans are reporting to CMS their medical loss ratio spending for the 2014 calendar year.

Next slide. Penalties for medical loss ratio noncompliance - commercial plans, a commercial plan that does not meet the medical loss ratio must submit a prorated rebate to all enrollees in the amount equal to the difference.

So an example, a health plan - when I was going through this process, I pulled up health plans in multiple markets and I looked at a health plan that many of us know that is in Texas.

And that health plan had an 80% medical loss ratio for the prior year. And then actually in the data, I saw exactly how much money they had to pay to the beneficiary, so it essentially equated to five - that 5%.

So they had to send a rebate check to every covered beneficiary during that period of time. The essentially took that - the difference of spend that they should have spent up to 85%.

The only did 80%. They took that dollar amount and then send out a notice for all beneficiaries along with a check stating that because it is not meeting the cost ratio, that here is their rebate.

There - one thing that's interesting is that their cost, as well as the bad PR that they're having to endure as a result of that, is entirely (unintelligible) and also is not added to the medical loss ratio for the following year. It's just a loss for them on both sides.

(Medicare Advantage) plans and Part D plans - so Medicare Advantage plans are getting their premium dollars from CMS, so they can't, in turn, send a rebate check to the beneficiaries.

What happens with the Medicare Advantage plan and that Part D plan, which begins this year, it's the first reporting year - January of 2014 was the start and then after this first year if they're not compliant, they have to send a rebate to CMS.

If they are noncompliant for three consecutive years, they are placed on prohibition of new enrollments. So the interesting thing that also occurs after three years, if they are not meeting that medical loss ratio requirement for

Medicare Advantage plans, which is 85%, a notification is sent to all of their currently enrolled beneficiaries notifying them that their Medicare Advantage plan has failed to meet the medical loss ratio requirement for consecutive years.

And that they need to consider looking for a new plan because if that plan continues to fail, then they will be terminated and that they will be banned from the Medicare Advantage program, which essentially could be the kiss of death for health plan because now all the beneficiaries are given the notice that they may need to begin looking for another plan because the plan you're in is in jeopardy of being terminated.

The few beneficiaries that remain may leave and then it's going to be even harder for the health plan to meet the medical loss ratio requirement. And so now, if they are noncompliant for five consecutive years, their contracts are terminated.

Next slide. So the medical loss ratio tip sheet that explains this is a guide - is available and it's available through the Center for Integrated Programs and there's a link for that.

Next slide. So another thing that incentivizes Medicare Advantage plans to increase their spending towards quality improvement activities that can be counted towards the medical loss ratio requirement is that in - for calendar year 2015, the final rule from CMS has expanded the rewards an incentive program that encourages Medicare Advantage beneficiaries to participate in activities that improve health.

And so it's called the Reward Incentive Program and it essentially can - it allows statutory authority for the health plan to pay a beneficiary of financial reward as an incentive for their participation in a health improvement activity.

And then the cost of all of that can be counted towards the Medicare Advantage plan's medical loss ratio requirements of 85%. So this is a significant sweetening of the pot to encourage Medicare Advantage plans to take full advantage of encouraging beneficiaries to have better health outcomes and participate in evidence-based programs and other quality improvement activities.

And they are even allowed to pay the beneficiary a cash reward. I remember when this was wrapping up, I was at a Medicare Advantage conference and there was a panel and they were talking about how Medicare Advantage plans were going to be using and participating in this. And many of them are speaking about paying the beneficiaries anywhere from \$75 to \$150 for their participation in a quality improvement activity.

And many times they were talking about things such as diabetes self-management classes and health coaching programs or other types of programs that they would pay the beneficiary between \$75 to \$150 for their participation and they were going to pay for the program as well. And then the entire cost of that, they would apply to the medical loss ratio.

Next slide. And so an example of that is one of the Medicare Advantage plans, at the same conference that we were talking about, they began pulling all of their beneficiaries with the known diagnosis of diabetes.

And then they began marketing directly to those beneficiaries that they needed to go to one of their Medicare Advantage network diabetes self-management,

or DSMT program, and then once the beneficiary completed the diabetes self-management training program, the beneficiary would receive a check for \$75 that they could spend on whatever they wanted.

And this was all now covered under the Medicare Advantage Reward Incentive program and many Medicare Advantage plans are now heavily marketing.

