AFFORDABILITY REVIEW
Mysteries of the Medical Loss Ratio

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WHO IS GORMAN HEALTH GROUP?

_Gorman Health Group_ is the leading solutions and consulting firm for government-sponsored health programs.

**Government Programs**
Leading enterprise of national consulting services and software solutions for payers and providers.

**Our Mission**
Our mission, as the industry’s most active professional services consultancy and provider of technology-based solutions, is to empower health plans and providers to deliver higher quality care to beneficiaries at lower costs, while serving as valued, trusted partners to government health agencies.

**Washington, DC**
Headquartered in Washington, DC, with more than 200 staff and contractors nationwide with over 2,000 combined years of Government Programs experience.

**Leadership**
Deep payer and provider knowledge coupled with Centers for Medicare & Medicaid Services (CMS) regulatory expertise.

**Privately Owned**
Founded in 1996
Our clients have **one-stop access to expert advice, guidance, and support**, in every strategic and operational area for government-sponsored programs, across seven verticals.

**CLINICAL**
Changing how you approach Medical Management, Quality and Stars.

**PHARMACY**
Leading experts in Part D, PBM, formulary and pharmacy programs.

**HEALTHCARE ANALYTICS & RISK ADJUSTMENT SOLUTIONS**
Implementing cross-functional risk adjustment programs for medical trend management and quality improvement.

**PROVIDER INNOVATIONS**
Supporting network design and medical cost control implementation.

**COMPLIANCE**
Offering guidance and support in every strategic and operational area to ensure alignment with CMS.

**OPERATIONS**
Bringing excellence to every aspect of your implementation from enrollment to claims payment.

**STRATEGY & GROWTH**
Driving profitable growth and member retention through strategic marketing, sales, and product development.
DEMystify Medical Loss Ratio

No Room for Error Under ACA

Members

Revenue

Claims Costs

Claims Utilization
MEMBERSHIP

• Positive growth
  • Improves dollars of income and absorbs fixed expenses
  • Assumes operational plans are in place
• Stagnant/stable growth
  • Requires answers to aging population
• Negative growth
  • Potential death spiral
• Impact on risk score
Risk adjustment plays major role –
  • Unknown impact of HCC on new ICD-10
  • Double-edged sword – timing of payment is after claims are paid
    Low scores
    • If understated due to bad coding, high financial risk and missed opportunity!
    High scores
    • If inaccurate, invites audits!
  • Star Ratings reflect membership and impact revenue as well as expected claims
CLAIMS COSTS

Networks are the backbone of a health plan

- Must meet CMS requirements
- Must align with population needs
- Insufficient network can quickly undermine the whole operation – costs, member satisfaction, medical management
- Place of service greatly impacts cost of care
- Partnership for low-cost quality of care
UTILIZATION

- CMS tracks inpatient readmits
  - Exceeding average means penalties
- Star Ratings tracks quality
  - bonuses or loss thereof
- Pressure on network adequacy
GOAL: ALIGN OPERATIONS TO BALANCE REVENUE AND CLAIMS (PLUS ADMINISTRATIVE EXPENSES)

Although maximizing revenue is an ongoing priority, claims review and efficiency is still a big part of the picture and not to be overlooked.
WARNING SIGNS OF FINANCIAL HURDLES

• Variance to budget not easy to explain
  o Future bids are based on historical claims – 18 mos. to 2-year gap in forecasting trends (claims and revenue)
  o One-time events that can mask trends
• Change in IBNR or reinsurance provisions
  o Claims backlogs can impact IBNR and/or budgeting
• Reorganizations
  o Change in organization and company personnel can overlook financial and operational changes
  o Allow gaps in reporting
• New systems – claims, vendors, etc.
  o Mapping of old to new systems distorts trends
• Comparison of claims to contract administration
  o Constant oversight needed for revised contract or impact of mix of services
  o Change in provider mix and provider performance
WARNING SIGNS OF FINANCIAL HURDLES

• Significant changes in membership
  o Increase, decrease, geographic shifts can impact revenue
• Complete and accurate medical diagnosis coding to ensure adequate revenue
  o Ongoing oversight of risk adjustment
  o Should coincide with claims costs
  o Requires strong collaboration with providers
• Different products – add or terminate plans and change product designs
  o Duals – little or no benefit from member cost share on utilization
  o HMO vs. PPO – provider access within networks
  o Competition
OPERATIONAL CHANGES WILL HAVE A FINANCIAL IMPACT

Root causes come from internal system and procedural changes, member driven claims, and diagnoses as well as CMS reimbursement.

