UNDERSTANDING THE
MEDICARE RADV
AND MARKETPLACE
IVA PROCESSES

AGENDA

• Who is Quadralytics?
• Risk Adjustment 101
• Medicare Risk Adjustment Data Validation (RADV) Audits
• Health Insurance Marketplace Initial Validation Audits (IVA)
• Understanding the Risk
• Questions
• Appendices

OUR MISSION

Our mission is to provide accurate and timely consulting & analytic services to our healthcare partners to assist them in formulating a comprehensive and unmitigated snapshot of members and providers based on quality metrics, risk adjustment, and operational effectiveness.
QUADRALYTICS, LLC

About Us
• Founded in 2011
• Primary focus is providing analytical solutions and consulting support to managed care organizations
• Team of consultants, SME, and technical staff with “hands on” experience
• Experience developing HEDIS and risk adjustment solutions and predictive models for Medicare, Medicaid, and Health Exchange plans

Our Clients
• Health plans
• Physician organizations
• Healthcare vendors
• Self-Insured employers
• Third-party administrators
• ACO physicians

WHAT IS RISK ADJUSTMENT?
• A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee
• Pay appropriate and accurate reimbursement for subpopulations with significant cost differences
• Purpose: to pay plans accurately for the risk of the beneficiaries they enroll
• Why: access, quality, protect beneficiaries, reduce adverse selection, etc.
TYPES OF RISK ADJUSTMENT

- **Prospective/Future Prediction:**
  - Uses historical diagnoses as a measure of health status and demographic information to predict future expense
  - Data from 2014 used to predict expected costs in 2015
  - Example: CMS Medicare HCC Model

- **Concurrent (aka Retrospective):**
  - Uses historical diagnoses as a measure of health status and demographic information to predict expected expense for the current period done from a retrospective perspective
  - Data from 2014 used to retroactively predict expected costs in 2014
  - Example – HHS-CC model for the Health Insurance Marketplace

PROVIDER VIEW OF RISK ADJUSTMENT

- My members are sicker
- I documented the services
- These numbers are not right
- This is risk adjusted?

PAYOR VIEW OF RISK ADJUSTMENT

- Why can’t they document correctly?
- Diabetes does not cure itself
- Was that really a stroke in the office?
- They need to hire a coder
WHY DOES CMS CONDUCT AUDITS?

“To follow by faith alone is to follow blindly.”

- Benjamin Franklin

MEMBER EXAMPLE

- 60-year-old male
- Originally disabled
- Medicaid
- Community
- HCC 17 – Diabetes w/Acute Complications
- HCC 19 – Diabetes w/o Complications
- HCC 80 – Congestive Heart Failure
- HCC 92 – Specific Heart Arrhythmias
- Interaction DM_CHF

HCC CALCULATION

<table>
<thead>
<tr>
<th>Variable</th>
<th>Accurate</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>60-year-old male</td>
<td>0.411</td>
<td>0.411</td>
</tr>
<tr>
<td>Originally disabled</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>HCC 17 – Diabetes w/Acute Complications</td>
<td>0.339</td>
<td>0.000</td>
</tr>
<tr>
<td>HCC 19 – Diabetes w/o Complications</td>
<td>0.162</td>
<td>0.162</td>
</tr>
<tr>
<td>HCC 80 – Congestive Heart Failure</td>
<td>0.410</td>
<td>0.000</td>
</tr>
<tr>
<td>HCC 92 – Specific Heart Arrhythmias</td>
<td>0.293</td>
<td>0.293</td>
</tr>
<tr>
<td>Interaction for Diabetes and CHF</td>
<td>0.154</td>
<td>0.000</td>
</tr>
<tr>
<td>Total Hierarchical HCC weight</td>
<td>1.807</td>
<td>0.895</td>
</tr>
<tr>
<td>Annual payment (assumes $800/mo.)</td>
<td>$15,427</td>
<td>$8,314</td>
</tr>
<tr>
<td>Payment Difference</td>
<td>$7,113</td>
<td></td>
</tr>
<tr>
<td>Medical expense (85% MLR)</td>
<td>$12,900</td>
<td>$12,900</td>
</tr>
<tr>
<td>Profit/Loss</td>
<td>$2,467</td>
<td>$(4,646)</td>
</tr>
</tbody>
</table>
MEDICARE AND RADV