And they're - at the same conference, they were talking about in markets where Medicare Advantage plans, there's - where there is heightened competition between plans, they're seeing higher and higher amounts where beneficiaries are being paid higher amounts for participation in these reward incentive programs, almost as a marketing tool to get - to encourage them to switch over to a different plan.

Next slide. So prevention and wellness activities they can be paid for by a Medicare Advantage plan and applied to the medical loss ratio - so any type of preventive health activities they can reduce the likelihood of high-cost disease complications.

It sounds just like a chronic disease self-management class or diabetes self-management class or a fall prevention class. It sounds very much like - and so the cost that the health plan spends towards that can be spent towards the 85% medical loss ratio.

If a Medicare Advantage plan has a high medical loss ratio, then expanded use of preventive health services hopefully can bring down their cost. And they'll show you some examples of that as well.

Next slide. So where can you find medical loss ratio data? The Centers for Medicare and Medicaid Services, there is a site or a section of CMS called the Center for Consumer Information and Insurance Oversight.

The link that will take you to the main page for that site, (ensures) report each year showing the money that was spent on healthcare and activities to improve health care for the past year, those reports are due June 1 of the following year.

So for June one of 2015, then every health plan submitted their data for performance here 2014. That reporting is done by state and for markets within a state.

Some of you are researching a plan that is operated in multiple states, then you will - when you go to the Web site, you will see data for that health plan in each state that they're in.

So an example, I was looking up Blue Cross of Texas. When I pulled up Blue Cross of Texas in the - for the medical loss ratio data, I saw Blue Cross of Arkansas, Blue Cross of Texas, Blue Cross of Oklahoma, so they were all listed there because they report by state. And the analysis of the medical loss ratio is also done by state.

Next slide. It's a little tough to see but that link (before) to the Center for Consumer Information and Oversight, when you go to that link, you'll bring up this Web page. It's highlighted at the top - medical loss ratio. When you scroll down, then there is a search tool, and the search tool will then allow you to pull up medical loss ratio data for analysis.

Next slide. So as you scroll down, then you get to the reporting - this lookup tool. So the data is reported by year and by state see with select the reporting

year. Right now the most current reporting year available is 2013 because they just submitted the 2014 data on June 1.

Once it's analyzed complete, then CMS will later post the 2014 data. But you can see the 2013 data now, and although the 85% medical loss ratio penalty did not apply to Medicare Advantage plans until 2014, they still had to report.

And so their data is still available and that is important to know because you can begin seeing trends, because if they did poorly for the medical loss ratio in 2013, they likely did poorly in 2014 as well.

Or it's doubtful that there was a huge shift because they likely were still managing a similar population with a similar disease set, and so you can see trends over time.

So with the lookup tool, you first select the year, then you select the state. I am going to walk you through an example. I pulled a plan in Maryland. And so I put in the year. I put in the date. I put in the state. And then I just put in B for boy and clicked search and then came up all the Blue - many of the Blue Cross plans.

So we don't know the full name of the plan, you just put in the first letter and then the search tool will pull you everything that begins or is closely related to a plan with that name. If you know the full name, you type out the full name and then click search. So when I selected Maryland, I selected 2013, I got the options below.

Next slide. Once you click on the particular plan of interest, you will see - I wanted to see how (Care First Blue Choice) was performing in the Maryland

market. So I - the circle there is something I did just for presentation purposes. It's not going to be there when you selected.

You'll just get the list, and then to the right you see the blue things that say selected download zip file, well if you wanted information about the first health plan, American Republic Insurance Company, then you'd select the corresponding zip file. I wanted information specifically about Care First, Blue Choice, so I selected the zip file there to the right.

Next slide. Once I open that, I - it get - you click on the zip file. You know, when she download and open the zip file, then they're going to give you the option to look at Excel files, and these are a lot of Excel files for the state in reference.

Remember I said that the health plan is reporting and the medical loss ratio analysis is done by state. Care First is one that serves people in DC, Maryland and Virginia. You all know that there's a lot of overlap there.

So they still have to split out and report separately, although essentially if you're in Virginia and you're in Care First, you still have the same health plan if you move to Maryland. But for reporting purposes, as it relates to medical loss ratio, they're separated out.

When you see the one in the second item that says grand total, that's a culmination of the entire market. But the culmination of the entire market, because the medical loss ratio is calculated per state, there's not a medical loss ratio report for the entire market because every market is assessed on their own. Next slide. This is tough to see. Lauren, can you pull up the Maryland file?

Lauren Solkowski: Sure. I'm going to - oops, there - okay, Maryland and down going to - oh, Maryland. Okay.

