2018 SOA BOOT CAMP

MEDICARE ADVANTAGE

REBATE REALLOCATION

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Agenda

- General Concept
- Which Plans Have Rebate Reallocations
- Plan Intentions
- Three Basic Examples
- Targeting LIPSA
- Additional Rules

General Concept

Part D BPTs – Worksheet 7

- Standardized Bid Amount (Bid Amt)
- Nat'l Avg Monthly Bid Amt (NABA)
- Basic Beneficiary Prem (NAPA)
- Part D Basic Prem = Bid Amt – NABA + NAPA

MA BPTs – Worksheet 6

- Sections III B & C – Use of MA Rebates
- One Use is to Buy-down Part D Basic Prem

July 31, 2018 Memo from CMS – Released Part D Premiums

- NABA $51.28
- NABPA $33.19
- de minimus $ 2.00
- Florida LIPSA $30.25

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General Concept (continued)

An MA-PD combined premium may not be the same after rebate reallocation – rebate reallocation is only an opportunity to get to the target Part D Basic Premium.

Which Plans Have Rebate Reallocation

Local MA Only bids – No Rebate Reallocation

Local MA-PD plans w/ no MA Rebates - No Rebate Reallocation

Local MA-PD plans w/ MA Rebates – Yes, Rebate Reallocation

Regional PPO Plans - Yes, Rebate Reallocation

Plan Intentions

Premium Amount Displayed in Line 7D

Low Income Premium Subsidy Amount (LIPSA)

Targeting Premium Amount in Line 7D

Example 1 – Published NABA & NAPA result in reducing the Part D Basic Premium to below zero.

"Excess" MA Rebate must be used to buy-down Other Premiums

	June	After Rebate	Rebate Reallocation
PD Basic Prem (prior)	$36	$34	$34
Alloc MA Rebate	$36	$36	$34
PD Basic Prem (after)	$ 0	-$2	$0

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Targeting Premium Amount in Line 7D

Example 2 – Published NABA & NAPA result in reducing the Part D Basic Premium (not below zero).

Two Options: (1) Leave Reduced PD Basic Premium (i.e., no change during Rebate Reallocation), (2) Reduce the MA Rebates allocated to buy-down PD Basic Premium in order meet the original (June Submission) premium.

	June	After Rebate	Rebate Reallocation
PD Basic Prem (prior)	$35	$30	$30
Alloc MA Rebate	$15	$15	$10
PD Basic Prem (after)	$20	$15	$20

A partial return to the PD Basic Premium is not acceptable

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Targeting Premium Amount in Line 7D

Example 3 – Published NABA & NAPA result in increasing the Part D Basic Premium.

Two Options: (1) Leave Reduced PD Basic Premium (i.e., no change during Rebate Reallocation), (2) Increase the MA Rebates allocated to buy-down PD Basic Premium in order meet the original (June Submission) premium.

	June	After Rebate	Rebate Reallocation
PD Basic Prem (prior)	$35	$40	$40
Alloc MA Rebate	$15	$15	$20
PD Basic Prem (after)	$20	$25	$20

A partial return to the PD Basic Premium is acceptable, only if there are insufficient MA Rebates available.

Targeting LIPSA

After the publishing of the NABA, NAPA and LIPSA the plan sponsor MUST reallocate MA Rebates to match the PD Basic Premium to the published LIPSA.

If MA Rebates are removed from PD Basic Premium and the plan bid has no other premiums, the plan may have to add A/B Mandatory Supplemental Benefits.

Targeting LIPSA

(insufficient to remove all MA Rebates)

If removing all MA Rebates from the PD Basic Premium allocation is insufficient to meet LIPSA (i.e., the premiums are still below LIPSA), then the plan sponsor MUST remove all MA Rebates from the PD Basic Premium allocation to get as close to the LIPSA as possible.

Targeting LIPSA

(insufficient to apply all MA Rebates)

If applying all MA Rebates to the PD Basic Premium allocation is insufficient to meet LIPSA (i.e., the premiums are still above LIPSA), then the plan sponsor MUST apply all MA Rebates to the PD Basic Premium allocation to get as close to the LIPSA as possible.

Further, if the resulting PD Basic Premium is less that the LIPSA plus the de minimus amount, then the plan sponsor is allowed to waive the Part D Basic Premium for LI members.

Additional Rules

No modifications to the Part D benefits or pricing is allowed.