MEDICARE HCC MODEL

- Model is prospective – previous diagnosis data used to predict future member expense
- Model is hierarchical – hierarchies apply to disease categories
- Model was essentially unchanged from 2004 implementation until 2014 payment year
- Risk scores correlate directly to plan payment

2013 VS. 2014 HCC MODEL

<table>
<thead>
<tr>
<th>Model Compare</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>2938</td>
<td>3033</td>
</tr>
<tr>
<td>Discontinued Diagnosis</td>
<td>129</td>
<td></td>
</tr>
<tr>
<td>New Diagnosis</td>
<td>724</td>
<td></td>
</tr>
<tr>
<td>HCC</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>New HCC</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Change HCC</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Hierarchy</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Community Interactions</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Institutional Interaction</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Disability Interactions</td>
<td>5</td>
<td>12</td>
</tr>
</tbody>
</table>
MEDICARE HCC AUDIT

Unlike other Medicare audits, the HCC audits do not have clear guidelines.

- Whether a diagnosis is acceptable is often left to plan interpretation.
- This may be different than what CMS determines to be acceptable.
- Every plan must determine its acceptable level of risk.
- Even when CMS provides guidelines, they are not always clear.

ACCEPTABLE PROVIDER SPECIALTIES...

<table>
<thead>
<tr>
<th>CODE</th>
<th>SPECIALTY</th>
<th>CODE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>General Practitioner</td>
<td>29</td>
<td>Pulmonary Disease</td>
</tr>
<tr>
<td>27</td>
<td>Infectious Disease and</td>
<td>14</td>
<td>Hematology</td>
</tr>
<tr>
<td>28</td>
<td>Psychiatry</td>
<td>17</td>
<td>Cardiology</td>
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<tr>
<td>29</td>
<td>Gastroenterology</td>
<td>26</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>01</td>
<td>General Surgery</td>
<td>58</td>
<td>Clinical Psychology</td>
</tr>
<tr>
<td>01</td>
<td>General Surgery</td>
<td>59</td>
<td>Dermatology/Developmental</td>
</tr>
<tr>
<td>01</td>
<td>General Surgery</td>
<td>99</td>
<td>Pediatrics</td>
</tr>
</tbody>
</table>

*Indicates that a number has been crossed.*

QUALIFIED PROVIDER FOR RISK ADJUSTMENT:

...OR ARE THEY?

Lab and Test Results - Guidelines:

- Some organizations have required the use of laboratory and pathology reports for data submission and medical record review. The following guidelines must be taken into account when determining data or clinical accuracy:
- Official Guidelines for Coding and Reporting (Section II-B, Necedary Findings):
- Pathology reports (e.g., microscopy, histology, and other diagnostic results) are not coded and reported unless the diagnosis is indicated from clinical information.
- Caloric should not enhance the report that the GLO code be used or an abnormal finding.
- A report containing the following pathologic data should be included in the following:
- Physician pathology (e.g., operative code) is acceptable for risk adjustment. When submitting risk adjustment data, the data submitted or as a separate mental health facility site to the physician stated in the section. AND
- If there is an indication that the report contains information that is not relevant to the risk adjustment decision, the report should be included in the risk adjustment decision.
**CMS RADV AUDIT PROCESS**

- Plan is notified of RADV audit
- Roughly 600 Medicare contracts and only 30 plans are selected annually
  - Odds of being selected for a RADV Audit: ~ 5% per year
- CMS selects 201 members for audit
  - Three strata – low, medium and high risk scores
- Plan required to provide support for every HCC via medical record submission to CMS

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**ARE YOU AT RISK?**

Signs your plan may be at risk for a RADV:

- Large change in year-over-year risk scores – CMS will focus on plans with big increases in score to ensure it is correct
- Very few delete records – if you are not doing deletes, you are not reviewing your own submissions for accuracy and correcting errors
- Other corrective actions – has your plan been reviewed for something else? It may increase your likelihood of audit as CMS sees you as a risk

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**WHICH MEMBERS ARE INCLUDED?**

- All Possible Members
- All Year?
- Current Year
- Hospice
- Had Part B
- Had an HCC Diagnosis mapping to an HCC in claim year
- Members effective in claim year
- Member still effective with plan U payment year
- No ESRD
- No ESRD Dx during 13 mo period
- Payment year
CAN I REALLY SEND IN THAT MANY RECORDS?

- While the original RADV guidelines allowed for only the one “best medical record,” the new RADV guidelines have changed.
- Plans can now submit up to five medical records to support a diagnosis and HCC.
- The same medical record can be used to support multiple HCC for a member as well.
- But the “best medical record” may not always be the best record to submit.

HOW WILL I KNOW HOW THE PLAN DID?

CMS will issue a “Preliminary Audit Report of Findings” (AROF)

- Shows HCC-level validation and errors and eligibility for dispute.
- At enrollee-level, AROF will show revised score and payment.
- Information and instructions for Medical Record Dispute (MRD) will be included with report.
- Plans allow to dispute findings only on certain types of RADV-related errors.

PLAN HAS MULTIPLE LEVEL OF APPEALS

- Plans can file initial appeal via MRD process for review by “Hearing Officer.”
- The plan must:
  - File appeal within 30 days from receipt of AROF.
  - Submit the “One Best Medical Record” from records submitted to IVC for this review though it does not have to be the record audited.
PLAN HAS MULTIPLE LEVEL OF APPEALS

- Plan will receive "Audit Report Post Medical Record Review," detailing results similar to AROF along with additional appeals instructions
- Only other appeal option is to CMS Administrator

ERROR EXTRAPOLATION

CMS Identifies HCC Errors
- Charts are read 2x by IVC
- Plan notified of error

HCC 17
   - HCC 15
   - HCC 19
   - No HCC

CMS Extrapolates Error
- HCC 17 drops to HCC 19
  \(0.248 - 0.459 = -0.211\)
- Multiply By Benchmark
  \(\$800 \times (-0.211) = -168.80\)
- Extrapolate to Population
  \(168.80 \times 8,000 = 1,350,400\)
- Other HCC for same member can change
- Interactions may no longer apply

VALIDATED

INITIAL VALIDATION AUDIT (IVA)
NOT YOUR MOTHER’S 3 “Rs”

THE 3 “Rs”

• The three keys to the risk adjustment and revenue of the Health Insurance Marketplace are:
  • Risk Adjustment – the adjustment of payment based on the demographic factors and severity of the illness of the member
  • Risk Corridors – The limiting or sharing of losses by the plan by HHS across all membership
  • Reinsurance – The limiting of loss on an individual member basis

MEDICARE RADV VS. MARKETPLACE VALIDATION (IVA)

<table>
<thead>
<tr>
<th>Item</th>
<th>Medicare RADV</th>
<th>Marketplace IVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Years</td>
<td>2011 – Forward</td>
<td>2014 - Forward</td>
</tr>
<tr>
<td>Timeline</td>
<td>2-3 years after payment</td>
<td>Six months after year-end</td>
</tr>
<tr>
<td>Minimum Plan Size</td>
<td>Every Plan</td>
<td>Not Addressed</td>
</tr>
<tr>
<td>Number of Plans Audited</td>
<td>Approximately 30, Stratified – 3 Strata</td>
<td>All, Stratified – 10 Strata</td>
</tr>
<tr>
<td>Members</td>
<td>All Supporting</td>
<td>All Supporting</td>
</tr>
<tr>
<td>Diagnoses Included Thru</td>
<td>13 months after year-end</td>
<td>4 months after year-end</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Applied to Strata</td>
<td>Not Currently Defined</td>
</tr>
<tr>
<td>Extrapolation</td>
<td>All Supporting</td>
<td>Not Defined</td>
</tr>
<tr>
<td>Appeal Process</td>
<td>Defined</td>
<td>Not Applicable 2014/15</td>
</tr>
<tr>
<td>FFS Offset</td>
<td>Included – Est. 11%</td>
<td>Vague</td>
</tr>
<tr>
<td>Clarity</td>
<td>Vague</td>
<td>Vendor</td>
</tr>
<tr>
<td>First Round Audits</td>
<td>CMS</td>
<td>Plan Contracted</td>
</tr>
<tr>
<td>Conducted By</td>
<td></td>
<td>Vendor</td>
</tr>
</tbody>
</table>
HHS-HCC MODEL