(Tim McNeill): Great. So this is an actual 2013 report for a health plan. And you see - I wanted you to see what you're actually going to get it if you're going down on that file. All of these tables and files are locked so you can make any adjustments.

In the first column you see the premiums. Item 1.1, that's on line 20, it says the total direct premium earned, so this is the actual amount that that health plan was paid in premium dollars for the performance year in question.

And so the actual amount paid to this health plan over this - over the year was \$81 million. Now if you go down to Section 2.1, you see the total incurred claims. So this is the amount of medical claims that health plans paid out in real dollars during the same time period.

So remember, the medical loss ratio is paid claims plus quality improvement divided by the total direct premium that's earned, minus allowable productions, which are things like taxes.

Can you scroll down some? So now as you see in Section 4, that's the healthcare quality improvement expenses incurred. And so now you see this is exactly, to the penny, because these are audited, how much the health plan paid and quality improvement activities for the year in question.

So you see activities to improve health outcomes, \$816,000, Line 4.1. Activities to prevent hospital readmissions, \$74,000. And so if you - if, you know, programs that are doing preventive health programs, wellness and health promotion activities, Line 4.4 - you see they spent \$117,869.

You can then look at 2012, as well, which I don't have, can see trends. And so you can begin seeing, you know, exactly what that health plan, how much they spent.

You don't know who they spend it with or who their vendors were, but you have an idea about how they're spending their dollars and this is great information in terms of analysis of your potential customers.

You see the tabs across the data. When you open up the files, we're on the summary data file. The next important file for all - I mean, the next important worksheet in this workbook is the Part 4 - MLR and rebate calculations.

Can you click on that, Lauren? This is where you actually see the medical loss ratio calculations are the health plans. So, for this health plan, you see - if you go down to Section 4, and it actually gives you the medical loss ratio.

And so the medical loss ratio for this health plan was 90% after adjustments. Across the tabs at the bottom, there's a rebate disbursement, number - Part 5, so there's nothing here because the health plan exceeded 85% medical loss ratio, so there was no requirement to pay.

If that same health plan had an 80% medical loss ratio, then, in this section, you would see how much the health plan in Section 3 - it would say the total amount of rebates and the amount of rebates that they paid out to the beneficiary as a result.

And then it also talks - see Section 4. It talks about prior-year rebates, so you can begin seeing trends for health plans.

So this is Maryland and now I want to - by contrast - look at DC for the same health plan.

Lauren Solkowski: Okay, this should be the DC. Do you see it?

(Tim McNeill): I do but I don't see - it's right - it's already at the - yes if you can scroll down. I mean up to the top.

Lauren Solkowski: Oh, okay. Yes, I see. Okay.

(Tim McNeill): So here's something striking - I think is striking. Section 1.1 - you see the premium collected. The premium collected for Care First in the (unintelligible) is 13 million. Then you look at 2.1 - total incurred claims 15 million. They're losing money before we even get to quality improvement agenda. They're two million over just from paying claims right off the bat.

So you may say oh my goodness, they're losing money left and right so they're not going to want to pay for any cost improvement activity. Well there's a dual edge sword. One, they have to improve outcomes. So if their medical loss ratio is two million - I mean if their spend - their incurred claims just from the beginning is \$2 million - 2 ½ -- \$2 ½ million more than their premium to start, you have to wonder what the performance measures are for that population because this population has a lot of costs.

So if they're healthy and well then their expenses shouldn't be that high and so health plans have to one, meet their cost projections but also have to meet their quality projections. So just because a health plan is meeting or exceeding the medical loss ratio doesn't mean there's not an opportunity. The opportunity here is to come in and say you have a population with very high costs and possibly without great health outcomes and our wellness prevention

programs can help to turn that dial so that we can begin helping you to bring down that medical loss ratio to somewhere where you're making a profit because they're bleeding money right now based on this status.

Can you scroll down a little bit more?

Lauren Solkowski: To four?

(Tim McNeill): To section four.

Lauren Solkowski: Okay.

(Tim McNeill): Yes, four. So now in the quality improvement activity do you see - I don't know what their readmission rate is but they're only spending \$17,000 to prevent hospital readmission. In Maryland - I mean in some health plans that's a six figure number there.

So if I had a solid hospital readmission program and I was operating in this particular market and I see their medical loss ratio they're spending on claims is out of control and then I see that their readmission spending or their readmission prevention spending is very low, I think that's an opportunity for me.