The value of added or eliminated A/B Mandatory Supplemental Benefits is required to match the amount of rebates that must be shifted to return to the Part D Basic Premium intention:

A. Add Mandatory Supplemental Benefits
B. Remove Mandatory Supplemental Benefits (priority)
    1. Reduce/remove Non-Medicare Covered Benefits
    2. Increase C.S. for widely used services (e.g., PCP Visits)
    3. Increase C.S. for limited-use services (e.g., SNF)

Additional Rules

The BPTs must reflect the value of changed A/B Mandatory Supplemental Benefits that are added or removed consistent with the pricing approach used in the initial June submission. Examples include:

1. Induced utilization related to changes in cost sharing
2. Non-benefit expenses priced as a percent of revenue, such as insurer fees

Additional Rules

The 50 cent rounding rule applies:

Gain may be adjusted by up to the amount that will impact the member premium by $0.50 PMPM

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MEDICARE ADVANTAGE

PRICING, DOCUMENTATION AND AUDIT

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Agenda

- Documentation
- General Comments
- OOPC & TBC
- Base Period Medical Expense Reconciliation
- Trend Factor Support
- Gain/Loss Rules
- Administrative Costs
- Related Parties
- Medicare as Secondary Payer

Documentation

•Audit = Documentation

•ASOP# 41 *Actuarial Communications*
Section 3.2 Actuarial Report
"In the actuarial report, the actuary should state the actuarial findings, and identify the methods, procedures, assumptions, and data used by the actuary with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary's work as presented in the actuarial report."

•Documentation = Work (Work Plan and Work Management Tool)

General Comments – Bid Development vs. Audit

•Bid development is extremely complex, with many inter-related components

•Keeping all moving parts connected during the hectic bid development process is almost impossible

•It is far easier to go in after the fact to search and find discrepancies than it is to keep all items in order for bid submission

General Comments – Purpose of Audit

•Review current bids with results intended to improve the next year's bid submissions

•All Findings & Observations must be stated in the next year's bid documentation with the initial submission – along with specifics on how the bid addresses these issues

•CMS OACT uses the results of these audits to help improve the bid instructions for future years

General Comments – Orange Blank

- Page 7 – reported medical expense and administrative expense
- Page 11 – medical expense by product and incurred time-frame
- Exhibit of Premiums and Enrollment – membership by quarter (without retro-activity)
- Schedule Y – Related Parties & Transactions
- Significant Accounting Policies – Information Concerning Parents, Subsidiaries & Affiliates (Generally Item #10 or #11)

Out-Of-Pocket-Cost (OOPC) Differentials

- Meaningful differences ($20 PMPM)
- SAS model made available by CMS

Total-Beneficiary-Cost (TBC) Changes

- Limit year-over-year changes ($36 PMPM – increased from $32/$34 in previous years)

- Limit is adjusted for Technical and for Payment reasons:
  - Technical – change in OOPC software
  - Payment – changes to county benchmarks or quality bonus percentages
  - STAR Rating Changes – movements up/down in the STAR rating will impact the TBC amount

- Intent is to avoiding "bait and switch"

Base Period Medical Reconciliation

Components of Medical Costs

- Medical Claims
- Capitation
- Off-System

Common Off-System Expenses:

- Newsletter,
- Nurse Hotline,
- Part B Rx from PBM,
- etc.

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Base Period Medical Reconciliation
(continued)

Purpose of Reconciliation

- Ensure data accuracy
- Confirm all components of medical expense are included
- IBNR is explicit and is required to exclude provisions for adverse deviation

Base Period Medical Reconciliation

(continued)

Reconciliations

- Amounts must be followed from bid entries to Financial Statements
- Common to tie GL to FS, then bid items to the GL
- Capitation to GL
  - This is usually a direct tie, as "paid" and "incurred" timing is typically the same
- Off-System to GL
  - This is usually a direct tie, as "paid" and "incurred" timing is typically the same
- Medical claims to GL
  - Bid includes DOS of base period, run-out through Feb or Mar
  - GL tied to FS show paid during base year, regardless of DOS
  - Medical claims triangles connect the bid data to the GL amounts
- IBNR – best estimate for run-out past date of data (no margins)
- Provider Incentives – to be included in base period medical costs
- Related-Party Medical Expenses – Adjustments to bid expenses will created reconciling items

Support for Trend Factors

General Trends

- Historical Trends
- Benchmark Trends
- Forecast Trend Selection
  (in and amongst historical and benchmarks, with explanation of the choice – notes and/or meeting notes)

Support for Trend Factors
(continued)

Provider Payment Change

- Underlying Fees Schedule Changes (Medicare FFS reimbursement)
- Contract Changes (compiled over provider/contract level volume)

Support for Trend Factors
(continued)

Population Change

- Geographic Shifts (county level costs)
- Risk Score Changes
- Other

Support for Trend Factors
(continued)

Other Factors

- MSP

  (Changes to the factor/membership or changes to the implemented identification process)

- Other

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Gain/(Loss) Rules

Combining Plans (Aggregate Support and Negative Margins)

Aggregate Support (General Enrollment & I/C SNP Plans - MA)

- Select Organization or Parent Org. Level
- Accumulated gains at this level must be within 1.5% of pricing gains for non-Medicare LOBs (alt rules if <10% is priced at plan's discretion)
- Each plan bid must be "reasonable" and be without anti-competitive practices (Product Pairings may be required to confirm this)
- D-SNP plans must be within -5% to +1% of Indiv & I/C SNP

