

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Wednesday, June 08, 2011 3:33 PM
To: Scott, John A. (CMS/CM); Creighton, Sean M. (CMS/CPC); Kornfield, Thomas (CMS/CPC)
Cc: Rice, Cheri M. (CMS/CPC)
Subject: RE: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)
Attachments: MA coding in Advance Notices and Announcements.doc

We have the summary of our findings and methodology from the 2010 Advance Notice and Announcement. (b)(5)
(b)(5) (Attached is MA coding language in Advance Notices and Announcements, through the
2011 Advance Notice (b)(5)

(b)(5)

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

From: Scott, John A. (CMS/CM)
Sent: Wednesday, June 08, 2011 3:29 PM
To: Creighton, Sean M. (CMS/CPC); Paul, Rebecca (CMS/CM); Kornfield, Thomas (CMS/CPC)
Cc: Rice, Cheri M. (CMS/CPC)
Subject: Fw: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)
Importance: High

(b)(5)

John

From: Stickell, Michele W. (CMS/CM)
Sent: Wednesday, June 08, 2011 03:24 PM
To: Scott, John A. (CMS/CM)
Subject: FW: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)

(b)(5)

From: Jones, Tavonia L. (CMS/OSORA)
Sent: Monday, June 06, 2011 2:05 PM
To: Jones, Tavonia L. (CMS/OSORA); Ahern, Robert (CMS/CM); Altman, Jessica (HHS/OCHIO); Andrews, Danielle Y. (CMS/OCSQ); Aragona, Elizabeth A. (CMS/OFM); August, Kimberly J. (CMS/CM); Aversa, Cheryl A. (CMS/CPC); Bauer, Christian J. (CMS/CM); Borys, Carol M. (CMS/MC); Boutte, Jeffrey P. (CMS/COO); Brewer, Ryan (CMS/OIS); Brown, Angela (CMS/OCSQ); Brown, Deborah J. (CMS/OL); Brown-Jones, Shanterri M. (CMS/OCSQ); Carmichael, Wanda E. (CMS/OFM); Cocchiara, John V. (CMS/CMHPO); Cones, Kenneth (CMS/OL); Cording, Kristina (CMS/OIS); Curtis, Catherine A. (CMS/OACT); Dibella, Michael E. (CMS/CM); Dinicola, Kelly A. (CMS/OEA); Farran, Patti A. (CMS/CMM); Francis, Shelis

V. (CMS/OFM); Franey, Maribel R. (CMS/OIS); Gange, Laura K. (CMS/OESS); Gelzer, Heidi J. (CMS/OFM); Gleimer, Anita (CMS/CPC); Grant, Monica (CMS/CPI); Grayson, April (CMS/CPC); Gurule, Roman (HHS/OCIIO); Held, William J. (CMS/CM); Helphenstine, Patricia J. (CMS/CMCS); Holmes, Tawanda (CMS/CM); Hughes, Paul J. (CMS/OSORA); Hutchinson, Barbara A. (CMS/OOM); Israel, Stormie (CMS/CPI); Johnson, Twanda B. (CMS/OEA); Johnson-James, Denise A. (CMS/CM); Jones, Greg A. (CMS/OL); Kelahan, Jean (CMS/CMHPO); Kerr, James T. (CMS/CMHPO); Ketcham, Michelle B. (CMS/CPC); Khalid, Zunaira (CMS/OL); Koepke, Christopher P. (CMS/OEABS); Kraft, Sandra L. (CMS/COO); Land, Marni B. (CMS/COO); Malcolm, Marissa (CMS/OFM); Massey, Beverly A. (CMS/OL); McCann, Susan A. (CMS/CMM); McNeill, Serrick A. (CMS/CPC); Meyers, Anna C. (CMS/CMCS); Moreno, Cynthia E. (CMS/CPI); Mosby, Tyritta T. (CMS/OA); Nishimoto, Kristy L. (CMS/CM); Ohata, Lauren (HHS/OCIIO); Pearson, Annette M. (CMS/CMCS); Peterson, Katrina (CMS/CMMI); Porras, Jessica (CMS/OEABS); Powell, Reginald (CMS/COO); Pryor, Karla C. (CMS/COO); Reilly, Megan C. (CMS/OBIS); Rowry, Flosetta L. (CMS/CM); Scott, John A. (CMS/CM); Smith, Kathryn (CMS/CSP); Squire, Angelic M. (CMS/OA); Starinsky, Melissa (CMS/OAGM); Voorhees, John S. (CMS/OEA); Walker, Wynethea N. (CMS/OSORA); Wallace, Mary H. (CMS/OBIS); Weaver, Mary Carol (CMS/CSP); Williams, Jackson (CMS/OSORA); Worrall, Chris M. (CMS/CM)
Cc: Creighton, Sean M. (CMS/CPC); Kornfield, Thomas (CMS/CPC); Rice, Cheri M. (CMS/CPC); McNearney, Joe (HHS/ASL); Stansbury, Kevin S. (CMS/OL); Dibella, Michael E. (CMS/CM)

Subject: RE: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)

Good afternoon,

The GAO exit conference titled, ***“Medicare Advantage Diagnostic Coding”*** (Job Code 290782), has been rescheduled for a new date and time. This conference will take place **Friday, June 10, 2011 @ 2:00 PM** in conference room C-113. Please forward this email to anyone I may have missed. I do apologize for the inconvenience.

Thank you.

From: Jones, Tavonia L. (CMS/OSORA)

Sent: Thursday, June 02, 2011 2:02 PM

Cc: Creighton, Sean M. (CMS/CPC); Kornfield, Thomas (CMS/CPC); Rice, Cheri M. (CMS/CPC)

Subject: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)

Importance: High

GAO Exit conference: **Medicare Advantage Diagnostic Coding** (Job Code 290782) **Previous title: Medicare Advantage Payments**

An exit conference has been scheduled for the GAO study titled ***“Medicare Advantage Diagnostic Coding”*** (Job Code 290782). This conference will take place **Wednesday, June 15, 2011 @ 2:00 PM** in conference room C-110 in Baltimore. Please email participants names to Tavonia.jones@cms.hhs.gov by Noon, **Thursday, June 9, 2011**. GAO’s job start notice from the entrance conference is attached. Thank you.

Lead: CM-CPC

Tavonia L. Jones

Division of Audit Liaison

Office of Strategic Operations and Regulatory Affairs (OSORA)

Centers for Medicare & Medicaid Services (CMS)

Desk: 410-786-0105

Fax: 410-786-5768

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Rice, Cheri M. (CMS/CPC)
Sent: Wednesday, February 03, 2010 3:24 PM
To: Creighton, Sean M. (CMS/CPC); PAUL, REBECCA (CMS/CPC); Moseley, Deondra S. (CMS/CPC)
Subject: FW: Medicare Advantage 2011 Rate Preview
Attachments: MA_45-day_Notice_Preview_2-03-10[1].pdf

>-----Original Message-----

>From: Hill, Timothy B. (CMS/CPC)
>Sent: Wednesday, February 03, 2010 3:15 PM
>To: Rice, Cheri M. (CMS/CPC); Hutchinson, Thomas E. (CMS/CDHPC)
>Subject: FW: Medicare Advantage 2011 Rate Preview

>

>

>

>-----Original Message-----

>From: Sutton, Erin (CMS/OA)
>Sent: Wednesday, February 03, 2010 3:11 PM
>To: Hill, Timothy B. (CMS/CPC)
>Subject: FW: Medicare Advantage 2011 Rate Preview

>

>

>

>>-----Original Message-----

>>From: Hall, Amy (CMS/OL)
>>Sent: Wednesday, February 03, 2010 11:49 AM
>>To: Blum, Jonathan D. (CMS/OA)
>>Cc: Sutton, Erin (CMS/OA)
>>Subject: FW: Medicare Advantage 2011 Rate Preview

>>

> (b)(5)

>>

>>>-----Original Message-----

>>>From: Brown, Ruth [mailto:Ruth.Brown@mail.house.gov]
>>>Sent: Wednesday, February 03, 2010 11:38 AM
>>>To: Hall, Amy (CMS/OL)
>>>Cc: Brooks-LaSure, Chiquita; Bjorklund, Cybele
>>>Subject: FW: Medicare Advantage 2011 Rate Preview

>>>

>>>Hi Amy - we're starting to hear noise about the Advance Notice. Can

>>>we have a quick convo about what to expect?