I also say well they're really spending a very meager amount on wellness and health promotion activities. They're spending 22,000 so they're spending 2 ½ million more on claims. So I think that's also a great opportunity to present how they can utilize my health and - my wellness and health promotion activities and hopefully we working together with them by them identifying their high cost high risk vulnerable population, referring them to my

community based program in the district and then serving those consumers so that we can help to turn that spending around.

So now that we see the summary data, heaven forbid let's see what the medical loss ratio looks like in part four.

Lauren Solkowski: Hold on one second. I'm going to pull up - I'm trying to make it - oh here we are. Okay, go ahead. Sorry.

(Tim McNeill): Can you scroll down a little and over to the left? Okay so you see section four. The medical loss ratio - we're sitting at 110%. So this plan needed, you know, it needed to get to 85% clearly because 85% -- they were already 2 ½ million over in claims of just beginning. They are at 110% so nobody's making money at this health plan because remember if the health plan has to spend 85% towards claims and quality improvement activities, that means all of their administrative overhead, administrative cost, profit - everything has to be squeezed into that 15% number.

In this scenario we're saying they're already at 110% just in the medical loss ratio. Now all of their administrative overhead, their marketing cost is plus, plus, plus that 110. So they're probably - their expenses are probably 130% of what they're getting in so there's tremendous opportunity for this particular plan in terms of working with a strong organization that can help them to manage that high risk, high cost population.

And this is also very interesting that this is the same health plan operating in the same market and the two populations that I showed you are separated by, you know, an imaginary border between the district and Maryland but there's tremendous difference in the cost of the burden of disease between the two populations.

So that's kind of the flavor of how you'd go about - when pulling up the medical loss ratio - assessing the data and then applying it to your market as part of a strength, weakness, opportunity and threat through a SWOT analysis. There's opportunity here.

I had - to give you an example of another market, I was doing a presentation for a group in California and I looked at the medical loss ratio for a particular health plan and I found that their medical loss ratio was 95%. So again they were spending in terms of quality improvement activity and claims. 95% of their premium dollars all went and it was paid out. And so all of their marketing, overhead, profit which if your medical loss ratio is 95%, there is no profit. It's all - it's all spent out. They didn't make any money.

And so when I talked about that, the community based organization I was working with said oh, now we understand that same health plan that had a 95% medical loss ratio the prior year, made a formal announcement that they were upping the premium for all beneficiaries for the subsequent year and it was going to be like a 20% increase in premium and a lot of the beneficiaries were complaining and saying that they needed to meet with the shift group team to see about switching to another plan because they didn't want that 20% increase in the - in their premium payments to participate in that Medicare Advantage plan.

So the data drives the decision. That health plan had a 95% medical loss ratio so the only two things they can do to fix that medical loss ratio - help bring down the cost of the population by making them healthier or increase premiums so they have a higher amount of collections so their premium collections are higher to offset their higher expenses. So those are the two strategies that have been added. That particular health plan I guess felt as

though they may have exhausted their efforts to improve the health of the population and so we're going to jump towards increasing the premium.

Many health plans that find themselves in that scenario try to delicately balance the two because if you increase premiums too high then you may have a wholesale abandonment of your health plan by - which is someone may go to your competitor. So it's much better to control the cost through wellness and prevention.

So Lauren if you want to go back to the top one. Great. So what is the opportunity with Medicare Advantage plan? So providers that can support these items can bring value to a Medicare Advantage plan. So increasing the accuracy of the hierarchical conditions floors for risk adjustment - that is one - and that is done by helping the health plans understand all of the conditions and complications of disease that a consumer has.

Often times when I'm working with a group, they say well the hospitals and the doctors are already doing that so I don't see how me as a community based organization can provide any value to the plant by helping them understand or having more information about the health of the population.

Well you may be mistaken because when the person is admitted to the hospital - and think about it - if a person's admitted to the hospital maybe for complications of diabetes so they get admitted to the hospital for complication of diabetes. The hospital's treating the diabetes but they may have heart disease. They may have an amputation. They may have a lot of other conditions but they're at the hospital for a complication of diabetes.

That hospital is coding and reporting and seeking reimbursement to the health plans for complications of diabetes. All of these other secondary and fourth,

fifth, sixth conditions that that person has - it may not get reported. I was meeting with Anthem in a particular market and they said that that was one of their primary problems is that they would only get one diagnosis from the doctor, one diagnosis from the hospital and they knew anecdotally that most of their population had three or more chronic conditions. None of that was in their database and that impacted them because they could not get the proper risk adjustment from CMS because they didn't have the data.

