



MINIMUM MEDICAL LOSS RATIO REBATE CALCULATION REPORT INSTRUCTIONS

INTRODUCTION

The following definitions and instructions outline the requirements for the Minimum Medical Loss Ratio (MMLR) process that is required by contract for the ACA (Expansion) Population. The Coordinated Care Organizations (CCO) contract includes a provision that requires CCOs to be held to an 80% MMLR for the ACA eligibility categories, and if a lower ratio occurs, then CCOs are required to rebate the difference back to OHA. CCOs are required to submit a form that reports the revenues and costs related to their OHP Line of Business, split out by ACA (Expansion Population) and non-ACA (Non-Expansion Population) eligibility groupings to calculate whether a rebate is required.

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GENERAL DEFINITIONS

Contractor means a Coordinated Care Organization (CCO) under contract with the Oregon Health Authority (OHA) through a Health Plan Services Contract (Contract).

Expansion Population means Members who are enrolled in the following Rate Categories:

- **2014 Reporting Period:** ACA Adults with Children and ACA Adults without Children
- **2015 Reporting Period:** ACA Ages 19-44, ACA Ages 45-54 and ACA Ages 55-64

Line of Business means revenues and costs associated with the Oregon Health Plan (OHP) Line of Business as reported on Exhibit L Report L8 OHP.

Member means a client who is enrolled with a Contractor under Contract with OHA.

MMLR means Minimum Medical Loss Ratio and equals Total Incurred Medical Related Costs, divided by Total Medical Related Revenues.

MMLR Standard means an MMLR exceeding 80% for the Expansion Population.

Reporting Period: The Rebate Calculation will be measured for the entire period of July 1, 2014 to December 31, 2015 (eighteen months). Separate input sheets are provided for the time periods July 1, 2014 – December 31, 2014 and January 1, 2015 – December 31, 2015 to assist in the reconciliation/review process. Each Contractor is required to submit a MMLR Calculation Report with accurate data by June 30, 2016 based on data paid through March 31, 2016:

- **Due Date:** June 30, 2016
- **Paid Through Date:** March 31, 2016

REPORT INSTRUCTIONS AND DEFINITIONS BY SECTION

SECTION #1: NET PREMIUMS AND OTHER REVENUES

1. **Gross Premiums** means Capitation Payments plus Case Rate Revenue. Case Rate Revenue includes any payments made on a case rate basis, including maternity and bariatric case rates. This value should tie to Exhibit L Report L8 OHP.
 - a. **Reinsurance/Stop Loss Premiums** means premiums paid/accrued for reinsurance or stop loss insurance but does not include reinsuring all or substantially all of Contractor's risk. This value should tie to Exhibit L Report L8 OHP.
 - b. **HRA Payments** means hospital reimbursement adjustment payments. This value should tie to Exhibit L Report L8 OHP.
 - c. **Federal and State Taxes and Licensing or Regulatory Fees** includes federal income taxes; other federal taxes and assessments; state income, excise, business and other taxes; state premium taxes; and regulatory authority licenses and fees. The following outlines instructions for each component:
 - **Federal income taxes** allocated to the OHP Line of Business. For the six month period July 1, 2014 – December 31, 2014 multiply the annual effective income tax rate times the corresponding taxable income for the six month period.

Exclude: Federal income taxes on investment income and capital gains.
 - **Other Federal Taxes (other than income tax) and assessments.**

Include: Federal taxes and assessments (other than income taxes) allocated to the OHP Line of Business and the ACA Health Insurance Provider Fee pertaining to the OHP Line of Business.

Exclude: Fines, penalties, and fees for examinations by any Federal departments.

- **State income, excise, business, and other taxes** allocated to the OHP Line of Business that may be excluded from Gross Premiums under 45 CFR §158.162(b)(1).

Include:

- Any industry wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State that are authorized by State law.
- Market stabilization redistributions, or cost transfers for the purpose of rate subsidies (not directly tied to claims) that are authorized by State law.
- Guaranty fund assessments.
- Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
- Advertising required by law, regulation or ruling, except advertising associated with investments.
- State income, excise, and business taxes other than premium taxes.

Exclude: Fines, penalties, and fees for examinations by any State departments.

- **State premium taxes.**

Include: State premium taxes or State taxes based on policy reserves if in lieu of premium taxes related to the OHP Line of Business.