>>>

>>>

>>>

>>>-----Original Message-----

>>>From: Brian D. Fortune [mailto:bfortune@marwoodgroup.com]

>>>Sent: Wednesday, February 03, 2010 10:34 AM

>>>Subject: Medicare Advantage 2011 Rate Preview

>>>

>>(b)(5)



>>

>>

>>>

>>> _____

>>>

>>>From: Marwood Group Research [mailto:asantangelo@marwoodgroup.com]

>>>Sent: Wed 2/3/2010 10:17 AM

>>>To: Brian D. Fortune

>>>Subject: Medicare Advantage 2011 Rate Preview

>>>

>>>

>>>(b)(5)



>>>

>>>

>>>

>>>

>>>(b)(5)



>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>(b)(5)



>>>

>>>(b)(5)

>>>

>>>

>>>

>>>

>>>

>>>

>>>

>>>Our attached report

>>><<http://www.capmarkets.com/ViewFile.asp?ID1=34291&ID2=210545258&ssid=>

>>>3 & d

>>>irectory=10969&bm=0&filename=MA_45-day_Notice_Preview_2-03-10.pdf>

>>>contains a detailed preview of the elements of the 45-day letter.

>>>Please contact Alison Santangelo at (212) 532-3651 with questions.

>>>

>>>

>>>

>>>Marwood Group

>>>

>>>733 Third Avenue

>>>

>>>New York, NY 10017

>>>

>>>(212) 532-3651

>>>

>>>

>>>If you experience difficulty clicking on the above link, please paste

>>>the following URL into your browser.

>>><http://www.capmarkets.com/ViewFile.asp?ID1=34291&ID2=210545258&ssid=3>

>>>& d i

>>>rectory=10969&bm=0&filename=MA_45-day_Notice_Preview_2-03-10.pdf

>>>

>>>

>>>The information herein is provided for informational purposes only.

>>>The information herein is not intended to be, nor should it be relied

>>>upon in any way, as investment advice to any individual person,

>>>corporation, or other entity. This information should not be

>>>considered a recommendation or advice with respect to any particular

>>>stocks, bonds, or securities or any particular industry sectors and

>>>makes no recommendation whatsoever as to the purchase, sale, or

>>>exchange of securities and investments. Reference herein to any

>>>specific commercial products, process, or service by trade name,

>>>trademark, manufacturer, or otherwise, does not necessarily
>>>constitute or imply its endorsement, recommendation, or favoring by
>>>Marwood Group
>Research, LLC ("Marwood").
>>>
>>>All information contained herein is provided "as is" without warranty
>>>of any kind. While an attempt is made to present appropriate factual
>>>data from a variety of sources, no representation or assurances as to
>>>the accuracy of information or data published or provided by third
>>>parties used or relied upon contained herein is made. Marwood makes
>>>no representations and disclaims all express, implied and statutory
>>>warranties of any kind, including any warranties of accuracy,
>>>timeliness, completeness, merchantability and fitness for a
>>>particular purpose.
>>>
>>>Neither Marwood nor its affiliates shall be liable to any other
>>>entity or individual for any loss of profits, revenues, trades, data
>>>or for any direct, indirect, special, punitive, consequential or
>>>incidental loss or damage of any nature arising from any cause
>>>whatsoever, even if Marwood has been advised of the possibility of
>>>such damage. Marwood and its affiliates shall have no liability in
>>>tort, contract or otherwise to any third party. The copyright for any
>>>material created by the author is reserved. The information herein is
>>>proprietary to
>Marwood.
>>>Any duplication or use of such material is not permitted without the
>>>author's written agreement.
>>>
>>>(c) 2010 Marwood Group Research, LLC
>>>
>>>
>>>
>>>
>>>
>>>
>>>-----
>>>This message (including any attachments) contains confidential
>>>information intended for a specific individual and purpose, and is
>>>protected by law. If you are not the intended recipient, you should
>>>delete this message. The information contained hereinafter may be
>>>proprietary, confidential, privileged and exempt from disclosure
>>>under applicable law. If the reader of this e-mail is not the
>>>intended recipient or agent responsible for delivering the message to

>>>the intended recipient, the reader is hereby put on notice that any
>>>use, dissemination, distribution or copying of this communication is
>>>strictly prohibited. If the reader has received this communication in
>>>error, please immediately notify the sender by telephone or by
>>>e-mail, and delete all copies of this e-mail and any attachments. Thank you.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Wednesday, April 04, 2012 7:09 PM
To: Decastro, Rebecca (CMS/CM)
Subject: MA coding paper & other documents
Attachments: Kronick Manuscript 10 8 09.docx; Manuscript.pdf; CMS_codingintensity_20090929.xlsx; MA coding in Advance Notices and Announcements.doc; calculating difference factor.xls

(b)(5)



Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Thursday, December 20, 2012 5:15 PM
To: Harlow, Jennifer A. (CMS/CM); Chaudhuri, Iina (CMS/CM); Decastro, Rebecca (CMS/CM); Franzel, Ashley S. (CMS/CM); Johnson, Whitney S. (CMS/CM)
Subject: MA coding in Advance Notices and Announcements.doc
Attachments: MA coding in Advance Notices and Announcements.doc

For reference, attached is my collection of MA coding discussions, as addressed in Advance Notice and Announcements over the years.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Friday, November 30, 2012 3:04 PM
To: Kapustij, Carolyn (CMS/CPC)
Subject: Advance Notice and Announcement text related to MA coding
Attachments: MA coding in Advance Notices and Announcements.doc

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: PAUL, REBECCA (CMS/CPC)
Sent: Tuesday, March 09, 2010 10:22 AM
To: Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Moseley, Deondra S. (CMS/CPC)
Subject: MA coding in Advance Notices and Announcements.doc
Attachments: MA coding in Advance Notices and Announcements.doc

For your reference... MA coding text in all Advance Notices and Announcements, updated with 2011 Advance Notice MA coding text.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Wednesday, February 02, 2011 4:13 PM
To: Moseley, Deondra S. (CMS/CPC); Kornfield, Thomas (CMS/CPC); Uebersax, Julie (CMS/CM); Hornsby, Anne M. (CMS/CM)
Subject: SGR in ratesetting
Attachments: FW: Can I see a copy of this, please? Seems like it's from sometime in March 2009; FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)

FYI to all.

Rebecca Paul
Medicare Plan Payment Group
Center for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: PAUL, REBECCA (CMS/CPC)
Sent: Sunday, January 17, 2010 6:11 PM
To: Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)
Subject: RE: coding
Attachments: MA coding in Advance Notices and Announcements.doc

(b)(5)



From: Rice, Cheri M. (CMS/CPC)
Sent: Sat 1/16/2010 2:29 PM
To: PAUL, REBECCA (CMS/CPC); Creighton, Sean M. (CMS/CPC)
Subject: coding

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Uebersax, Julie (CMS/CM)
Sent: Thursday, February 07, 2013 3:58 PM
To: Kornfield, Thomas (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

Julie A. Uebersax

Special Assistant
Medicare Plan Payment Group (MPPG)
Center for Medicare (CM)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd | Baltimore, Maryland 21244
☐: C1-13-26 | ☎: 410.786.9284 | ✉: julie.uebersax@cms.hhs.gov

Information not releasable to the public unless authorized by law: The information transmitted has not been publicly disclosed and may be privileged and confidential. It is intended only for the person or entity to which it is addressed and must not be disseminated, distributed, or copied to persons not authorized to receive it. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete it without reading it. Also, please notify the sender that you have received this communication in error. Your receipt of this message is not intended to waive any applicable privilege.

From: Uebersax, Julie (CMS/CM)
Sent: Thursday, February 07, 2013 3:47 PM
To: Rice, Cheri M. (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Julie A. Uebersax

Special Assistant
Medicare Plan Payment Group (MPPG)
Center for Medicare (CM)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd | Baltimore, Maryland 21244
☐: C1-13-26 | ☎: 410.786.9284 | ✉: julie.uebersax@cms.hhs.gov

Information not releasable to the public unless authorized by law: The information transmitted has not been publicly disclosed and may be privileged and confidential. It is intended only for the person or entity to which it is addressed and must not be disseminated, distributed, or copied to persons not authorized to receive it. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete it without reading it. Also, please notify the sender that you have received this communication in error. Your receipt of this message is not intended to waive any applicable privilege.