They didn't get the risk adjustment. It directly impacted the medical loss ratio because without the risk adjustment, they're getting a lower amount than they should be getting for a population that has multiple chronic conditions. If they had properly reported the multiple chronic conditions, they get a higher premium then the higher premium would go into the denominator which could help to offset these claims and quality improvement costs to help improve that medical loss ratio.

So that - the other opportunities to increase access and utilization or prevention and wellness activities. If that Medicare Advantage plan or commercial plan should include state insurance plans for state employees and health plans for federal employees, this applies - these medical condition requirements apply to all health plans across the country.

So now that health plans can apply the cost that they spend or the expense that they spend on prevention and wellness toward quality improvement and we can increase access to utilization, the health plan is a win, win for everyone. The consumers get access to wellness and prevention activities. Hopefully they have less complications of disease so they also have less cost and less claims and the health plan can incur all of those expenses and apply them to the medical loss ratio so there's not an offset.

So some people say well if you bring down the cost too much then the plan's going to be penalized and so they want the cost to be at a certain level. Well if they - they would likely much rather spend dollars toward the medical loss ratio and prevention than spending it on complications of disease because remember the health plan also has to meet the quality requirements because they have to maintain a high level of quality and meet the medical loss ratio requirement as it relates to cost and expenditure.

Lastly it also provides initiative for health plans to reduce the cost of care and actually incentivize them to pay for things like care transition program because now that cost of a care transition program - every dollar spent is then reported. And you saw in the actual medical loss ratio file that you download from CMS that hospital prevention - readmission prevention activities are separately reportable line items in the medical loss ratio. So not only can you see how a particular plan did, you can compare them side by side with their competitors in a particular marketplace. Next slide.

So that's the information about the medical loss ratio. I'd like to open it up to questions at this time.

Lauren Solkowski: Thanks so much (Tim). Oh, go ahead operator.

Coordinator: Thank you. If you would like to ask a question, please press star one and you will be prompted to record your first and your last name. Please unmute your phone when recording your name and to withdraw your question, press star two. One moment.

Lauren Solkowski: Thank you. So while we're waiting for some questions to come over the phone, we received a few over the chat so I'll start there. The first question is

how far can plans go to justify their risk adjustment or how far back can they go to justify the risk adjustment?

(Tim McNeill): So if that health plan has had that member for the prior year and they had documentation of that condition then it carries over. If that's a new beneficiary for them like after open enrollment they get new beneficiaries then the health plan has to verify.

So there's this after open enrollment in Medicare - this is specific to Medicare Advantage plan so it doesn't apply to commercial plans. But after open enrollment for a Medicare Advantage plan, often you can add that to complete a health assessment on the population.

The reason that there's this mad dash to complete that health assessment is because they want that data to go into that risk adjustment right away because they want to get the maximum premium collection that they can as soon as possible.

Lauren Solkowski: Okay and another question is what is the Medicare fee for service administrative overhead allowance?

(Tim McNeill): Well health plans don't administer original Medicare. So original Medicare - a beneficiary with original Medicare is essentially managed by the Centers for Medicare and Medicaid Services and providers file their claims with something called a Medicare administrative contract or MAC contracts which used to be called physical intermediary. So they process the claims in their pay but they have a contract with the Centers for Medicare and Medicaid Services to be a MAC that as the administrator that processes the claims.

So there's no payment to - there's no plan - there's no health insure involved with original Medicare beneficiaries.

Lauren Solkowski: Okay and operator, we'll check back with you to see if any questions have come in on the phone.

Coordinator: At this time I'm showing no phone questions.

Lauren Solkowski: Okay - go ahead (Tim).

(Tim McNeill): So I did not go over - we didn't show them the sheet. I just realized it - the document tip sheet. I don't know if you wanted me to show that as well.

Lauren Solkowski: Sure. I will pull that up. In the meantime I'll ask this next question. Who reviews the quality improvement activities? Is the data compared over time?

(Tim McNeill): When you said who reviews it - the Medicare - the health plan and I'm talking about Medicare Advantage plan so it does only apply to Medicare Advantage plan (unintelligible).

So if the plans submit the data to CMS by June 1 of the following year for the report year from 2015 - all of the 2014 data to CMS by June 1, 2015. CMS analyzes the data of the health plans and a quality assurance decision that closely monitors and tracks how that health plan is performing in terms of the medical loss ratio. It also tracks (unintelligible).