Negative Margins (Product Pairings)

- May Pair a Negative Margin plan with other plans
  - Identical service areas
  - Local Plans or RPPO or PFFS
  - Combine to Positive Margin
- Or must file Business Plan to achieve profitability

Base Period Administrative Costs

GL or TB – With tie to Financial Statements (FS are audited and considered to be accurate)

Cost Allocations of expenses by Account, Department or Cost Center tied to GL or TB (allocated to Medicare, MA vs. PD, and to Bid Entries)

Documentation – should show a mapping of all costs from bid entries to the Financial Statements

Audit – Review the documentation trail from FS to bid entries, select allocations of a few Accounts, Departments or Cost Centers for reasonable allocation methodologies

User Fees – include as Direct Administrative Expenses

Contract Period Administrative Costs

- Projected from base period expenses or current budget (if from budget, tie to base period must be shown and available for validation)

- Similar modeling to base period is helpful for review – and easier for Reviewer/Auditor to understand

- Forecast assumptions documented and supported

- Clear mappings to bid entries (PMPM)

Related-Party Expenses
(Definition)

Bid Instructions Definition:

The related-party requirements apply to all MAOs that enter into any type of arrangement with or receive services from an entity that is associated with the MAO by any form of common, privately held ownership, control, or investment. This includes any arrangement where the MAO does business with a related party through one or more unrelated parties.

Review all company Legal Entities (Statutory FS – Schedule Y and Significant Accounting Policies: Concerning Parents, Subsidiaries and Affiliates)

State Waiver for reporting on Schedule Y does not alleviate CMS disclosure

Related-Party Expenses
(Disclosures)

Disclosure #1 – Statement of Related Parties (even if there are none)

Disclosure #2 – Details of agreement

- Declare every related party arrangement
- Disclose all services provided by each arrangement
- Explain the relationship and the common ownership, control or investment
- Summarize the contractual terms, including services and payments
- Disclose the Method used in preparing the bids
- Provide qualitative and quantitative summary for Actual Cost Method
- Show fee associated with the related-party arrangement are within 5% or $2 PMPM ($2 PMPM rule is only for Medical expenses) for Market Comparison Methods
- Provide signed attestation from related-party for Market Comparison Methods that come from the related-party perspective

Related-Party Expenses
(Administrative Services Methods)

Method #1 Actual Cost – consistent with not recognizing the independence of the entity (i.e., cost allocations)

Method #2 Market Comparison – comparable fees paid by unrelated parties

- from the perspective of the plan sponsor, or
- from the perspective of the related-party

Also,

- comparison contracts with unrelated parties have sufficient cost to be valid contracts
- Fees to related-party is less than the greater of 5% difference from unrelated party

Related-Party Expenses
(Medical Expense Methods)

Method #1 Actual Cost – Consistent with not recognizing the independence of the entity (for medical expense this can be extremely difficult)

Method #2 Market Comparison – comparable fees paid by unrelated parties

- from the perspective of the plan sponsor, or
- from the perspective of the related-party

Also,

- comparison contracts with unrelated parties have sufficient cost to be valid contracts
- Fees to related-party is less than the greater of 5% diff from unrelated party or $2 PMPM

Related-Party Expenses

(Medical Expense Methods - continued)

Method #3 Comparison to FFS – actual fees paid are less than the greater of 5% diff from Medicare FFS or $2 PMPM

Method #4 FFS Proxy Method – replace actual provider payments with 100% of Medicare FFS provider reimbursements

- Must demonstrate at bid submission that it is not possible to comply with Methods 1, 2 or 3

Medicare as Secondary Payer (MSP)

CMS Direct Subsidies Pay at 17.3%

Instructions provide mathematics and examples for the calculation by evaluating member costs uniquely for MSP and Non-MSP

The use of CY2017 MMRs

- Consistent with base period medical expense
- True MSP membership is better identified (early 2018 MSP identified members have not been fully evaluated by the plan sponsor confirming their status as MSP)

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MEDICARE ADVANTAGE

REVENUE & RISK SCORES

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Agenda

- Goals of CMS Risk Adjustment
- The CMS HCC Risk Adjustment Model
- Timing of Data Submissions related to Risk Scores
- Risk Score Projections

Goals of Risk Adjustment

- **Objective of Risk Adjustment:**
  - To pay plans for the risk of the beneficiaries they enroll, as a way to incent the plan to better manage the member's care.
  - Allows CMS to directly compare bids on a standardized basis.
  - Reduce adverse selection and promotes plans to enroll all types of risks. This increases access for beneficiaries and reduces gaming.