From: Szefflinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:13 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Don already sent this to Sean. f

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 10:35 AM
To: Szefflinski, Francis C. (CMS/CPC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

FYI- I found it.

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:35 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) ; McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

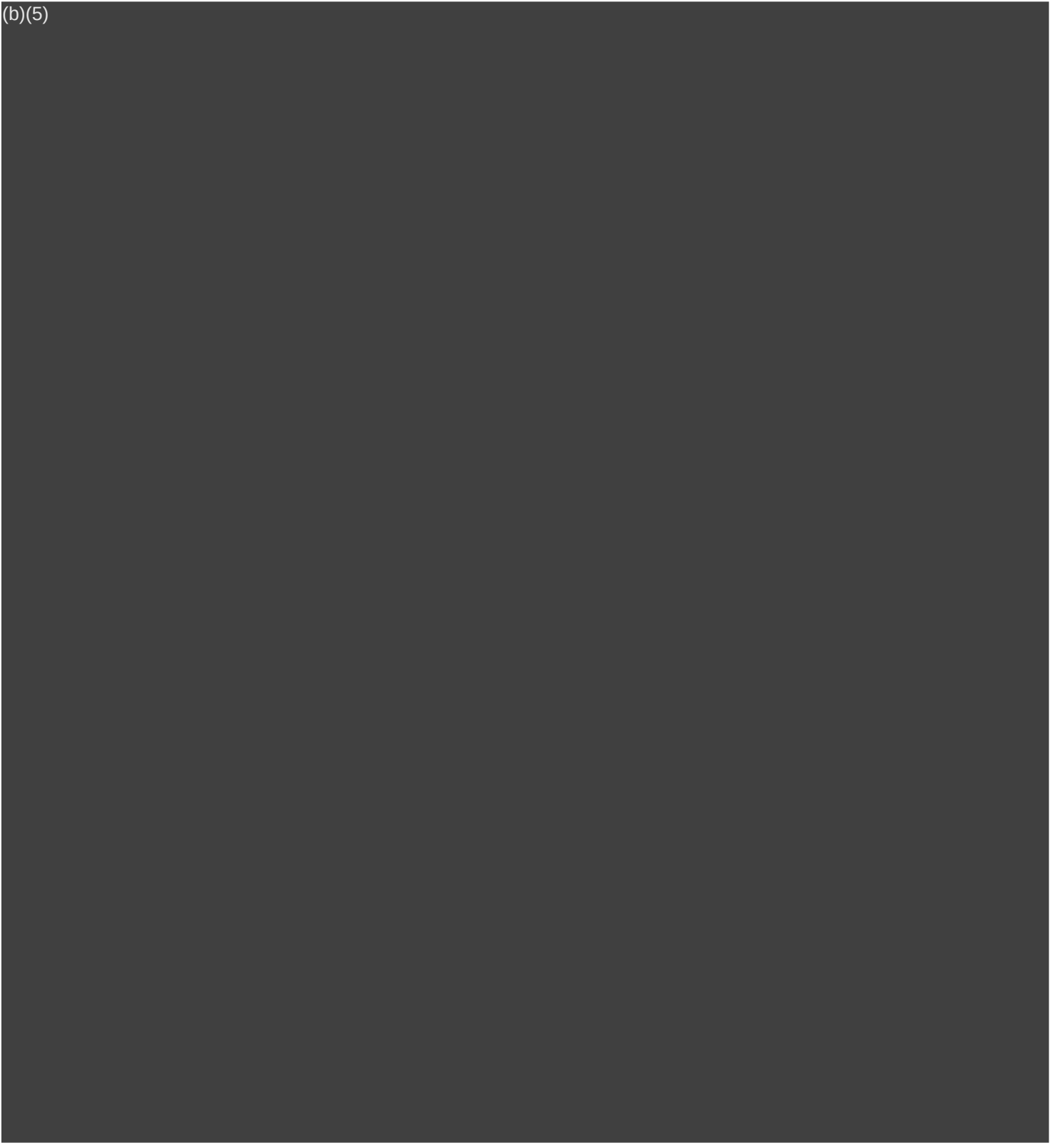


Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)
To: Don Kosin (b)(6) ; McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Sent: Wed Mar 25 17:16:34 2009
Subject: RE: 45 day notice and call letter re: MA rate adjustments

Don,

(b)(5)



Richard S. Foster
Chief Actuary

Paul I. Spitalnic
Director, PC DAG

Solomon M. Mussey
Director, MMCEG

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6) ; [Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)

Sent: Tuesday, March 24, 2009 10:47 PM

Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>

To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)

Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>

Sent: Tue Mar 24 19:29:02 2009

Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Szeftlinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 2:23 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: Can I see a copy of this, please? Seems like it's from sometime in March 2009
Attachments: Joffe opinion - 3-13-09 growth assumptions and physician pay cut.pdf

From: Mark Joffe [<mailto:mjoffe@erols.com>]
Sent: Wednesday, February 02, 2011 12:22 PM
To: Szeftlinski, Francis C. (CMS/CPC)
Subject: RE: Can I see a copy of this, please? Seems like it's from sometime in March 2009

(b)(5)



From: Szeftlinski, Francis C. (CMS/CPC) [<mailto:Francis.Szeftlinski@cms.hhs.gov>]
Sent: Wednesday, February 02, 2011 2:10 PM
To: Mark Joffe
Subject: Can I see a copy of this, please? Seems like it's from sometime in March 2009

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:22 PM
To: Sands, Evan [USA]; Comer, Erin [USA]; Meyer, Mary Lynn [USA]
Cc: Jenkins, Samuel (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM); Smith, Jonathan (CMS/CM)
Subject: FW:
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 2 of 4 - CMS CY 2010 strategic planning deliverables

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)

>Sent: Friday, October 28, 2011 12:19 PM

>To: Pulley, Tobi A. (CMS/CDHPC)

>Cc: Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM)

>Subject:

>

>Tobi,

>

>Attached to this email are the items needed for next week's meeting with BAH.

>Advanced notice has been saved as a pdf. Please let me know if you

>need anything further or if you have questions.

>

>Thanks

>Sam

>

>

>Samuel B. Jenkins

>Centers for Medicare & Medicaid Services Medicare Plan Payment Group

>410-786-3261

>samuel.jenkins@cms.hhs.gov

>

>

McFarland, Bridget W. (CMS/OSORA)

From: Porter, Nancy K (IS) <Nancy.Porter@ngc.com>
Sent: Tuesday, September 06, 2011 5:15 PM
To: Hughes, Lateefah C. (CMS/CPC)
Subject: RE: CME085 audit cases.xlsx -- Please verify/clarify rules

Lateefah,

(b)(5)

A large rectangular area of the email body is redacted with a solid dark gray background.

Nancy

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Friday, September 02, 2011 4:48 PM
To: Porter, Nancy K (IS); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :Re: CME085 audit cases.xlsx -- Please verify/clarify rules

Hi Nancy,

(b)(5)

A large rectangular area of the email body is redacted with a solid dark gray background.

(b)(5)

Thanks,

Lateefah
Lateefah Hughes, Health Insurance Specialist
Division of Payment Validation
CMS/CPC/Medicare Plan Payment Group
410.786.2491
Lateefah.hughes@cms.hhs.gov

From: Hughes, Lateefah C. (CMS/CPC)
Sent: Friday, September 02, 2011 03:59 PM
To: 'Nancy.Porter@ngc.com' <Nancy.Porter@ngc.com>; 'Marilyn.Mattes@ngc.com' <Marilyn.Mattes@ngc.com>
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: Re: CME085 audit cases.xlsx

(b)(5)

Lateefah Hughes, Health Insurance Specialist
Division of Payment Validation
CMS/CPC/Medicare Plan Payment Group
410.786.2491
Lateefah.hughes@cms.hhs.gov

From: Porter, Nancy K (IS) [mailto:Nancy.Porter@ngc.com]
Sent: Friday, September 02, 2011 03:57 PM
To: Hughes, Lateefah C. (CMS/CPC); Mattes, Marilyn L (IS) <Marilyn.Mattes@ngc.com>
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

(b)(5)

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Friday, September 02, 2011 3:36 PM
To: Porter, Nancy K (IS); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :Re: CME085 audit cases.xlsx

Nancy,

(b)(5)

Lateefah

Lateefah Hughes, Health Insurance Specialist
Division of Payment Validation
CMS/CPC/Medicare Plan Payment Group
410.786.2491
Lateefah.hughes@cms.hhs.gov

From: Hughes, Lateefah C. (CMS/CPC)
Sent: Thursday, September 01, 2011 05:51 PM
To: Porter, Nancy K (IS) <Nancy.Porter@ngc.com>; Mattes, Marilyn L (IS) <Marilyn.Mattes@ngc.com>
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

Ok, thanks!