- **Regulatory authority licenses and fees.**

Include: Statutory assessments to defray operating expenses of any State or Federal regulatory authority, and examination fees in lieu of premium taxes as specified by State law.

Exclude: Fines, penalties, and fees for examinations by any State or Federal regulatory authority.

2. **Net Premiums** means Gross Premiums reduced by:

- Reinsurance/Stop Loss Premiums;
- HRA Payments; and
- Federal and State Taxes and Licensing or Regulatory Fees.

3. **Other Health Care Related Revenues** means other supplemental revenues received by Contractor.

Include: Quality Pool payments made by OHA to Contractor.

4. **Total Medical Related Revenues** means the sum of Net Premiums and Other Health Care Related Revenues.

SECTION #2: INCURRED MEDICAL RELATED COSTS

5. **Paid Claims** means amounts paid for claims through March 31, 2016 that were for services incurred or provided during the Reporting Period. This amount should be reduced by any reinsurance recoveries, Third Party Reimbursement (TPR), Coordination of Benefits (COB), subrogation or similar payments received.

Include: Claims paid on a fee-for-service basis and payments made for “in-lieu of services” as described in the CMS section 1115 Waiver and as reported on Line 16 of Exhibit L Report L8 OHP.

Exclude: Administrative component of sub-capitated payments to non-providers.

6. **Unpaid Claim Reserve** means reserves and liabilities established to account for claims incurred during the Reporting Period that were unpaid as of March 31, 2016.

Review consideration: Supplemental information may be requested to substantiate these estimates. (i.e. claim triangles, etc.)

7. **Incurred Medical Incentive Pools and Bonuses** means risk sharing and other arrangements with Participating Providers whereby the Contractor agrees to share savings with Participating Providers or to pay bonuses based on achieving defined measures and/or outcomes.

Include: Payments to Participating Providers representing monetary incentive arrangements that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives.

8. **Experience Rating Refunds and Reserves for Experience Rating Refunds** includes:

Experience Rating Refunds means retrospective premium adjustments arising from retrospectively rated contracts, plus any incurred state premium refunds.

Reserves for Experience Rating Refunds means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement, or due but unpaid for a state premium refund.

9. **Change in Contract Reserves** means change during the Reporting Period in reserves that are established which, due to the Gross Premium pricing structure, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation Net Premiums at that time. Contract reserves do not include premium deficiency reserves or reserves for expected MMLR Rebates.

10. **Other Incurred Medical Costs** means medical or health-related costs not otherwise classified.

Include: Sub-capitated payments or other forms of alternative payments made to Participating Providers.

11. **Total Incurred Medical Costs** means the sum of:

- Paid Claims;
- Unpaid Claim Reserve;
- Incurred Medical Incentive Pools and Bonuses;
- Experience Rating Refunds and Reserves for Experience Rating Refunds;
- Change in Contract Reserves; and
- Other Incurred Medical Costs.

12. **Health Care Quality Improvement (QI) Expenses Incurred** includes expenses related to the following:

- Activities to improve health outcomes
- Activities to prevent hospital readmission
- Activities to improve patient safety and reduce medical errors
- Wellness and health promotion activities
- Health information technology (HIT) expenses related to improving health care quality
- Allowable ICD-10 implementation expenses

The next section outlines the definitions of each item above.

13. **Total Incurred Medical Related Costs** means the sum of:

- Total Incurred Medical Costs; and
- Health Care Quality Improvement Expenses Incurred.

14. **Minimum Medical Loss Ratio** or **MMLR** means Total Incurred Medical Related Costs, divided by Total Medical Related Revenues.
15. **Rebate** means the dollar amount which, if added to Contractor's Total Incurred Medical Related Costs, would result in an MMLR equal to the MMLR Standard. If MMLR exceeds the MMLR Standard, the Rebate is zero.

LINE 12 – HEALTH CARE QUALITY IMPROVEMENT EXPENSES DEFINITIONS

The information contained in this section outlines the expenses to include and exclude for **Line 12: Health Care Quality Improvement Expenses Incurred** in the MMLR Rebate Calculation Report.