- More diagnoses are included and map to additional HCC because of broader disease implications for the commercial population
- What occurs in the year, affects payment for the year – retrospective or concurrent payment model
- Differences in plan type (Bronze, Silver, etc.) affect the risk score and associated payment
- Model is a zero-sum – if one plan’s risk score is higher than another plan’s, the lower risk score plan will have to make payments to higher risk score plan

ZERO SUM PAYMENTS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Plan A</th>
<th>Plan B</th>
<th>Plan C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Revenue</td>
<td>$10,000,000</td>
<td>$10,000,000</td>
<td>$10,000,000</td>
</tr>
<tr>
<td>Initial Risk Score</td>
<td>1.15</td>
<td>1.07</td>
<td>1.23</td>
</tr>
<tr>
<td>Normalized Risk Score</td>
<td>1.00</td>
<td>0.93</td>
<td>1.07</td>
</tr>
<tr>
<td>Revised Revenue</td>
<td>$10,000,000</td>
<td>$9,104,347</td>
<td>$10,695,653</td>
</tr>
<tr>
<td>Payment Change</td>
<td>$0</td>
<td>($695,653)</td>
<td>$695,653</td>
</tr>
</tbody>
</table>

MODEL POPULATION

- Because the HHS Model includes a much more varied population than the Medicare model, some additional changes were necessary
  - Age groups include infant through adults and seniors.
  - Age groups are banded smaller for children and infants
INITIAL VALIDATION AUDIT

Unlike Medicare Advantage, the Health Insurance Marketplace
Initial Validation Auditors are contracted by the plan
• Both Health Insurance Marketplace and “Off-Exchange
  Plans” are included
• Members with and without HCC will be audited
• All auditors must be certified by the American Association of
  Professional Coders (AAPC) or the American Health
  Information Management Association (AHIMA)
• Senior auditors must have at least three years of experience
  in 2014 & 2015 and five years in 2016 and beyond
• Enrollment sources will be verified
• Initial Validation Auditors must be free from conflicts of
  interest

CONFLICTS OF INTEREST

• Issuer must attest to being conflict free to the best of its knowledge
• Neither the issuer nor any member of its management team (or any
  member of the immediate family of such a member) may have any
  material financial or ownership interest in the initial validation auditor
• Owners, directors and officers of the issuer may not be owners,
  directors or officers of the auditor (and vice versa)
• Audit Team members may not be married to, in domestic relationship
  with or immediate family of owners, directors, officers or employee of
  the issuer
• The initial validation auditor may not have had a role in establishing
  any relevant internal controls of the issuer related to the risk
  adjustment data validation process

AUDIT STRATA

80% of Members
No HCC – Demographic Only

<table>
<thead>
<tr>
<th>Adult High Risk Score</th>
<th>Child High Risk Score</th>
<th>Infant High Risk Score</th>
</tr>
</thead>
</table>
| 20% of Members
Adult Medium Risk Score | Child Medium Risk Score | Infant Medium Risk Score |
| Adult Low Risk Score  | Child Low Risk Score  | Infant Low Risk Score  |
MEMBERS WITH NO HCC

For enrollees without risk adjustment HCCs for whom the issuer has submitted a risk adjustment eligible claim or encounter, HHS would require the initial validation auditor to review all medical record documentation for those risk-adjustment eligible claims or encounters, as provided by the issuer, to determine if HCC diagnoses should be assigned for risk score calculation, provided that the documentation meets the requirements for the risk adjustment data validation audits.