From: Porter, Nancy K (IS) [mailto:Nancy.Porter@ngc.com]
Sent: Thursday, September 01, 2011 5:24 PM
To: Hughes, Lateefah C. (CMS/CPC); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

Lateefah,

(b)(5)



Nancy

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Thursday, September 01, 2011 5:10 PM
To: Porter, Nancy K (IS); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :RE: CME085 audit cases.xlsx

Thanks Nancy,

(b)(5)



From: Porter, Nancy K (IS) [mailto:Nancy.Porter@ngc.com]
Sent: Thursday, September 01, 2011 4:31 PM
To: Hughes, Lateefah C. (CMS/CPC); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

Lateefah,

(b)(5)



Nancy

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Thursday, September 01, 2011 3:59 PM
To: Mattes, Marilyn L (IS); Porter, Nancy K (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :FW: CME085 audit cases.xlsx

Hello Nancy and Marilyn,

(b)(5)



Thanks,
Lateefah

McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:21 PM
To: Meyer, Mary Lynn [USA]; Comer, Erin [USA]; Sands, Evan [USA]
Cc: Hornsby, Anne M. (CMS/CM); Jenkins, Samuel (CMS/CM); Mierwald, Raymond (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Smith, Jonathan (CMS/CM)
Subject: FW: Items for the BAH meeting
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 1 of 4 - CMS deliverables for CY 2010 strategic planning

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Monday, October 31, 2011 9:22 AM
>To: Hughes, Lateefah C. (CMS/CPC)
>Cc: Pulley, Tobi A. (CMS/CDHPC); Mierwald, Raymond (CMS/CM)
>Subject: FW: Items for the BAH meeting
>
>Anne's PEDIR information is attached as well.



McFarland, Bridget W. (CMS/OSORA)

From: Harlow, Jennifer A. (CMS/CPC)
Sent: Monday, July 25, 2011 5:45 PM
To: Rice, Cheri M. (CMS/CPC); Scott, John A. (CMS/CM)
Subject: FW: request for a meeting

(b)(5)

Jennifer

From: Moreno, Cynthia E. (CMS/CPI)
Sent: Wednesday, July 20, 2011 6:33 PM
To: Harlow, Jennifer A. (CMS/CPC)
Cc: Kint, Carrie A. (CMS/CPI)
Subject: request for a meeting

Jennifer – (b)(5) May we schedule the meeting based on the availability on your calendar?

From: (b)(6), (b)(7)c (OIG/OI) [mailto:(b)(6), (b)(7)c@oig.hhs.gov]
Sent: Monday, July 18, 2011 6:37 PM
To: Knickman, Bobbie K. (CMS/CPI)
Cc: Martina Gilly
Subject:

Hi Bobbie,

(b)(5)

(b)(6), (b)(7)c

(b)(6), (b)(7)c

HHS/OIG/OI

(b)(6), (b)(7)c (phone)
(b)(6), (b)(7)c (fax)

Cynthia Moreno
410.786.1164

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Szefflinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:13 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

[Don already sent this to Sean.](#) f

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 10:35 AM
To: Szefflinski, Francis C. (CMS/CPC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

[FYI- I found it.](#)

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:35 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



(b)(5)

Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)

To: Don Kosin (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)

Sent: Wed Mar 25 17:16:34 2009

Subject: RE: 45 day notice and call letter re: MA rate adjustments

Don,

(b)(5)

(b)(5)

Richard S. Foster
Chief Actuary

Paul I. Spitalnic
Director, PCDAG

Solomon M. Mussey
Director, MMCEG

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6)
[Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)

Sent: Tuesday, March 24, 2009 10:47 PM

Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>

To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)

Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>

Sent: Tue Mar 24 19:29:02 2009

Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Hornsby, Anne M. (CMS/CM)
Sent: Wednesday, November 02, 2011 5:11 PM
To: Harlow, Jennifer A. (CMS/CPC)
Subject: FW: Items for the BAH meeting
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Categories: Red Category

>-----Original Message-----

>From: Pulley, Tobi A. (CMS/CDHPC)
>Sent: Monday, October 31, 2011 3:21 PM
>To: Meyer, Mary Lynn [USA]; Comer, Erin [USA]; Sands, Evan [USA]
>Cc: Hornsby, Anne M. (CMS/CM); Jenkins, Samuel (CMS/CM); Mierwald, Raymond (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Smith, Jonathan (CMS/CM)
>Subject: FW: Items for the BAH meeting

>

>Email 1 of 4 - CMS deliverables for CY 2010 strategic planning

>

>>-----Original Message-----

>>From: Jenkins, Samuel (CMS/CM)
>>Sent: Monday, October 31, 2011 9:22 AM
>>To: Hughes, Lateefah C. (CMS/CPC)
>>Cc: Pulley, Tobi A. (CMS/CDHPC); Mierwald, Raymond (CMS/CM)
>>Subject: FW: Items for the BAH meeting

>>

>>Anne's PEDIR information is attached as well.

McFarland, Bridget W. (CMS/OSORA)

From: Moreno, Cynthia E. (CMS/CPI)
Sent: Wednesday, July 20, 2011 6:33 PM
To: Harlow, Jennifer A. (CMS/CPC)
Cc: Kint, Carrie A. (CMS/CPI)
Subject: request for a meeting

Jennifer – (b)(5) May we schedule the meeting based on the availability on your calendar?

From: (b)(6), (b)(7)c (OIG/OI) [mailto:(b)(6), (b)(7)c@oig.hhs.gov]
Sent: Monday, July 18, 2011 6:37 PM
To: Knickman, Bobbie K. (CMS/CPI)
Cc: Martina Gilly
Subject:

Hi Bobbie,

(b)(5)

(b)(6), (b)(7)c

(b)(6), (b)(7)c

HHS/OIG/OI

(b)(6), (b)(7)c (phone)
(b)(6), (b)(7)c (fax)

Cynthia Moreno
410.786.1164

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Rice, Cheri M. (CMS/CPC)
Sent: Thursday, February 03, 2011 2:39 PM
To: Harlow, Jennifer A. (CMS/CPC); Scott, John A. (CMS/CM)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 2:37 PM
To: Blum, Jonathan D. (CMS/CM); Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Salters, Tony A. (CMS/OEA); Milgate, Karen (CMS/CSP); Brennan, Niall J. (CMS/OP)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:12 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:11 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Ashkenaz, Peter (CMS/OEABS)

Sent: Thursday, February 03, 2011 02:07 PM

To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Segal, Misha (CMS/OP)

Sent: Thursday, February 03, 2011 1:47 PM

To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Newsom, Mark (CMS/CM)
Sent: Wednesday, September 26, 2012 8:48 PM
To: Scott, John A. (CMS/CM); Abrams, Jill (HHS/OGC)
Cc: Corke, Victoria (HHS/OGC); Bucksten, William (CMS/CM); Bennett, Carol (HHS/OGC); Rice, Cheri M. (CMS/CM); Gover, Julie (CMS/CM); Johnson, Amanda S. (CMS/CPC); Chaudhuri, Ilina (CMS/CM)
Subject: RE: Fox administrative brief re: recon
Attachments: Announcement2010.pdf; 2010CallLetter.pdf; Advance2006.pdf; Announcement2006.pdf

(b)(5)

A large rectangular area of the document is redacted with a solid dark gray fill.

(b)(5)

A very large rectangular area of the document is redacted with a solid dark gray fill, covering the majority of the page content below the first redaction.