- Budget Variances
- New Claims Systems
- Claims Backlogs
- New Vendors, PBM
- New benefits, products, territories or membership
- Member-driven claims and risk adjustment
- Mix of service changes

ANALYTICS
TO FIND A SOLUTION, FIRST YOU NEED TO IDENTIFY THE PROBLEM

**INITIAL ASSESSMENT**
- Management Interviews
- Financial Reviews
- Performance Reviews: IT Systems, Vendors, Providers
- Contract Reviews: Vendors, Providers
- Risk Adjustment Overview and History
- Medical Management review
- Product and membership growth

**PHASE 1A IDENTIFY DRIVERS**
- Develop trend reports by service and split by cost vs. utilization
- Identify trend drivers
- Identify high-volume providers and services
- Monitor risk adjustment accuracy and timing

**PHASE 1B QUANTIFY OPPORTUNITIES**
- Follow the money
- Quantify potential opportunities for improvement

**PHASE 2 ACTION PLANS**
- Customize implementation plans
- Set performance metrics and goals
- Develop oversight and monitoring as needed
- Ensure best practices for staffing, quality and performance
- Implement risk adjustment strategies
ANALYTICS CAN LOOK ACROSS DEPARTMENTAL SILOS
LAKE WOBE GON HEALTH PLAN –
A NOT SO FICTIONAL TALE

Case Study
LAKE WOBEGON HEALTH PLAN –
A NOT SO FICTIONAL TALE

Case Study

- Plan owned by health system
- Operating in Medicare Advantage (MA) for multiple years
- Multiple lines of business with matrix organization
- Whole suite of reporting capabilities
  - Budget year views
  - Meetings to review and ask questions frequently missed
- Past had been real good to them
IDENTIFY THE PROBLEM

Despite 18 months of financial losses, unable to identify root cause(s)

<table>
<thead>
<tr>
<th>Category</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales</td>
<td>• Membership below budget</td>
</tr>
<tr>
<td>Revenue</td>
<td>• Star Ratings bonus at risk at end of demonstration program</td>
</tr>
<tr>
<td>Networks</td>
<td>• System-owned facilities</td>
</tr>
<tr>
<td></td>
<td>• Conflict of interest</td>
</tr>
<tr>
<td>Medical Management</td>
<td>• Not very aggressive</td>
</tr>
<tr>
<td></td>
<td>• Insufficient staff</td>
</tr>
<tr>
<td>Finance/Claims</td>
<td>• Calendar year reports masking problems</td>
</tr>
</tbody>
</table>
DETERMINING ROOT CAUSES OF CLAIMS TREND

1. Review financials including membership trends
2. Gain insight into operations through in-depth interviews with subject matter experts
3. Review existing reports and financial performance
   o Analyze 3 calendar years or minimum rolling 24 months of FFS claims data by product
   o Generate reports, graphics, and analytics
   o Compare membership by month with demographics (age/gender/county) and risk score for each product
4. Identify trends in cost and utilization at aggregate or detailed level – compare to provider contracts and industry standards
DETERMINING ROOT CAUSES OF CLAIMS TREND

5. Determine financial impact – “follow the money”
6. Present interim and final recommendations for “real” solutions
7. Customize action plans to current and future business strategy
8. Isolate barriers to growth – providers, high-cost claimants, geographic considerations, benefit design
9. Maximize provider network – align access and affordability to membership needs
10. Monitor and manage to new objectives – this is an ONGOING process
$7M trend is further aggravated by revenue shortfall (neither trend was projected in the budget)