ENROLLMENT VALIDATION

The initial validation auditor would validate information by reviewing plan source enrollment documentation, such as the 834 transaction, which is the HIPAA-standard form used for plan benefit enrollment and maintenance transactions. These enrollment transactions reflect the data the issuer captured for an enrollee’s age, name, sex, plan of enrollment, and enrollment periods in the plan.

ISSUER AUDIT RISK

• While no direct financial penalties will result from the 2014 and 2015 payment year audits, the possibility of financial penalties and further audit does exist:
  • Office of the Inspector General (OIG) – as noted in the OIG Work Plan, the OIG is cracking down on over-coding of HCC.
  • False Claims Act – knowingly submitting false diagnoses
  • Whistleblowers – disgruntled employees, etc. may cry foul.
UNDERSTANDING THE RISKS

BLIND FAITH

“Blind faith in your leaders or anything will get you killed.”

- Bruce Springsteen, “War”

BLIND FAITH

“Blind faith in your providers and claim submission will get you adverse findings.”

- Scott Weiner, Quadralytics
TOP 10 MEDICARE RISK ADJUSTMENT CODING ERRORS

1. The record does not contain a legible signature with credential.
2. The electronic health record (EHR) was unauthenticated (not electronically signed).
3. The highest degree of specificity was not assigned the most precise ICD-9-CM code to fully explain the narrative description of the symptom or diagnosis in the medical chart.
4. A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record. If the record indicates depression, NOS (311 Depressive disorder, not elsewhere classified), but the diagnosis code written on the encounter document is major depression (296.20 Major depressive affective disorder, single episode, unspecified), these codes do not match; they map to a different HCC category. The diagnosis code and the description should mirror each other.

TOP 10 MEDICARE RISK ADJUSTMENT CODING ERRORS

5. Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT).
6. Status of cancer is unclear. Treatment is not documented.
7. Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
8. Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
9. Chronic conditions or status codes aren't documented in the medical record at least once per year.
10. A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

WHY DO MEDICAL RECORD REVIEW?

Single Medical Record

<table>
<thead>
<tr>
<th>Original Claim Diagnoses</th>
<th>New Diagnoses</th>
</tr>
</thead>
</table>

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WHY DO MEDICAL RECORD REVIEW?

Two to Three Medical Records

<table>
<thead>
<tr>
<th>Unsupported Diagnoses</th>
<th>Supported Diagnoses</th>
<th>New Diagnoses</th>
</tr>
</thead>
</table>

WHY DO MEDICAL RECORD REVIEW?

Four or More Medical Records

<table>
<thead>
<tr>
<th>Unsupported Diagnoses</th>
<th>Supported Diagnoses</th>
<th>New Diagnoses</th>
</tr>
</thead>
</table>

CLAIMS DATA SUBMISSION

Advantages
- Chart review volume would be too great if we had to look at every record
- Can provide additional dates of services for a diagnosis beyond what is found via chart review

Disadvantages
- "75%" Accurate
- Will not stand up to a RADV Audit
- Limited to how many the provider can submit on a claim
- May not be able to tell if the service was done by an acceptable provider
MEDICAL RECORD REVIEW

Advantages
- More accurate than claim submission only
- More complete than claim submission
- Able to identify the provider of service
- Additional diagnoses that may not have been on claim
- Fix the “30/30” issue

Disadvantages
- Time consuming
- Intrusion on the provider office
- Retrospective
- Chart coding is often open to interpretation
- Physician handwriting
- EMR issues

PROSPECTIVE ASSESSMENTS

Advantages
- Provides real-time picture of the patient
- Provides a method to address care for home-bound or facility-bound patients
- Provides a look into the member’s living conditions
- More complete than the typical physician’s office health exam
- Not just about risk adjustment
- Provides complete and accurate documentation for RADV support depending on quality of data capture

Disadvantages
- More costly than office visit
- Office visit - $45-205 in Dallas
- Prospective Assessment ($300+)
- Physicians often see it as competition to their services
- Breaks the PCP/member relationship if not done correctly.
- Changes to CMS guidelines

PAPER VS. EMR RECORD

Paper
- Often not much more than a “super bill”
- Poor handwriting leads to misinterpretations
- Need legible signature and credentials on each page
- Need date on each page
- Need member name on each page

Electronic Record
- Usually cleaner than paper
- Menial tasks that must be done on a paper claim are done automatically.
- Several issues do exist with EMR records
- Cloning
- Drug lists not updated
- Meaningful use
REDUCING RISK

WHAT CAN BE DONE TODAY?