- Medicare Advantage Plans are paid on a **Prospective** basis, using CMS' "Risk Based" methodology related to the health risk status of plan members.
  - Prospective payment approach uses diagnosis as a measure of health status (based on historical claims experience) and demographic information of each beneficiary
  - Pay appropriate and accurate payments for subpopulations with significant cost differences based on their risk

- The risk factor is determined by the claims and encounter data submitted by the Medicare Advantage plan (as well as FFS claim data) on behalf of each member, each year. The diagnosis data accepted by CMS in the prior year will determine the payment the plan will receive for that member the following year (i.e. 2018 dates of service determine 2019 CMS risk score and payment)

- The claims and encounters must be supported by an appropriate, accurate and complete medical record, as the medical record is the only credible documentation recognized by CMS during audits.

CMS HCC Model

(Hierarchical Condition Categories)

- Used to predict contract medical claims for Medicare Advantage enrollees

- Based on diagnosis codes from either MA plans or Medicare FFS. 2019 RS developed:
  - Using 2017 HCC Model & 2019 HCC Model
  - 75% based on RAPS & FFS Data using the 2017 HCC Model
  - 25% based on EDS and FFS Data using the 2019 HCC Model

- Prospective using inpatient and ambulatory diagnoses from prior year to predict costs for the current year

- Starting point is a demographic/Medicaid/originally disabled factor

- Non-ESRD HCCs for Community and Institutional Members:
  - Diagnostic categories
  - Disease Interactions
  - Disabled/Disease Interactions

- New Enrollees are based on demographics

- Raw Risk Scores are Adjusted for Payment Risk Scores for 2019 Payments
  - Coding Pattern Differences (0.9410)
  - FFS Normalization (1.041 w/ 2017 HCC Model & 1.038 w/ 2019 HCC Model)

HCC Starting Point is a Demographic Factor

Table 1. 2017 CMS-HCC Model Relative Factors for Community and Institutional Beneficiaries (there are more categories)

Variable	Community (Non-Dual)	Institutional
Female		
0-34 Years	0.244	1.031
35-44 Years	0.303	0.999
45-54 Years	0.322	1.007
55-59 Years	0.250	0.986
60-64 Years	0.411	1.028
65-69 Years	0.312	1.200
70-74 Years	0.374	1.092
75-79 Years	0.448	0.995
80-84 Years	**0.537**	0.860
85-89 Years	0.664	0.749
90-94 Years	0.797	0.626
95+ Years	0.816	0.456
Male		
0-34 Years	0.155	1.049
35-44 Years	0.190	1.074
45-54 Years	0.221	1.008
55-59 Years	0.271	1.055
60-64 Years	0.303	1.039
65-69 Years	0.300	1.269
70-74 Years	0.379	1.323
75-79 Years	0.466	1.331
80-84 Years	0.561	1.189
85-89 Years	0.694	1.129
90-94 Years	0.857	0.964
95+ Years	0.976	0.781
Medicaid and Originally Disabled Interactions with Age and Sex		
Medicaid		0.062
Originally Disabled_Female	0.244	
Originally Disabled_Male	0.152	

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The Conditions and their Risk Factors

Disease	Coefficients	Community (non-Dual disabled)	Institutional
HCC1	HIV/AIDS	0.288	1.747
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.532	0.346
HCC6	Opportunistic Infections	0.704	0.580
HCC8	Metastatic Cancer and Acute Leukemia	2.644	1.143
HCC9	Lung and Other Severe Cancers	0.927	0.727
HCC10	Lymphoma and Other Cancers	0.656	0.401
HCC11	Colorectal, Bladder, and Other Cancers	0.352	0.293
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.202	0.199
HCC17	Diabetes with Acute Complications	0.371	0.441
HCC18	Diabetes with Chronic Complications	0.371	0.441
HCC19	Diabetes without Complication	0.128	0.160
HCC21	Protein-Calorie Malnutrition	0.753	0.260
HCC22	Morbid Obesity	0.227	0.511
HCC86	Acute Myocardial Infarction	**0.306**	0.497
HCC170	Hip Fracture/Dislocation	**0.513** -	0.000

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Disease Interactions

Disease Interactions	Description	Community(non-Dual/Dis)	Institutional
CANCER_IMMUNE	Cancer*Immune Disorders	0.675	-
CHF_COPD	Congestive Heart Failure*Chronic Obstructive Pulmonary Dis	0.096	0.154
CHF_RENAL	Congestive Heart Failure*Renal Disease	0.493	-
COPD_CARD_RESP_FAIL	Chronic Obstructive Pulmonary Disease*Cardioresp Failure	0.256	0.423
COPD_ASP_SPEC_ BACT_PNEUM	COPD*Aspiration and Specified Bacterial Pneumonias	-	0.254
SCHIZOPHRENIA_CHF	Schizophrenia*Congestive Heart Failure	-	0.173
SCHIZOPHRENIA_COPD	Schizophrenia*Chronic Obstructive Pulmonary Disease	-	0.363
SEPSIS_ASP_SPEC_ BACT_PNEUM	Sepsis*Aspiration and Specified Bacterial Pneumonias	-	0.321
ETC			

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Disabled Interactions

(Disabled & Disease)