Cost drivers dominate in Inpatient, Professional, and Pharmacy paid claims

Allowed PMPM data is being worked on to isolate benefit and contracting changes

Multiple operating areas being reviewed for improvement

### METRICS (PMPM, UTILIZATION, UNIT COSTS)

<table>
<thead>
<tr>
<th>Service Category</th>
<th>PMPM Change</th>
<th>Trend</th>
<th>Utilization Change</th>
<th>Unit Cost Change</th>
<th>Utilization Change</th>
<th>Unit Cost Change</th>
<th>Trend Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>+$21.43</td>
<td>5.8%</td>
<td>$5.18</td>
<td>$16.25</td>
<td>24%</td>
<td>76%</td>
<td>$2,856,065</td>
</tr>
<tr>
<td>Outpatient: Visit Based</td>
<td>+$ 6.22</td>
<td>3.9%</td>
<td>$7.19</td>
<td>-$0.97</td>
<td>116%</td>
<td>-16%</td>
<td>$828,285</td>
</tr>
<tr>
<td>Professional</td>
<td>+$10.39</td>
<td>3.9%</td>
<td>$3.29</td>
<td>$7.09</td>
<td>32%</td>
<td>68%</td>
<td>$1,384,509</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>+$15.91</td>
<td>15.1%</td>
<td>$0.96</td>
<td>$14.95</td>
<td>6%</td>
<td>94%</td>
<td>$2,119,829</td>
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<tr>
<td>Total</td>
<td>$53.94</td>
<td>5.7%</td>
<td>$14.01</td>
<td>$39.93</td>
<td>26%</td>
<td>74%</td>
<td>$7,188,688</td>
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</tbody>
</table>
HISTORICAL PMPM BY CATEGORY

Inpatient

$330.42 $340.14 $349.43 $369.47 $385.08 $375.73 $366.55 $387.98 $334.22

Outpatient

$247.68 $252.58 $252.52 $255.75 $262.82 $258.02 $263.48 $273.87 $250.85

Physician

$247.68 $252.58 $252.52 $255.75 $262.82 $258.02 $263.48 $273.87 $250.85

Retail Pharmacy

$33.77 $74.95 $100.47 $106.65 $103.92 $106.58 $105.45 $121.36 $78.08
INPATIENT RECOMMENDATIONS

- As a provider-owned health plan, need to recognize cost differences among providers
- Review waivers of pre-auth to “preferred” providers – consider ongoing reviews and health plan audits
- One teaching hospital outside of provider system is driving up costs – consider redirection to system facilities
- Use hospitalists and plan case managers to expand discharge planning to increase home health and decrease admissions
- Compare diagnoses for inpatient DRG payments to outpatient and professional diagnoses and correlate to risk adjustment recovery
FACILITIES A-D OWNED BY PARENT PROVIDER, FACILITIES E-H NON-OWNED

Costs (adjusted for severity) vary by facility, and “E” is a non-owned teaching hospital, which suggests stricter authorizations and discharge planning could control costs and utilization.

System and Non System Owned Providers of Inpatient Acute
READMITS ON THE RISE

Need to manage readmits with better discharge planning, including goals for home health
OUTPATIENT RECOMMENDATIONS

- Utilization up 10% in Emergency Room – need for frequent flyer report and review of copays to manage ER utilization. Engage PCPs to avoid ER utilization by improved access to care in office settings.
- Pharmacy includes injectables with 20% coinsurance, but claims system needs auditing – no difference in paid vs. allowed costs.
- Outpatient therapy up 30% for utilization and 29% for costs – review pre-authorization requirements and implement quantity limits.
- Other includes dialysis opportunities for combined savings.
20% COINSURANCE NOT BEING COLLECTED

Audit Claims System Configuration

Outpatient Injectables

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Net Pay PMPM</th>
<th>Allowed PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0885</td>
<td>Epoetin Alfa, Non-ESRD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J0878</td>
<td>Daptomycin Injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J1441</td>
<td>Filgrastim 480 Mcg Injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J9041</td>
<td>Bortezomib Injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J9355</td>
<td>Trastuzumab Injection</td>
<td></td>
<td></td>
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<tr>
<td>J1569</td>
<td>Gammagard Liquid Injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J9055</td>
<td>Cetuximab Injection</td>
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<td></td>
</tr>
<tr>
<td>J2505</td>
<td>Injection, Pegfilgrastim 6mg</td>
<td></td>
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</tr>
<tr>
<td>J9033</td>
<td>Bendamustine Injection</td>
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</table>

$0.00 $0.20 $0.40 $0.60 $0.80 $1.00 $1.20 $1.40 $1.60
FINANCIAL IMPACT OF ACTION PLANS

1. More focused Quality Improvement (QI) and Star Ratings program with specific action plans
2. Work with PCPs on specific coding initiatives
3. Enhanced focus on risk adjustment program with optimal mix of retrospective and prospective targets