- Assess organizational readiness
- Assess data quality
- Validate existing charts
- Acquire and abstract charts where gaps exist

ASSESS THE ORGANIZATION

- What does your Revenue Improvement Program look like?
- RADV Response Team includes:
  - Business Sponsor (Senior Executive)
  - Medical Directors to call doctors
  - Executives to call office managers
  - Project Manager(s)
  - Review/Audit staff
  - Other Team Members
- Meet internally to develop strategy for RADV and determine need for assistance from vendor
- Are policies and procedures up-to-date?
ASSESS DATA

Assess and clean up data
• Have "Deletes" been processed for bad data?
• Code Sets
  • Specialty codes (recently released)
  • CPT codes – may be acceptable provider, but not face-to-face visit
  • Are all RAPS (EDPS) resubmitted?
  • Are specialty codes updated?
  • Are CPT/Dx codes reviewed?
• Update policies and procedures

CHARTING THE COURSE

• Which HCC do medical charts substantiate?
• Are the diagnoses from acceptable providers?
• Are "Rule-out" diagnoses used?
• What is the frequency of the diagnoses?
• If using a vendor, have all charts been reviewed?

TOP 10 COMPLIANCE ISSUES

#3 Electronic Medical Records

Some early adopters of Electronic Medical Records (EMR) software are now having to respond to "cloning" and/or "carry over" concerns raised by ZPICs and Program Safe Guard Contractors (PSCs).

"These audits appear to be the result (at least in part) of inadequately designed software programs which generate progress notes and other types of medical records that do not adequately require the provider to document individualized observations. Instead, the information gathered is often sparse and similar for each of the patients treated."


(emphasis added)
# THE IMPACT

<table>
<thead>
<tr>
<th>Calculation</th>
<th>Sample</th>
<th>Strata 1 - Hi</th>
<th>Strata 2 - Mid</th>
<th>Strata 3 - Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modeled Payment</td>
<td>$1,679,213</td>
<td>$1,164,902</td>
<td>$364,531</td>
<td>$149,779</td>
</tr>
<tr>
<td>Modeled Errors</td>
<td>$218,256</td>
<td>$150,125</td>
<td>$43,392</td>
<td>$24,739</td>
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<tr>
<td>Extrapolated Payment</td>
<td>$204,061,950</td>
<td>$141,561,722</td>
<td>$44,298,702</td>
<td>$18,201,526</td>
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<tr>
<td>Extrapolated Errors</td>
<td>$26,522,990</td>
<td>$18,243,524</td>
<td>$5,273,099</td>
<td>$3,006,367</td>
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<tr>
<td>Variance Estimates</td>
<td>$17,169,893,090</td>
<td>$111,951,352,722</td>
<td>$19,300,754,327</td>
<td>$11,474,234,772</td>
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<tr>
<td>Standard Error</td>
<td>$4,150,066</td>
<td>$333,095</td>
<td>$138,927</td>
<td>$107,118</td>
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<tr>
<td>Lower Bound</td>
<td>$13,272,424</td>
<td>$18,243,524</td>
<td>$5,273,099</td>
<td>$3,006,367</td>
</tr>
<tr>
<td>Final Amount Due</td>
<td>$12,169,827</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total HCC-related payment made by CMS to the plan.