Disabled/Disease Interactions	Description	Community(non-Dual/Dis)	Institutional
DISABLED_HCC6	Disabled, Opportunistic Infections	-	0.277
DISABLED_HCC39	Disabled, Bone/Joint Muscle Infections/Necrosis	-	0.567
DISABLED_HCC77	Disabled, Multiple Sclerosis	-	0.425
DISABLED_HCC85	Disabled, Congestive Failure	-	0.321
DISABLED_HCC161	Disabled, Chronic Ulcer of the Skin, Except Pressure Ul	-	0.369
DISABLED_PRESS_ULCER	Disabled, Pressure Ulcer	-	0.608

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Hierarchies

Table 4. Disease Hierarchies for the 2017 CMS-HCC Model

Hierarchical Condition Category (HCC)	If the HCC Label is listed in this column…	…Then drop the HCC(s) listed in this column
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28,29,80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
54	Drug/Alcohol Psychosis	55
57	Schizophrenia	58
70	Quadriplegia	71,72,103,104,169
71	Paraplegia	72,104,169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83,84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87,88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Cerebral Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107,108,161,189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135,136,137
135	Acute Renal Failure	136,137
136	Chronic Kidney Disease (Stage 5)	137
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158,161
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	161
166	Severe Head Injury	80,167

New Enrollee Factors - Aged & Disabled

(There are Different Factors for Chronic Condition SNPs)

Table 2. 2017 CMS-HCC Model Relative Factors for Aged and Disabled New Enrollees

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.644	0.985	-	-
35-44 Years	0.936	1.221	-	-
45-54 Years	1.035	1.337	-	-
55-59 Years	1.004	1.342	-	-
60-64 Years	1.122	1.438	-	-
65 Years	0.522	1.059	1.130	1.566
66 Years	0.516	0.946	1.167	1.619
67 Years	0.544	0.946	1.167	1.619
68 Years	0.581	0.946	1.167	1.619
69 Years	0.605	0.946	1.167	1.619
70-74 Years	0.674	0.975	1.167	1.619
75-79 Years	0.892	1.092	1.167	1.619
80-84 Years	1.066	1.395	1.167	1.619
85-89 Years	1.324	1.458	1.167	1.619
90-94 Years	1.324	1.678	1.167	1.619
95 Years or Over	1.324	1.678	1.167	1.619
Male				
0-34 Years	0.456	0.766	-	-
35-44 Years	0.665	1.095	-	-
45-54 Years	0.834	1.357	-	-
55-59 Years	0.889	1.422	-	-
60-64 Years	0.923	1.582	-	-
65 Years	0.514	1.201	0.790	1.613
66 Years	0.533	1.208	0.957	1.613
67 Years	0.575	1.208	1.005	2.202
68 Years	0.641	1.208	1.074	2.202
69 Years	0.671	1.311	1.398	2.202
70-74 Years	0.776	1.311	1.398	2.202
75-79 Years	1.040	1.361	1.398	2.202
80-84 Years	1.270	1.603	1.398	2.202
85-89 Years	1.511	1.850	1.398	2.202
90-94 Years	1.511	1.850	1.398	2.202
95 Years or Over	1.511	1.850	1.398	2.202

Risk Score Example

(Using 2017 HCC Model for 2019 Payments)

- **Risk Score Example: Mrs. Jones**
  - 81 years old, Resides in her home
  - Original reason for entitlement is Aged
  - Not Medicaid eligible
  - Plan submitted six diagnostic codes with dates of service during last year
    - Acute Myocardial Infarction – 410.21, 410.41, 410.91
    - Hip Fracture – 821.00, 821.10, 821.20
- **Which model applies?**
  - Part C CMS-HCC
- **Which risk factors apply?**
  - Community (non-Dual)
  - Female 80-84 years old = ***0.537***
  - ICD-9 410.21, 410.41, 410.91 map to HCC 86 Acute Myocardial Infarction = ***0.306***
  - ICD-9 821.00, 821.10, 821.20 map to HCC 170 Hip Fracture/Dislocation = ***0.513***
- **What is her raw risk score?**
  - ***0.537+0.306+0.513 = 1.356***
- **Final Adjustments to 2017HCC Model Score for CY2019 Payments:**
  - **Apply Coding Pattern Differences & FFS Normalization**
  - ***1.356 x 0.9410 / 1.041 = 1.2257***
- ***In practice this will be developed once from RAPS data with the 2017 HCC Model and once from EDS data using the 2019 HCC Model and blended 75%/25%***