REVENUE

$5.75 M to $8.75 M
FINANCIAL IMPACT OF ACTION PLANS

1. Reduce inpatient admits and readmissions through multiple mechanisms
2. Part B coinsurance on specialty drugs
3. OP cost drivers
4. IP cost drivers
5. OP utilization drivers

COST REDUCTION

- $1.3 M
- $1.06 M
- $0.74 M
- $0.65 M
- $0.20 M
# REDUCE ER VISITS/1000 PROJECT DASHBOARD

= $400,000 TARGET OVER FY 2015

<table>
<thead>
<tr>
<th>Major Milestones</th>
<th>Target Date</th>
<th>Overall</th>
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<tbody>
<tr>
<td>Overall Track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop ER utilization metric to produce target savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop enhanced reports and generate action plans regarding ER billing practices, member engagement, coordination with disease management and PCPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop tracking reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engage PCPs and vendors as needed</td>
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</table>

<table>
<thead>
<tr>
<th>Track Milestones</th>
<th>Status</th>
<th>Delivery Date</th>
<th>Comments/Updates</th>
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</thead>
<tbody>
<tr>
<td>Develop high-cost hospitals report</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Develop high-cost members report</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop action plans</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Develop tracking reports</td>
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## Accomplishments

- Translate best practices from Medallion

## Issues / Risks

- Work the frequent flyer list and include medication cost and utilization
- Steerage of non-emergent diagnoses to alternate place of care
- Engage PCPs and BH vendor for follow up to ER - assign clerk to contact PCPs. Coordinate with Provider Relations.
- Develop provider profiles - gaps in network, access to specialists - identify best practices within PCP offices
- Partner with shelters and public health centers
- Explore member education and engagement through community events and health fairs, etc.
- Develop case manager reports with combined medical and pharmacy spend by member. Better utilize auth and Rx data for fast track reports.

## Upcoming Events & Work in Progress

## Dependencies

- Coordinate with disease management
- Incorporate student nurses and pharmacy students for outreach
- Leverage nurse line, transportation and CAHM services
- Coordinate with Magellan for BH services
- Member and provider education
- Leverage VA data exchange
RESOURCE OPTIMIZATION

Return on Investment

Probability of Success

Network Structure

Risk Adjustment

Claims System

Medical Mgmt

Star Rating Mgmt
RECAP: BEST PRACTICES AND VIGILANCE ARE HERE TO STAY

On average, an MA HMO needs 12-15% savings from better contracting and medical management just to break even.

• Continued downward pressure from CMS on revenue through tighter risk adjustment methodology and projected trend rates
• CMS still phasing in new county rates for ACA
• Ongoing impact of benefit designs and changing demographics on future costs
• Ongoing vigilance of provider reimbursement strategies, including, but not limited to, contract changes
• Ongoing review and audit of clinical best practices to achieve Star Ratings

Even PPOs, ACOs, and non-HMO models require cost controls through benefit design and provider access
OPERATIONAL EXCELLENCE CAN NEVER STOP

- Set goals for providers and performance benchmarks
- Constant monitoring of financial and operational performance
- MLR performance is more than a budget variance report – need both to survive changing regulatory and clinical dynamics
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Gorman Health Group, LLC (GHG) is a leading consulting and software solutions firm specializing in government health programs, including Medicare managed care, Medicaid and Health Insurance Marketplace opportunities. For nearly 20 years, our unparalleled teams of subject-matter experts, former health plan executives and seasoned healthcare regulators have been providing strategic, operational, financial, and clinical services to the industry, across a full spectrum of business needs. Further, our software solutions have continued to place efficient and compliant operations within our client’s reach.

GHG offers software to solve problems not addressed by enterprise systems. Our Valencia™ software reconciles membership of more than 10 million members in Medicare, Medicaid and the Health Insurance Marketplace. Over 3,000 compliance professionals use the Online Monitoring Tool™ (OMT), our complete Medicare Advantage and Part D compliance toolkit, while more than 33,000 brokers and sales agents are certified and credentialed using Sales Sentinel™. In addition, hundreds of health care professionals are trained each year using Gorman University™ training courses.

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