QUALITY IMPROVEMENT ACTIVITIES—GENERAL OVERVIEW

In general, expenses for Quality Improvement (QI) activities are costs incurred by Contractor that is designed to:

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

QI activities must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent hospital readmissions through a comprehensive program for hospital discharge;
- Improve patient safety, reduce medical errors, and lower infection and mortality rates;
- Implement, promote, and increase wellness and health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 CFR §158.151.

Expenditures and activities that must not be included in quality improving activities are:

- Those that are designed primarily to control or contain costs.
- The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.
- Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from Total Medical Related Revenues included on Line 4.
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §1320d-2, as amended, and ICD-10 implementation costs in excess of 0.3% of Gross Premiums.
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
- Provider credentialing.
- Marketing expenses.
- Costs associated with calculating and administering individual Member incentives.
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.
- Any function or activity not expressly described below, unless otherwise approved by and within the discretion of OHA, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes in this section or otherwise support monitoring, measuring or reporting health care quality improvement.

ACTIVITIES TO IMPROVE HEALTH OUTCOMES

Include expenses for the direct interaction of the Contractor (including those services delegated by contract for which the Contractor retains ultimate responsibility for), providers, and the Member or the Member's representatives (e.g., face-to-face, telephonic, web-based interactions, or other means of communication) to improve health outcomes. This category can include costs for associated activities such as:

- Effective case management, care coordination, and chronic disease management, including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act.
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in this section.
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
- Quality reporting and documentation of care in non-electronic format.

ACTIVITIES TO PREVENT HOSPITAL READMISSION

Include expenses for implementing activities to prevent hospital readmissions. This category can include costs for associated activities such as:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital.
- Personalized post discharge counseling by an appropriate health care professional.
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

ACTIVITIES TO IMPROVE PATIENT SAFETY AND REDUCE MEDICAL ERRORS

Include expenses for activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates. This category can include costs for associated activities such as:

- The appropriate identification and use of best clinical practices to avoid harm.
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns.
- Activities to lower risk of facility acquired infections.

- Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions.
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

WELLNESS AND HEALTH PROMOTION ACTIVITIES

Include expenses for activities primarily designed to implement, promote, and increase wellness and health activities. This category can include costs for associated activities such as:

- Wellness assessment.
- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements.
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition.
- Public health education campaigns that are performed in conjunction with state or local health departments.
- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI activities for the group market to the extent permitted by section 2705 of the PHSA.
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities.
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity).

HEALTH INFORMATION TECHNOLOGY (HIT) EXPENSES RELATED TO IMPROVING HEALTH CARE QUALITY

Report information technology expenses associated with the activities reported in this section (45 CFR §158.151 allows “Health Information Technology” expenses that are required to accomplish the activities allowed in 45 CFR §158.150).

Include: HIT expenses required to accomplish the activities reported in this section that are designed for use by health plans, health care providers, or members for the electronic creation, maintenance, access, or exchange of health information as well as activities that are consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

- Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in 45 CFR §158.140;
- Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;
- Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
- Monitoring, measuring, or reporting clinical effectiveness, including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law);
- Advancing the ability of Members, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately, and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by Members and appropriate providers to monitor and document an individual patient’s medical history and to support care management;
- Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
- Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or
- Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §1320d-2.

ALLOWABLE ICD-10 IMPLEMENTATION EXPENSES

Include: ICD-10 conversion costs incurred in the MLR reporting year up to 0.3% of Gross Premiums.

Exclude: ICD-10 maintenance costs, as well as ICD-10 implementation expenses in excess of 0.3% of Gross Premiums.

FREQUENTLY ASKED QUESTIONS

Question: How do I allocate a cost between Expansion and Non-Expansion eligibility categories that was not paid based on enrollment? (i.e. incentive payments)?

Answer: OHA recommends using an allocation based on the targeted eligibility categories and include the costs allocated to Expansion Population under that column in the MMLR Calculation Report. Please provide your allocation methodology in the scratch sheet of the template.

Question: Can healthcare professional hotline expenses be included in the MMLR Calculation Report?

Answer: Expenses for healthcare professional hotlines should be **excluded** to the extent they do not meet the criteria for **line 12: Health Care Quality Improvement Expenses** as defined in the previous section.

Question: Can expenses for Prospective Utilization Review be included in the MMLR Calculation Report?

Answer: Expenses for prospective Utilization Review should be **excluded** to the extent they do not meet the criteria for **line 12: Health Care Quality Improvement Expenses** as defined in the previous section; AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.