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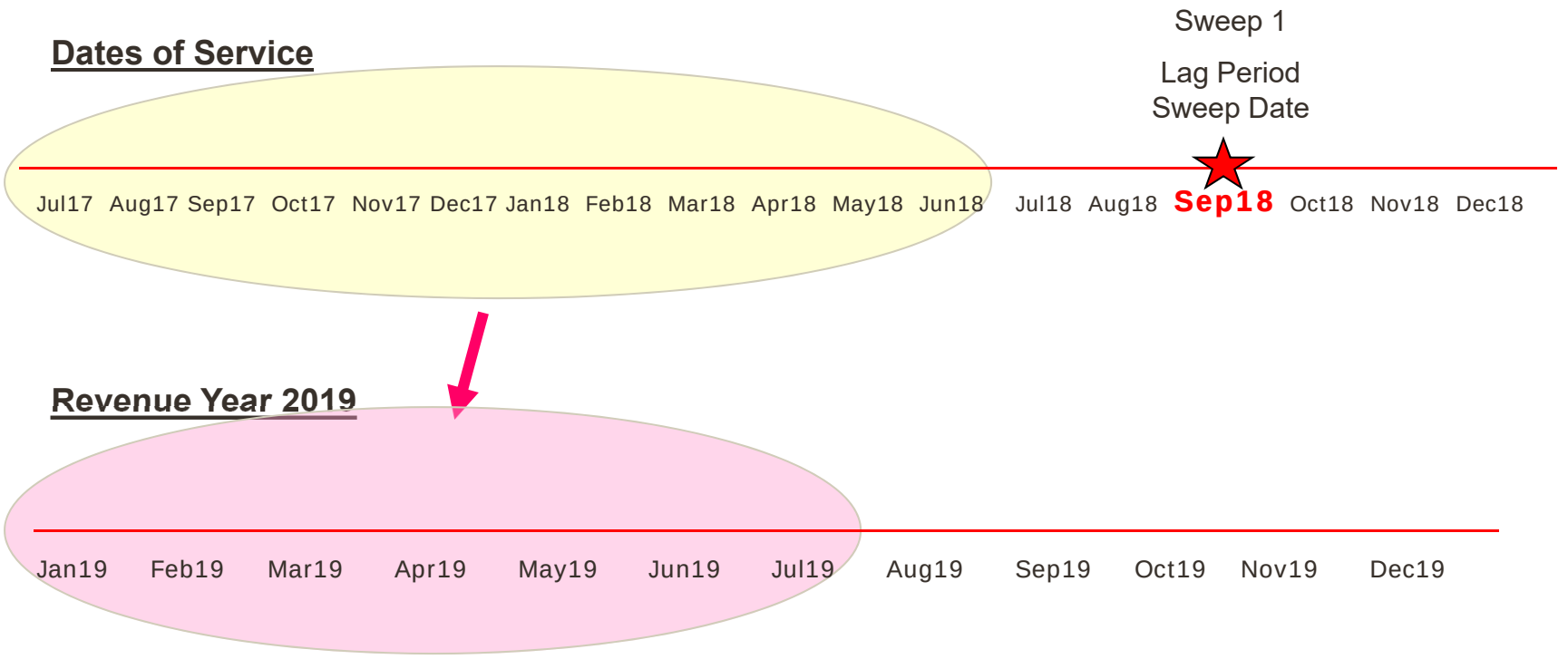
Revenue Payments

(January through July)



Ultimately, CY 2019 revenue will be based on diagnosis codes from services that were incurred in CY 2018. However, starting in January 2019, the Risk Scores and the associated CMS revenue are estimated based upon a lagged time period (July 2017-June 2018) due to data availability.

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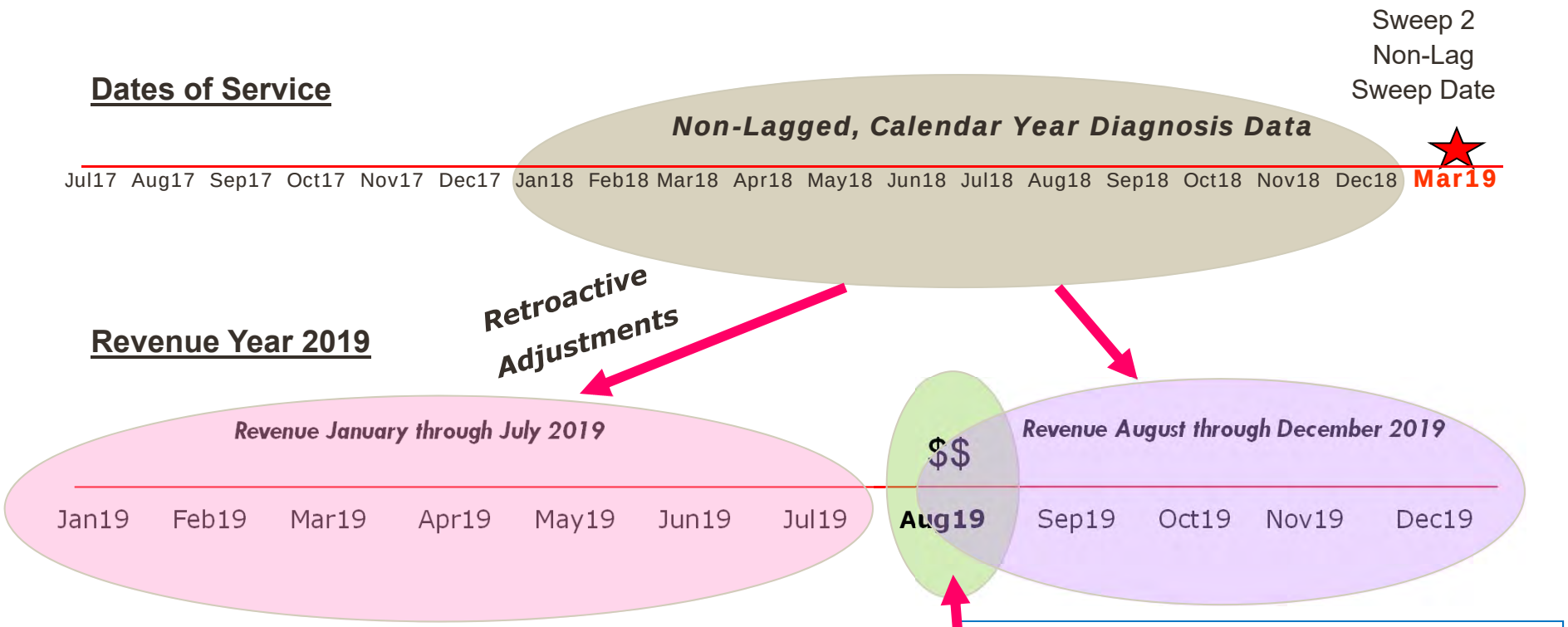
Revenue Payments