From: Scott, John A. (CMS/CM)
Sent: Wednesday, September 26, 2012 5:22 PM
To: Abrams, Jill (HHS/OGC)
Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Bucksten, William (CMS/CM); Bennett, Carol (HHS/OGC)
Subject: RE: Fox administrative brief re: recon

Jill,

(b)(5)



John

From: Abrams, Jill (HHS/OGC)

Sent: Tuesday, September 25, 2012 10:37 AM

To: Abrams, Jill (HHS/OGC); Scott, John A. (CMS/CM)

Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM); Bennett, Carol (HHS/OGC); Rice, Cheri M. (CMS/CM)

Subject: RE: Fox administrative brief re: recon

(b)(5)



From: Abrams, Jill (HHS/OGC)

Sent: Monday, September 24, 2012 4:01 PM

To: Scott, John A. (CMS/CM)

Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)

Subject: RE: Fox administrative brief re: recon

(b)(5)



From: Scott, John A. (CMS/CM)

Sent: Monday, September 24, 2012 3:54 PM

To: Abrams, Jill (HHS/OGC)

Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)

Subject: RE: Fox administrative brief re: recon

(b)(5)



John

From: Abrams, Jill (HHS/OGC)

Sent: Monday, September 24, 2012 10:40 AM

To: Newsom, Mark (CMS/CM); Scott, John A. (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)

Cc: Corke, Victoria (HHS/OGC)
Subject: FW: Fox administrative brief re: recon
Importance: High

(b)(5)

A solid black rectangular redaction box covering the content of the email body.

From: Abrams, Jill (HHS/OGC)
Sent: Thursday, September 20, 2012 11:57 AM
To: Newsom, Mark (CMS/CM); Scott, John A. (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)
Cc: Corke, Victoria (HHS/OGC)
Subject: Fox administrative brief re: recon
Importance: High

(b)(5)

A large solid black rectangular redaction box covering the majority of the email body content.

McFarland, Bridget W. (CMS/OSORA)

From: Ceja, Kathryn S. (CMS/OEABS)
Sent: Tuesday, November 15, 2011 8:35 PM
To: Rice, Cheri M. (CMS/CPC); Jones, Greg A. (CMS/OL); Segal, Misha (CMS/CSP)
Cc: Cook, Brian T. (CMS/OEABS); Bataille, Julie (CMS/OEABS); Stansbury, Kevin S. (CMS/OL); Unruh, Patti (CMS/OEABS)
Subject: Fw: UBS (Lake): Medicare Advantage/MCOs - CMS Error Rates Incremental Positive for RADV
Attachments: UBS - Medicare Advantage Error Rates 11-15-2011.pdf; Risk Score Decisions Trump Rate For 2012.pdf; CMS May Be Looking to Calm the Waters.pdf; Thoughts on Medicare Risk Score Audits.pdf; Legal Disclaimer.txt

From: kenneth.lavine@ubs.com [<mailto:kenneth.lavine@ubs.com>]
Sent: Tuesday, November 15, 2011 08:09 PM
To: kenneth.lavine@ubs.com <kenneth.lavine@ubs.com>
Subject: UBS (Lake): Medicare Advantage/MCOs - CMS Error Rates Incremental Positive for RADV

(b)(5)



<<UBS - Medicare Advantage Error Rates 11-15-2011.pdf>>

[Prior UBS Reports](#)

<<Risk Score Decisions Trump Rate For 2012.pdf>> <<CMS May Be Looking to Calm the Waters.pdf>> <<Thoughts on Medicare Risk Score Audits.pdf>>

Please do not hesitate to call with any questions.

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

Kenneth LaVine, CFA
UBS Investment Research
Healthcare Services
(212) 713-4237
Kenneth.Lavine@ubs.com

McFarland, Bridget W. (CMS/OSORA)

From: PAUL, REBECCA (CMS/CPC)
Sent: Thursday, October 28, 2010 4:27 PM
To: Kornfield, Thomas (CMS/CPC); Moseley, Deondra S. (CMS/CPC); Uebersax, Julie (CMS/CM); Elrington, Keshanna (CMS/CM)
Subject: MA coding in Advance Notices and Announcements
Attachments: MA coding in Advance Notices and Announcements.doc

(b)(5)

Rebecca Paul
Medicare Plan Payment Group
Center for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: Ceja, Kathryn S. (CMS/OEABS)
Sent: Thursday, February 10, 2011 4:12 PM
To: Rice, Cheri M. (CMS/CPC)
Cc: Segal, Misha (CMS/OP); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: analyst reports on RADV
Attachments: Market Insight RADV Section and MA.docx; citigroup and ma.pdf; barclays and 2012 rates.pdf; CMS May Be Looking to Calm the Waters On RADV Audits.pdf; Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf; U_S_HEALTH_CARE_MANAGED_102685386.pdf; mco_ma_radv_audits.pdf; bernstein radv.pdf; wells fargo RADV audits.pdf; humana investor transcript.pdf

Cheri,

(b)(5)

Kathy

Kathryn Ceja
Office of Communications
Centers for Medicare and Medicaid Services
Kathryn.ceja@cms.hhs.gov
202.205.9288

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 10, 2011 4:08 PM
To: Ceja, Kathryn S. (CMS/OEABS)
Subject: RE: analyst reports on RADV

Here you go...

Docs:

(b)(5)

(b)(5)

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Tudor, Cynthia G. (CMS/CPC)
Sent: Friday, February 04, 2011 3:05 PM
To: Rice, Cheri M. (CMS/CPC)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits
Attachments: CMS May Be Looking to Calm the Waters On RADV Audits.pdf; HPMS_Transmittal_--_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf; Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf; Preliminary RADV Methodology 12-21-2011.pdf; Legal Disclaimer.txt

FYI

From: (b)(6)
Sent: Friday, February 04, 2011 2:57 PM
To: Tudor, Cynthia G. (CMS/CPC)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

From: (b)(6)
Sent: Thursday, February 03, 2011 8:56 PM
To: (b)(6)
Subject:

From: justin.lake@ubs.com [<mailto:justin.lake@ubs.com>]
Sent: Thursday, February 03, 2011 12:33 PM
Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)

<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 2:37 PM
To: Blum, Jonathan D. (CMS/CM); Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Salters, Tony A. (CMS/OEA); Milgate, Karen (CMS/CSP); Brennan, Niall J. (CMS/OP)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:12 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)

Sent: Thursday, February 03, 2011 02:11 PM

To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Blum, Jonathan D. (CMS/CM)

Sent: Thursday, February 03, 2011 2:10 PM

To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)

Sent: Thursday, February 03, 2011 02:07 PM

To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)

Sent: Thursday, February 03, 2011 1:47 PM

To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

(b)(5)

From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_-_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500
Richard Mauro
High Yield- 203.719.1471
Todd Corsair
CDS- 203.719.3896
Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:12 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:11 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

(b)(5)



From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA

UBS Investment Bank

Analyst - Healthcare Services

Phone (212)-713-2765 Mobile

justin.lake@ubs.com

(b)(6)



UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 2:11 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_-_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500
Richard Mauro
High Yield- 203.719.1471
Todd Corsair
CDS- 203.719.3896
Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: justin.lake@ubs.com [<mailto:justin.lake@ubs.com>]
Sent: Thursday, February 03, 2011 1:33 PM
Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

(b)(5)

<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 2:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits
Attachments: CMS May Be Looking to Calm the Waters On RADV Audits.pdf; HPMS_Transmittal_--_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf; Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf; Preliminary RADV Methodology 12-21-2011.pdf; Legal Disclaimer.txt

(b)(5)



From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: justin.lake@ubs.com [<mailto:justin.lake@ubs.com>]
Sent: Thursday, February 03, 2011 1:33 PM
Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Creighton, Sean M. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:55 PM
To: Rice, Cheri M. (CMS/CPC); Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Larrick, Amy (CMS/CM); Fegraus, Laura (CMS/CM); Hornsby, Anne M. (CMS/CM)
Subject: Fw: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:34 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) [redacted] McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