Lauren Solkowski: (Tim) you're breaking up some.

(Tim McNeill): Oh sorry. So every health - every health plan has a quality assurance division that monitors the medical loss ratio. It also - they also monitor the quality

performance for that health plan as it relates to their performance on HETUS measures.

And so on both sides the health plan closely tracks and monitors it and then they submit that data to CMS and then use the data. All of the data (unintelligible) sent up to audit and so if a health plan is selected for audit then CMS will have the MAC - likely the MAC contractor or the QIO or whoever the vendor is will come in and work with that plan to (unintelligible) in terms of this.

Lauren Solkowski: (Tim) you're breaking up some more.

(Tim McNeill): Is that better?

Lauren Solkowski: Can you hear me? We can't hear you now.

(Tim McNeill): Is that better?

Lauren Solkowski: Yes, that's much better.

(Tim McNeill): Okay. Sorry about that. I lost my train of thought.

Lauren Solkowski: Sorry.

(Tim McNeill): Oh the audit - the audit. So the health plan submits the data to CMS and then the data has to stand up to audit. And so CMS at any time can have a vendor come in, work with the health plan and audit the regs to see what they reported in terms of dollars spent on services, IE claims and quality improvement activity can stand up to audit, can be verified, justified and if not then they will receive a subsequent penalty for not reporting properly.

So the health plan internally monitors and that's usually monitored by the quality assurance (unintelligible) and they submit the data to CMS and then (unintelligible) in case they're audited. CMS will forward it properly.

Lauren Solkowski: Okay and operator, I'll check back with you again to see if questions have come in.

Coordinator: At this time I am showing no questions but if you would like to ask a question, please press star one.

Lauren Solkowski: Thank you. So (Tim) I pulled up the sheet. I don't know did you just want to show it or did we want to walk through it quickly or...

(Tim McNeill): Sure, I can walk through it quickly and then if anyone has any additional questions on this one (unintelligible) actually walk through the tip sheet.

Lauren Solkowski: Okay.

(Tim McNeill): So if you go to the ACL link, you'll pull up this medical loss ratio and it's a file that you download as a PDF and in a sense that it will walk you through the medical loss ratio so just the background. If you scroll down some, it talks about what are medical loss ratio services. So you see again here how the medical loss ratio formula is calculated.

So it's paid medical services claims plus QIA again is quality improvement activities divided by premium revenue minus liable deductions equals the medical loss ratio. So the numerator of the paid medical service claims for QIA - the denominator is the premium revenue minus the allowable deductions and as I said, allowable deductions are things like federal and state

taxes, licensing and regulatory fees - all of those things are allowable deductions.

So you see if a plan needs to adjust their medical loss ratio, the only thing they can do is increase the premium that - so these are just things that they can do. Increase the premium that they collect by either changing the monthly payments that are required or they can increase or adjust that in quality improvement activities.

Their payment for paid medical service claims - I mean if someone needs heart bypass surgery, you need heart bypass surgery. There's not much you can do to adjust that other than improving the health of the population. So the easiest things to do to adjust the medical loss ratio is you see in looking at in comparison to the numerator and the denominator is to adjust the slide rule (unintelligible) and or clean the revenue. Scroll down some.

Here again is the list of client improvement activities that I went over in the PowerPoint and all of the quality improvement activity must stand up to audit and they're categorized and reported out.

So in the tip sheet it also gives an example of services that meet the medical loss ratio requirement and this tip sheet is focused on community based organizations. And so we gave an example of community based organization contracting (unintelligible) to provide a diabetes sub management training program using the Stanford model.

The program method was fully accredited because it met the national standards of the credit by the American Association of Diabetes Educators. It's the CBO and the registered dietician. That dietician is credentialed and registered with the health plan then they are a network provider for diabetes

self-management training program and then that beneficiary that comes to that program - the cost of paying the CBO to deliver that diabetes sub management class to that beneficiary - the health plan counts toward their costs even in claims and quality improvement activities towards that medical loss ratio requirement.

So what is not part of the MLR is also on this (unintelligible) of use protection. I mentioned services. Cost containment and a broken condition - so cost containment helped some health plans have divisions where they really closely focused on requests for services so that they can contain the cost and not pay for medical services that are unnecessary or may be seen unnecessary or maybe the beneficiary maybe did not need them at this time.