(August through December)



In August of the 2019 Revenue Year, CMS will switch from lagged to non-lagged diagnosis data. CMS will restate the risk scores for the 1st seven months of the year based on the updated data. This will generate a lump sum positive or negative payment between CMS and the Company. In addition, all monthly payments going forward for the rest of the year will be based on the non-lagged calendar year data.

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Revenue Payments

(Final Adjustment)

- In August of the year after a "Revenue Year" (August 2020 for Revenue Year 2019), CMS will make one final true-up payment and restatement of risk scores to account for any diagnosis codes that were incurred in CY2018 that were reported to CMS by 1/31/20
- Companies get more than a full year of opportunity to report run-out .
- This provides opportunities for companies to perform retroactive initiatives to ensure correct diagnosis reporting.

Projecting Risk Scores

(CMS Preferred Methodology for Bid Development)

- **Two Sources of starting risk score data (both provided by CMS)**
  - Beneficiary-Level File containing 12 months of 2017 membership with retroactive enrollment and retroactive status adjustments (Most Common).
  - Plan-level data for the July 2017 enrollee cohort that reflects retroactive enrollment and retroactive status adjustments.
- **Advantages of Using 2017 Risk Scores from CMS as base:**
  - Consistent with the base period medical expenses
  - Requires no adjustment for seasonality since the values reflect CY2017 (or avg. for 2017)
  - Reflects complete CY2016 diagnosis data through final 1/31/18 submission.
  - CMS adjusts the risk scores to reflect the latest risk score models (2017 HCC Model & 2019 HCC Model)
  - Do not need to reflect:
    - Transition from lagged to non-lagged
    - Incomplete reporting of diagnosis data
    - Seasonality

Projecting Risk Scores

(CMS Preferred Methodology Sample Calculation)

2019 MA Risk Score Development Illustration

Risk Score Element	RAPS Data 2017 HCC Model	EDS Data 2019 HCC Model
A Starting Data	1.1000	1.0900
B Covert to Raw - remove normalization	n/a	n/a
C Covert to Raw - remove Coding Pattern Adjustment	n/a	n/a
D Plan Specific Coding Trend	1.0404	1.0404
E Starting Data Adjustments (i x ii x iii below)	n/a	n/a
i) Transition from lagged to non-lagged diagnosis data	n/a	n/a
ii) Incomplete reporting of diagnosis data	n/a	n/a
iii) Seasonality	n/a	n/a
F Other Plan Specific Data Adjustment (Population)	1.0000	1.0000
G Risk Model Adjustment (i x ii / iii below)	1.0100	1.0150
i) Raw 2014 HPMS Posted Data	n/a	n/a
ii) Missing diagnosis adjustment	n/a	1.0150 *
iii) Raw 2013 HPMS Posted Data	n/a	n/a
H Raw Risk Score	1.1559	1.1510
I MA Coding Pattern Adjustment	0.9410	0.9410
J Normalization Factor (must calibrate to denominator year; divide)	1.041	1.038
K Frailty Factor	0.0000	0.0000
L Interim Risk Score (H x I / J + K)	1.0448	1.0435
M Weight	75%	25%
N Final Weighted Risk Score		**1.0445**

The CMS provided Beneficiary-Level files have these starting risk score for each member once from RAPS and FFS data using the 2017 HCC Model and again from EDS and FFS data using the 2019 HCC Model.

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Projecting Risk Scores
(Alternate Methodology)

- Used for plans with limited or no enrollment during the base period. May also be appropriate if there were significant changes to the plan or enrollment characteristics since the base period.