Modeled payment for 201 enrollees in the sample and expand to my entire population of ~24,600

The net effect of payment errors on the model assuming ~17% error rate.
### THE IMPACT

<table>
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<td>$218,256</td>
<td>$150,125</td>
<td>$43,392</td>
<td>$24,739</td>
</tr>
<tr>
<td>Extrapolated Payment</td>
<td>$204,061,950</td>
<td>$141,561,722</td>
<td>$44,298,702</td>
<td>$18,201,526</td>
</tr>
<tr>
<td>Extrapolated Errors</td>
<td>$26,522,990</td>
<td>$18,243,524</td>
<td>$5,273,099</td>
<td>$3,006,367</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>$238,449</td>
<td>$333,095</td>
<td>$138,927</td>
<td>$107,118</td>
</tr>
<tr>
<td>Standard Error</td>
<td>$4,150,066</td>
<td>$4,150,066</td>
<td>$22,372,924</td>
<td>$22,372,924</td>
</tr>
<tr>
<td>FFS Adjuster (5%)</td>
<td>$10,203,097</td>
<td>$10,203,097</td>
<td>$10,203,097</td>
<td>$10,203,097</td>
</tr>
<tr>
<td>Final Amount Due</td>
<td>$12,169,827</td>
<td>$12,169,827</td>
<td>$12,169,827</td>
<td>$12,169,827</td>
</tr>
</tbody>
</table>

*Modeled payment errors for 201 enrollees in the sample and expanded to my entire population of ~24,000.*

\[ \text{Final Amount Due} = \frac{\text{Modeled Errors}}{\text{Sample Size}} \times \text{Total Population} \]

\[ \text{Standard Error} = \sqrt{\frac{\text{Modeled Errors}}{\text{Sample Size}}} \]

\[ \text{Lower Bound} = \text{Final Amount Due} - 1.96 \times \text{Standard Error} \]

\[ \text{Final Amount Due (w/ FFS Adjuster)} = \text{Final Amount Due} + 0.05 \times \text{Final Amount Due} \]

\[ \text{Standard Error (w/ FFS Adjuster)} = 0.05 \times \text{Standard Error} \]

\[ \text{Final Amount Due (w/ 6% adjustment)} = \text{Final Amount Due} + 0.06 \times \text{Final Amount Due} \]
The maximum pay back to CMS for overpayments = Extrapolated Errors – Standard Error

For illustrative purposes only based on 5% of Extrapolated HCC Payments

The Three “Rs” of HHS Risk
RISK CORRIDORS

- Similar to Part D plans at start-up; the federal government will apply risk corridors to profit and loss of individual health plans in- and out-of the Marketplace

<table>
<thead>
<tr>
<th>Loss Ratio</th>
<th>Plan Risk</th>
<th>HHS Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>50%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>25%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Under 25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

RISK CORRIDOR - LOSS

- Plan has $125M revenue
- Plan expense ratio 15%
- Actual plan medical spend - $120M
RISK CORRIDOR – GAIN

- Plan has $125M revenue
- Plan expense ratio 15%
- Actual plan medical spend - $10M

<table>
<thead>
<tr>
<th>Total Plan Revenue</th>
<th>$125,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Gains</td>
<td>$78,700,000</td>
</tr>
<tr>
<td>Total Medical Fund</td>
<td>$46,300,000</td>
</tr>
<tr>
<td>Medical Spend</td>
<td>$100,000,000</td>
</tr>
<tr>
<td>Benefit Limit</td>
<td>$103,000,000</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>$3,000,000</td>
</tr>
<tr>
<td>Net Waste</td>
<td>$134,200</td>
</tr>
<tr>
<td>Plan Share</td>
<td>$138,000</td>
</tr>
</tbody>
</table>

REINSURANCE

- Reinsurance designed to protect plans from impact of a few high risk member/catastrophic claims
  - For 2014, members with total claims in excess of $45,000 (attachment point) will be covered at 80% to a $250,000 maximum per member/claim
  - For 2015, the attachment point is $70,000
- Payments are funded from payment - all plans pay whether they are in the exchange or not.
  - 2014 - $63 per member payment
  - 2015 - $44 per member
- Plans will typically carry traditional reinsurance above the $250,000 threshold.