So a good example of that is sometimes a cost containment management activity of the city beneficiary is given a brand name drug. Maybe it's a very high cost antacid like Protonix. Protonix is probably one of the most expensive ones and so but they've never had a lower cost one like a Pepcid and so the health plan says you need to use generic first instead of going to the more expensive brand names. That's a cost containment management activity. It's not anything that's improving the health and outcomes of that beneficiary.

So any staff time, labor, personnel that are sent towards doing cost containment activities - they cannot count towards the medical loss ratio whatsoever.

The next portion of the tip sheet talks about the standard so 80% for small plans, 85% for large plans. Again all Medicare Advantage plans beginning in 2014 - 85%. Of course I don't know (unintelligible). Part D plans 85%. On a more important note, the medical loss ratio does not apply to page (unintelligible). It also doesn't apply to original Medicare because there is no

health plan involved with original Medicare beneficiaries or fee for service beneficiaries as I also referred to.

So what happens if a health plan does not comply with the requirements? And to recap here everything that we've talked about in the slide where they have to pay a rebate and then if they're a Medicare managed plan, they get of course a penalty. Then we gave you a real life example. So there's a hypothetical example whether health ADC is a managed care plan in the distribution but this is not the health plan that I chose. So this is totally fictional.

So this health plan had 100,000 members and they received \$350 per member per month for this particular health plan. The medical loss ratio calculated claims with client improvement over total premium so if they have 100,000 members covered over 12 months at \$350 per member per month, that's 420 million is their total premium. That's the denominator.

The numerator for this fictional health plan - they spent \$294 million on claims and 42 million on quality improvement activities. So their total numerator is 336 million. So now the medical loss ratio is calculated by that numerator of 330 by the denominator of 0.20 million which gives you a medical loss ratio of 80.

So if this particular fictional health plan is held to the 85% medical loss ratio, they did not meet that requirement so as a result they have to pay 5% of the premium (unintelligible) to \$21 million. So see, that's a tremendous amount of money and if they just spent that money on services or quality improvement activity, they would not have to pay that penalty. They would not be put on this watch list and have their whole contract in jeopardy let alone that (unintelligible) margin to the beneficiary. And there are multiple

plans I want us again looking through (unintelligible). I saw plans all over the steps of this.

As we just saw some plans who are right at a percentage, you know, if they're at 85%, they're at max profitability because profit - their overhead expense, their labor cost, their marketing expense all has to be contained so 85% is the desired goal. The closer they are to 85%, the greater the likelihood that they're in positive cash flow. If they're too high in the medical loss ratio, they're losing money. If they're too low, they're paying penalties.

Their profit's gone down some and so now this is just an overview of why understanding the medical loss ratio is important. Also it's important to understand how health plans are graded and governed. So health plans have to meet quality plus cost. For Medicare Advantage plans the Centers for Medicare and Medicaid services have contacted an NCQA to provide monitoring and credentialing of health plans that are in the Medicare Advantage program.

So every Medicare Advantage plan has to be credentialed by NCQA and be accredited by NCQA in order to be a Medicare Advantage plan. Many Medicaid managed care plans and the health insurance of safety plans also have to adhere to the same performance because CMS is also contracted with NCQA to accredit those plans. It's a little different for Medicaid plans because it - it has to go through CMS at the state.

But for the exchange products as well as the Medicare Advantage plan it is - NCQA is the contractor to accredit those plans which means the health plan has to maintain - they have to successfully achieve and maintain accreditation by NCQA. The NCQA standards makes the health plans adhere to quality and performance metrics and that also flows down to their contractors or vendors.

And so that's why we say that it's important that you're able to provide services to the beneficiaries and report them and you should be aware of the NCQA requirements that the health plans have to adhere to especially if you're working with the Medicare Advantage or an insurance exchange product because they have to maintain accreditation advised NCQA.

And so one of the - how this applies or think it's something as simple as the case management - there are specific guidelines and regulations to case management that are outlined by NCQA that health plans have to adhere to in order to maintain the NCQA accreditation. But NCQA goes back and says well health plan if you contract out your case management services to a third party vendor then that third party has to adhere to the same standards that I'm holding you to for case management. So that's why understanding the NCQA accreditation requirements that are held to the health plan are important to you as you're marketing to the health plan.