- For example for the 2019 bids, if there was a plan that was new in 2017 (base year) that had very little enrollment in 2017; however, it had a significant enrollment increase for January 2018. In this case, you will likely have reliable risk scores from the CMS Monthly Membership Report (MMR) for January 2018 through March 2018 when you are preparing your 2019 bids.

- Must take care to understand base period population in connection with the 2017 medical costs, and make any necessary medical expense pricing adjustments to reflect the early 2018 population from which risk scores (and hence revenues) are being projected.

Projecting Risk Scores

(Alternative Methodology Likely Adjustments)

- **Conversion to a "Raw" Risk Score-** MMR risk scores reflects FFS Normalization and Coding Pattern Adjustments for the data year. Need to back this out.
- **Impact of Lagged vs. Non-Lagged Diagnosis Data-** If using MMR risk scores from first quarter of 2018, which are based on 6 month lagged diagnosis codes, then will need to adjust to reflect what those risk scores will actually look like once the risk scores are restated to reflect the non-lagged risk score which will be based on calendar year 2017 diagnoses.
- **Run-out of Diagnosis Data** (submissions of diagnoses through January 2019)
- **Seasonality-** often see a decline in risk scores throughout the year as members with higher risk scores may pass away and new entrants usually have lower risk scores.
- **Risk Model Change** (2018 MMR is based on the 2017 HCC Model, which for 2019 is not the same model)
- **Plan Specific Coding Trend**
- **Population Changes**
- **Convert back to a "Payment" Risk score-** by adjusting for the FFS Normalization and Coding Pattern Difference factors for CY2019 Payments

Projecting Risk Scores

(Alternative Methodology Sample Calculation)

2019 MA Risk Score Development Illustration

Risk Score Element		Jan-Mar 2018 RS from MMR File
A Starting Data (from MMR – not split by RAPS/EDS or 2017 and 2019 HCC Models)		1.0376
B Covert to Raw - remove FFS Normalization (CY2017 HCC Model for 2018 pay)		1.017 multiply
C Covert to Raw - remove Coding Pattern Adjustment		0.9409 divide
D Plan Specific Coding Trend (one year)		1.0200
E Starting Data Adjustments (i x ii x iii below)		1.0160
i) Transition from lagged to non-lagged diagnosis data	*1.0180*	
ii) Incomplete reporting of diagnosis data	*1.0250*	
iii) Seasonality	*0.9737*	
F Other Plan Specific Data Adjustment (Population)		1.0000
G Risk Model Adjustment (MMR based on 2017HCC)		1.0230
H Projected Raw Risk Score		1.1890
I MA Coding Pattern Adjustment		0.9410
J Normalization Factor (75% of 1.041 & 25% of 1.038)		1.04025
K Frailty Factor		0.0000
L Final Risk Score (H x I / J + K)		1.0755

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Risk Score Projection

(Coding Trends: Retrospective Initiatives)

Use vendors or internal resources to identify "suspected opportunities" for missed diagnosis codes (i.e. look back at the diagnoses that you already have and see if anything seems to be missing). For example, if a member has been a diabetic for the last 5 years, but no diagnosis for diabetes is in the current year claims, then check the medical record for evidence of diabetes.

- Usually involves an on-site visit to the physician's office to check the medical record for recorded diagnoses that were not submitted on the claim form. Process gets easier as electronic medical records evolve.
- Sample timeframe: For the 2017 revenue year which is based on 2016 diagnoses, on-site visits usually occur during the second half of 2017 so that diagnoses can be submitted by the final RAPS submission on 1/31/18.
- **Critical to consider these initiatives when projecting risk scores.**

Risk Score Projection

Coding Trends: Prospective Initiatives

Often utilizes vendors to send a physician or nurse to a member's home to perform a Health Risk Assessment to identify potentially undiagnosed conditions. Usually uses a predictive algorithm to identify likely candidates.

- An actual claim is created and since it is a face-to-face visit between a health practitioner and the member, any identified diagnoses can be used for risk adjustment.
- Sample timeframe: For the 2017 revenue year which is based on 2016 diagnoses, a health practitioner would have needed to visit someone in their home during 2016 for it to impact 2017 revenue.
- **Critical to consider these initiatives when projecting risk scores.**

Risk Score Projection

Risk Score Credibility

CMS MA Risk Score Credibility Guidelines

- 3,600 MM for full credibility
- Formula = square-root of (base period MM / 3,600)

Choice of Manual Rate Risk Score

- Manual rate risk score must be shown to have similar characteristics to the projected experience rate risk score
- Essentially, the manual rate reflects the claims and risk scores for the same set of risks as the experience rate
- ASOP #25, Paragraph 3.3 – "The actuary should use care in selecting the related experience that is to be blended with the subject experience. Such related experience should have frequency, severity, or other determinable characteristics that may reasonably be expected to be similar to the subject experience."