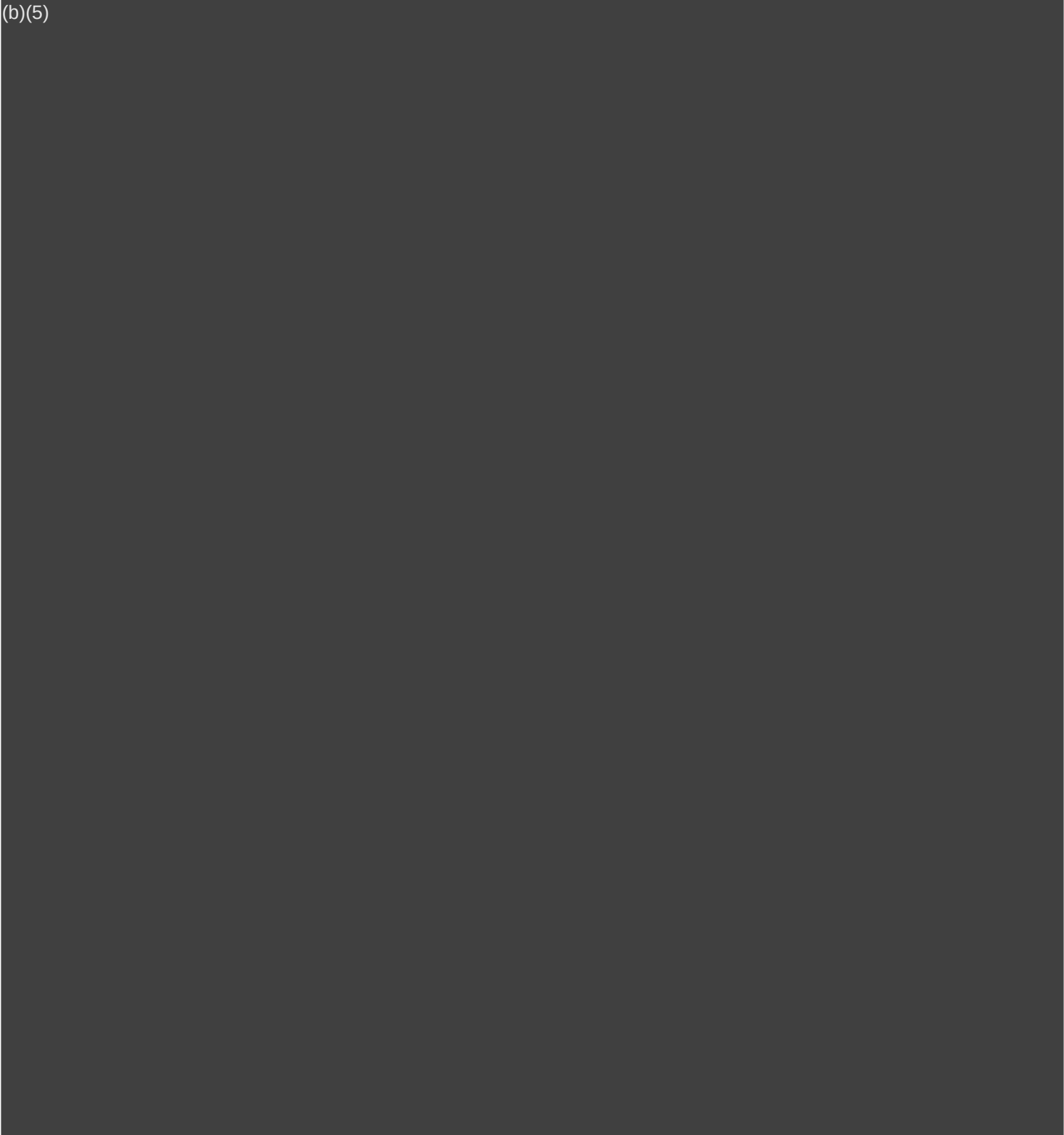


Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)
To: Don Kosin (b)(6) [redacted]; McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy

(CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Sent: Wed Mar 25 17:16:34 2009
Subject: RE: 45 day notice and call letter re: MA rate adjustments
[Don,](#)

(b)(5)



Richard S. Foster

Paul I. Spitalnic

Solomon M. Mussey

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6) ; [Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)

Sent: Tuesday, March 24, 2009 10:47 PM

Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>

To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)

Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>

Sent: Tue Mar 24 19:29:02 2009

Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Miller, Dan (CMS/CCIIO)
Sent: Monday, July 09, 2012 5:13 PM
To: Paul, Rebecca (CMS/CM); Keenan, Patricia S. (CMS/CCIIO)
Subject: RE: call with Henry on RA validation stuff

(b)(5)



Dan

Dan Miller
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
301-492-4178

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Paul, Rebecca (CMS/CM)
Sent: Monday, July 09, 2012 2:16 PM
To: Keenan, Patricia S. (CMS/CCIIO)
Cc: Miller, Dan (CMS/CCIIO)
Subject: RE: call with Henry on RA validation stuff

Hi Dan --

(b)(5)



Thanks.

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

From: Keenan, Patricia S. (CMS/CCIIO)
Sent: Monday, July 09, 2012 10:00 AM
To: Paul, Rebecca (CMS/CM)

Cc: Miller, Dan (CMS/CCIIO)

Subject: FW: call with Henry on RA validation stuff

(b)(5)

From: Miller, Dan (CMS/CCIIO)

Sent: Friday, July 06, 2012 10:40 AM

To: Keenan, Patricia S. (CMS/CCIIO)

Subject: call with Henry on RA validation stuff

Patricia,

(b)(5)

Thanks,
Dan

Dan Miller
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
301-492-4178

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Uebersax, Julie (CMS/CM)
Sent: Thursday, February 07, 2013 3:47 PM
To: Rice, Cheri M. (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

Julie A. Uebersax

Special Assistant
Medicare Plan Payment Group (MPPG)
Center for Medicare (CM)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd | Baltimore, Maryland 21244
☐: C1-13-26 | 📞: 410.786.9284 | ✉: julie.uebersax@cms.hhs.gov

Information not releasable to the public unless authorized by law: The information transmitted has not been publicly disclosed and may be privileged and confidential. It is intended only for the person or entity to which it is addressed and must not be disseminated, distributed, or copied to persons not authorized to receive it. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete it without reading it. Also, please notify the sender that you have received this communication in error. Your receipt of this message is not intended to waive any applicable privilege.

From: Szeftlinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:13 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 10:35 AM
To: Szeftlinski, Francis C. (CMS/CPC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:35 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)
To: Don Kosin (b)(6); McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Sent: Wed Mar 25 17:16:34 2009
Subject: RE: 45 day notice and call letter re: MA rate adjustments
Don,

(b)(5)



(b)(5)



Richard S. Foster
Chief Actuary

Paul I. Spitalnic
Director, PCDAG

Solomon M. Mussey
Director, MMCEG

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6)
[Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)
Sent: Tuesday, March 24, 2009 10:47 PM
Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>
To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)
Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>
Sent: Tue Mar 24 19:29:02 2009
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:22 PM
To: Sands, Evan [USA]; Comer, Erin [USA]; Meyer, Mary Lynn [USA]
Cc: Jenkins, Samuel (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM); Smith, Jonathan (CMS/CM)
Subject: FW:
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 2 of 4 - CMS CY 2010 strategic planning deliverables

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Friday, October 28, 2011 12:19 PM
>To: Pulley, Tobi A. (CMS/CDHPC)
>Cc: Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM)
>Subject:

>

>Tobi,

>

(b)(5)

A large black rectangular redaction box covers the body of the email. The text "(b)(5)" is visible in the top left corner of the redacted area.

>

>Thanks

>Sam

>

>

>Samuel B. Jenkins

>Centers for Medicare & Medicaid Services Medicare Plan Payment Group

>410-786-3261

>samuel.jenkins@cms.hhs.gov

>

>

McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:21 PM
To: Meyer, Mary Lynn [USA]; Comer, Erin [USA]; Sands, Evan [USA]
Cc: Hornsby, Anne M. (CMS/CM); Jenkins, Samuel (CMS/CM); Mierwald, Raymond (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Smith, Jonathan (CMS/CM)
Subject: FW: Items for the BAH meeting
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 1 of 4 - CMS deliverables for CY 2010 strategic planning

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Monday, October 31, 2011 9:22 AM
>To: Hughes, Lateefah C. (CMS/CPC)
>Cc: Pulley, Tobi A. (CMS/CDHPC); Mierwald, Raymond (CMS/CM)
>Subject: FW: Items for the BAH meeting
>
>Anne's PEDIR information is attached as well.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Friday, April 20, 2012 4:49 PM
To: Keenan, Patricia S. (CMS/CCIIO)
Cc: Cohen, Michael L. (CMS/CCIIO); Creighton, Sean M. (CMS/CPC); Decastro, Rebecca (CMS/CM); Keenan, Andrew K.(CMS/CM)
Subject: MA coding documents
Attachments: exhibit 1 combined 20110815.xlsx; Exhibit 1 Chart 11.09.2011.xlsx; CMS_codingintensity_20090929.xlsx; Manuscript.pdf; MA coding in Advance Notices and Announcements.doc

(b)(5)



Let me know if you have any questions!