It doesn't mean that in order for - there's no requirement for a community based organization to have NCQA accreditation before the health plan can apply the cost for the medical loss ratio. But what is important to know is that the NCQA accreditation standards applies to the health plans and those requirements sometimes roll downhill to their subcontractor. And then at that point all of those costs can still be applied because they have to meet the quality and the cost containment requirement to operate.

So lastly we talk about what the opportunity is for community based organizations and how you can get more information and we've highlighted kind of around what the opportunities are and how understanding the medical loss ratio and performance of a health plan is important before you begin a negotiation. So it's important to do your market analysis up front and that

market analysis should include looking to see how that health plan performs in the medical loss ratio as well as seeing how that health plan performs from the quality metrics.

Lauren Solkowski: Okay operator, I'll check back to see if any questions have come in.

Coordinator: I am showing no phone questions.

Lauren Solkowski: Okay (Tim) we have another question that came in on the chat that says could you connect the dots for us between the language of medical loss ratio and return on investment.

(Tim McNeill): So return on investment - the return - the return on investment - for every dollar that a health plan pays for an activity, they want to have a greater return on the amount of money they spend. So you want that return to always be greater than the spend out.

So if I'm spending money for the diabetes self-management training program, there's an expectation that the amount of money that I spend on the diabetes self-management training program and the hope is that the outcome of that will be less complications of disease. The cost of the complications of disease should be greater than the cost of my clad to present or my effort to present which is the complication of the disease occurring and therein lies the return on investment.

So as it relates to the net loss ratio, increasing access and utilization of quality improvement activities should equate out to a reduction in total cost of claims which will help that health plan get closer to the 85% because it's much easier to control your costs around prevention than it is for disease complication.

You never know when disease complications are going to occur and you never know the cost of disease complications.

So the quadruple bypass surgery is always going to be much (unintelligible) than preventing that and it's also much harder to manage when that cost for that quadruple bypass is going to occur amongst your population. The return on investment is the positive...

Lauren Solkowski: (Tim) we can't hear you. No, nothing yet.

(Tim McNeill): (Unintelligible). Hello?

Lauren Solkowski: I can vaguely hear you. Like I hear - I think you're saying hello.

(Tim McNeill): Hello?

Lauren Solkowski: No.

(Tim McNeill): Hello? Can you hear me?

Lauren Solkowski: There you are, yes. Now I can hear you.

(Tim McNeill): Oh, okay. Okay, sorry about that.

Lauren Solkowski: Now it's clear.

(Tim McNeill): So the - with the medical loss ratio or with the cost the health plan really wants to get to 85% because at 85% they've maximized their potential profit and anything over the 85%, they're going to - they're losing money - and anything under the 85% they have the problem of they're going to have to pay

this rebate and then they're going to have that crust because they have the additional cost of the rebate.

So they want to manage their expenses very closely. It's much easier to manage your expenses around quality improvement than it is to manage complications of disease. And so as long as your - the cost of your program or your preventive health service or quality improvement activity is going to be lower than your potential complications plus you have the added value of helping that health plan to get closer to the medical loss ratio requirements and then when you add in this potential of helping to report out HETUS measures which we'll talk about at a later presentation.

All of that is your return on investment that you then have to quantify and present.

Lauren Solkowski: Okay and then we've got one - another question that came in that says is the MLR rounded up or down for payout and do decimals count.

(Tim McNeill): Is the MLR rounded up? So it's rounded - I think it uses the regular. If it's above five, it goes up. If it's less than five, it goes down.

Lauren Solkowski: Okay. Operator, are there any questions that have come in on the phone?

Coordinator: I have no phone questions.

Lauren Solkowski: Okay well I think we've - those are - let me just check. Those are all the questions that we've received and since we have about four minutes left - before we go I did want to say the - so the MLR - the tips sheet that tip reviewed is on the ACL website. It's not the easiest thing to find. We're working on improving that. But if you have any trouble finding it, it's in the

slides that (Tim) just presented that you'll have a copy of that. But if you are having a hard time finding it in the meantime, just send me an email and I can direct you to that tips sheet among some of the other tips sheets that (Tim) referenced are all listed on our business document page on the ACL website.

So with that I just want to thank you again to (Tim) for his presentation today and for answering all of our questions. Thank you to our participants for asking such stimulating questions and again if you think of any other questions or comments that you have following the webinar, please feel free to email them to me. I have added my email address in the chat box here on the webinar. So I think we'll conclude with that and thank you again to everyone for joining us and enjoy the rest of your day.

Coordinator: Thank you for your participation. You may disconnect at this time.

END