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

From: Keenan, Patricia S. (CMS/CCIIO)
Sent: Friday, April 20, 2012 3:34 PM
To: Paul, Rebecca (CMS/CM)
Cc: Cohen, Michael L. (CMS/CCIIO)
Subject: FW: Analysis Standing Meeting

(b)(5)



From: Hughes, Lateefah C. (CMS/CCIIO)
Sent: Friday, April 20, 2012 12:04 PM
To: Hughes, Lateefah C. (CMS/CCIIO); Keenan, Patricia S. (CMS/CCIIO); Cohen, Michael L. (CMS/CCIIO)
Subject: RE: Analysis Standing Meeting

(b)(5)



From: Hughes, Lateefah C. (CMS/CCIIO)
Sent: Friday, April 20, 2012 12:02 PM
To: Keenan, Patricia S. (CMS/CCIIO); Cohen, Michael L. (CMS/CCIIO)
Subject: RE: Analysis Standing Meeting

(b)(5)



Lateefah

From: Keenan, Patricia S. (CMS/CCIIO)
Sent: Friday, April 20, 2012 11:58 AM
To: Cohen, Michael L. (CMS/CCIIO); Hughes, Lateefah C. (CMS/CCIIO)
Subject: Re: Analysis Standing Meeting

(b)(5)



----- Reply message -----

From: "Cohen, Michael L. (CMS/CCIIO)" <michael.cohen@cms.hhs.gov>
To: "Hughes, Lateefah C. (CMS/CCIIO)" <Lateefah.Hughes@cms.hhs.gov>
Cc: "Keenan, Patricia S. (CMS/CCIIO)" <patricia.keenan@cms.hhs.gov>
Subject: Analysis Standing Meeting
Date: Fri, Apr 20, 2012 11:23 am

Lateefah,

(b)(5)



-Michael

From: Hughes, Lateefah C. (CMS/CCIIO)
Sent: Friday, April 20, 2012 11:20 AM
To: Cohen, Michael L. (CMS/CCIIO)
Subject: RE: Analysis Standing Meeting

Michael,

(b)(5)



From: Cohen, Michael L. (CMS/CCIIO)
Sent: Friday, April 20, 2012 11:03 AM
To: Arnold, Grace C. (CMS/CCIIO); Gerrits, Diane T. (CMS/CCIIO); Davis, Jeffrey L. (CMS/CCIIO); Lauer, Johanna R. (CMS/CCIIO); Miller, Dan (CMS/CCIIO); Wu, Jeff (CMS/CCIIO); Hughes, Lateefah C. (CMS/CCIIO); McWright, Laurie (CMS/CCIIO); Doshi, Alok (CMS/CCIIO); Novick, Ariel D. (CMS/CCIIO); Sutton, Erin E. (CMS/CCIIO); Shah, Milan (CMS/CCIIO); Russell, Brigid M. (CMS/CCIIO); Grant, Jeffrey (CMS/CCIIO); Scott, Wakina L. (CMS/CCIIO); Keenan,

Patricia S. (CMS/CCIIO); Arnold, Sharon B. (CMS/CCIIO)

Subject: RE: Analysis Standing Meeting

All,

Today's analysis meeting will have the following agenda items:

1. 2013 Plans
2. Market Reform Issues
3. Catastrophic Plan Next Steps
4. Criteria for Selection of HCCs for Risk Adjustment - Upcoding

Please note additional materials will be forthcoming on the 2013 plan issue. Thanks.

<< File: upcoding Issuepkmlc.docx >> << File: MarketReforms-FM Issues (4-20-12).docx >> << File: Catastrophic -- 4-13-12.docx >>

Segal, Misha (CMS/OP)

From: MISHA SEGAL, CMS [cmscapmks@bloomberg.net]
Sent: Tuesday, February 08, 2011 11:22 AM
To: Segal, Misha (CMS/OP)
Subject: (BT) Humana Earnings Teleconference HUM US

+-----+
Humana Earnings Teleconference HUM US
2011-02-07 15:34:00.378 GMT

Event Date: 02/07/2011
Company Name: Humana
Event Description: Q4 2010 Earnings Call
Source: Humana
For more event information and transcripts,
visit bloomberg.com/EVTS%20%2FD%3AF%2D1742947%3CGO%3E EVTS
Q4 2010 Earnings Call

MANAGEMENT DISCUSSION SECTION

Operator:

Good morning. My name is Steve, and I will be your conference operator today. At this time, I would like to welcome everyone to the Humana Fourth Quarter 2010 Earnings Release Conference Call. All lines have been placed on mute to prevent any background noise. [Operator Instructions] I'll now turn the call over Regina Nethery, Vice President of Investor Relations. Please go ahead.

Regina C. Nethery, Vice President of Investor Relations:

Good morning, and thank you for joining us.

In a moment, Mike McCallister, Humana's Chairman of the Board and Chief Executive Officer and Jim Bloem, Senior Vice President and Chief Financial Officer will briefly discuss highlights from our fourth quarter 2010 and full-year 2010 results, as well as comment on our earnings outlook for 2011. Following these prepared remarks, we will open up the lines for a question and answer session with industry analysts. Joining Mike and Jim for the Q&A session will be Jim Murray, our Chief Operating Officer, and Chris Todoroff, Senior Vice President and General Counsel. We encourage the investing public and media to listen in to both management's prepared remarks and the related Q&A with analysts.

This call is being recorded for replay purposes. That replay will be available on the Investor Relations page of Humana's website, Humana.com, later today. This is also being simulcast via the Internet, along with a virtual slide presentation. For those of you who have company firewall issues and cannot access the web presentation, an Adobe version of the slides has been posted to the Investor Relations section of Humana's website.

Before we begin our discussion, I need to cover a few other items. First, our cautionary statement. Certain of the matters discussed in this conference call are forward-looking and involve a number of risks and uncertainties. Actual results could differ materially. Investors are advised to read the detailed risk factors discussed in this morning's press release, as well as our filings with the Securities and Exchange Commission. Today's press release, our historical financial news releases, and our filings with the SEC are all

available on Humana's Investor Relations website.
Finally, any references made to earnings per share or EPS in this morning's call refer to diluted earnings per common share.
With that, I'll turn the call over to Mike McCallister.

Michael B. McCallister, Chairman of the Board and Chief Executive Officer:
Good morning, everyone. Thank you for joining us.

Today, Humana announced fourth quarter earnings of \$0.63 per share, in line with our most recent guidance. Our underlying operating results were very strong during the quarter. Excluding the \$1.02 a share in incremental fourth quarter expenses highlight in this morning's press release, this quarter's results were actually up compared to the fourth quarter of 2009.

Our full-year 2010 earnings per share of \$6.47, in line with our previous guidance, reflects the strength of our businesses and was driven by our Medicare membership growth, our disciplined pricing, continued focus on our "15% solution," our administrative cost reduction initiatives, and the benefit of unusually low medical cost trends.

The fourth quarter expenses that were not included in our prior guidance were the strengthening of our long-term care reserves, a contribution to the Humana Foundation, and transaction costs associated with our acquisition of Concentra in December. Additionally, the quarter included incremental investment spending for the 2011 Medicare enrollment season that we have discussed in previous calls. Jim Bloem will provide more color around each of these items in his remarks.

In the just-completed Medicare enrollment season, our net sales for both Medicare Advantage and stand-alone PDP offerings were better than we had previously projected, and our commercial operations continue to improve as well. Accordingly, we have raised our 2011 EPS guidance this morning to a range of \$5.70 to \$5.90 from our previous range of \$5.45 to \$5.65.

My remarks today will focus primarily on the 2011 Medicare open enrollment season, our continued progress in improving seniors' health outcomes through our Medicare clinical initiatives and our strategic acquisition of Concentra at the end of 2010. But first I'll briefly touch on a topic of interest to many of you, the Risk Adjustment Data Validation, or RADV, Medicare audits. Just this past week, CMS issued a statement that it was thoroughly evaluating all comments received on its proposed methodology, and based on that input, it anticipates making changes before issuing the final RADV audit methodology.

As we noted in our comment letter to them on this matter, we believe the proposed methodology is incorrect. We hope CMS's statement is indicative of substantive changes forthcoming to ensure Medicare Advantage payment models are actuarially sound. A lack of substantive changes to the proposed methodology would, we believe, jeopardize the program itself and disrupt coverage for the 12 million seniors in Medicare Advantage plans across the nation.

For their part, seniors continue to depend on the value proposition our Medicare plans offer, as evidenced by our recent sales results. Starting with Medicare Advantage, while we had previously projected 2011 to grow by 60,000 to 65,000 net new members, we now estimate net growth of 90,000 to 110,000 members. Both gross sales and member retention exceeded our expectations. By developing robust networks in multiple areas of the country over the past few years, we made it possible for many of our private fee-for-service members to transition automatically and seamlessly to network-based products. Further, for the 115,000 Humana private fee-for-service members who needed to actively enroll in an HMO or PPO offering for 2011, we experienced a higher-than-forecast number who chose network offerings during the 2011 enrollment season.

As for stand-alone PDP offerings. Our innovative Humana-Walmart plan drew a great deal of interest, and sales significantly exceeded our expectations. We've recently evaluated the geographic distribution of the membership in this nationwide premium plan, as well as pharmacy claims data through the first month of the year. These are in line with our expectations for the Humana-Walmart offering.

Gross PDP sales, particularly for the Humana-Walmart plan, together with an increase in auto-assigned membership, resulted in us raising guidance for stand-alone PDP membership growth to a range of 525,000 to 575,000 net new members during 2011 versus our previous guidance of an increase of 325,000 to 375,000.

It should be noted that our Medicare sales results were achieved against the background of our annual Medicare margin reset overall. As in the past, we believe it to be prudent policy to target a 5% margin longer term. Hence, to the extent we exceed our longer-term goal, we in turn pass that incremental margin back to our Medicare members in the form of lower premiums and/or richer benefits. Just as importantly, we will continue to strive diligently in the interest of our members to improve outcomes while lowering costs for them, for the company, and for the country.

It's no exaggeration to say "for the country." Whatever else it might have done or will do, last year's health insurance reform debate put the spotlight on the fact that the nation's rising healthcare costs - especially in Medicare - and the growing incidence of expensive and largely preventable chronic diseases such as diabetes is unsustainable. Unless consumers are engaged in their health, and unless companies like ours, with a track record of success in consumer engagement, continue to offer attractive programs that make healthy things fun and fun things healthy, and to lower costs, a crisis will soon be upon us.

We're doing what we can to mitigate such a crisis and, for our own members, seeing very good results. On the most basic level, favorable comparisons versus traditional fee-for-service Medicare on such important measures as hospital admissions, re-admissions, and emergency room use, which I've shared with you in the past, are the result of an integrated program of member- and physician-focused services that simply does not exist in original Medicare. We believe that the consequence is better health outcomes and quality of life for our members, along with lower costs compared with seniors in traditional Medicare.

The program begins with health risk assessments of new members and follows that up, where warranted, with proactive outreach for clinical guidance. This outreach can be in the form of personal nurses, disease management programs, integrated medical and behavioral health, and/or hands-on assistance with feeding, bathing, and other key components of daily living. There are also a wide variety of healthy-living, healthy-eating options available to members, including the SilverSneakers Fitness Program, Well Dine for nutrition, health and wellness classes, and a variety of plan-based and community-based support services for our most at-risk members through Humana Cares.

As it evolves, our clinical program is increasingly aligned with CMS's star rating system in anticipation of coming changes in the Medicare Advantage revenue model. Such alignment has already yielded progress. From 2010 to 2011, Humana's star rating summary score improved from 2.74 to 3.1 stars, a 13.1% increase. For the 30 Humana plans rated in both years, 17 plans improved their star ratings, 13 remained constant, and none experienced a decrease.

As you probably know, star ratings are comprised of service measures as well as clinical ones. To give you a sense of the progress we're making on the clinical side, certain clinical measures, such as rheumatoid arthritis management and controlling blood pressure, improved by at least 15% year over

year.

It's worth noting that for every star measure, Humana tracks data on which members are compliant and which are not, and follows that up with a focused outreach effort. Last year, in our Florida HMO, for example, we conducted more than 9,000 colon cancer screenings, 5,000 glaucoma screenings, and 2,000 kidney function tests for diabetics after analyzing member compliance data. Once again, in comparison, none of this proactive health support is available to members of traditional Medicare.

Looking ahead, we anticipate further improvements in star ratings for the implementation later this year of automated, personalized member messaging. Clinical standards will enable us to identify Medicare Advantage members who could benefit from our programs, according to evidence-based care guidelines, and we'll customize messaging through a variety of channels: telephonic, electronic, and one-to-one conversations with clinical experts.

Beyond Medicare, making a difference at the level of individual health is one of the reasons we acquired Concentra late last year. As I've said on several recent calls, Humana is progressively expanding its strategy to embrace the concept of lifelong well-being. The Concentra model is a good stepping-stone in this overall strategy. Through its affiliated clinicians, Concentra delivers occupational medicine, urgent care, physical therapy, and wellness services to workers and the general public from more than 300 medical centers in 42 states.

The geographic fit with Humana is ideal. Nearly 3 million Humana medical members live near a Concentra center. Concentra is the respected market leader, with more than 14% of work-related injuries in the U.S. treated at a Concentra center, and it has relationships or formal accounts with more than 100,000 employers. We expect Concentra to support our commercial business immediately while we simultaneously proceed with plans to expand the availability of these services to our Medicare members, all while being accretive to our 2011 financial results.

We will continue to look for acquisition opportunities like Concentra as part of evaluating the most prudent near-term use of capital to ensure long-term value appreciation for our shareholders.

In summary, Humana completed in the fourth quarter a very solid 2010, which we believe positions us well for 2011. The 2011 Medicare selling season in November and December surpassed our expectations, and we continue to advance our ability to improve the quality of life and health outcomes of our members while achieving ever-higher value for money in the Medicare program.

With that, I'll turn the call over to Jim Bloem.

James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer:

Thanks, Mike, and good morning, everyone.

I'd like to begin by summarizing our 2010 financial performance, followed by a discussion of today's increase in our full-year 2011 earnings per share guidance range.

As indicated on the slide, our 2010 earnings per share of \$6.47 came within our previous guidance range of \$6.40 to \$6.50. However, the \$6.47 per share includes four noteworthy items, which arose since the time of our Investor Day on November 18th. Since three out of the four were unusual expenses, we are pleased with our fourth quarter operating performance. Let's quickly review the four post-November 18 items in order of their size.

First, as discussed in this morning's press release, we strengthened the reserves for our closed block of long-term care policies in the amount of \$138.9 million or \$0.52 per share. This block of 35,000 policies was acquired in connection with our acquisition of KMG America in late 2007. No policies in this block have been sold since 2005. This reserve strengthening occurred

as part of our annual year-end review of these long-duration liabilities. In this year's review, we revised our original acquisition assumptions with respect to three things: First, the amount and frequency of regulatory-allowed premium rate increases. Second, annual claims and claims management expense levels. And third, expected rates of investment returns over the 30-plus-year expected life of these liabilities. These revised assumptions were based on our experience over the last three years with respect to premiums and expenses, as well as the current outlook for long-term interest rates.

Second, on the positive side, we experienced greater-than-anticipated favorable development of prior years' medical claims in the amount of \$37.8 million, or \$0.14 per share during the quarter. This brought the full-year benefit of better-than-expected prior years' medical claims development to \$231.2 million or \$0.86 a share.

Finally, we incurred two other significant expenses during the quarter that were not included in our previous guidance of November 18. First, a \$35 million or \$0.13 per share contribution to the Humana Foundation. And second, \$15 million or \$0.08 per share of transactions cost associated with the closing of the Concentra acquisition.

With respect to the Humana Foundation, we believe the company's philanthropic efforts are an important part of its mission. We've not been able to make a contribution of this scale since at least the year 2000, and we were pleased to be afforded that opportunity during the fourth quarter. Our remaining fourth quarter results of \$165 million pre-tax or \$0.61 per share compares favorably with our previous guidance. This better-than-expected operating performance consisted of approximately \$90 million from the Commercial segment and \$75 million from our Government segment.

With respect to our Commercial segment operations, we continued to benefit from the unusually low medical cost trends experienced by the entire health insurance sector during 2010. Of the \$90 million of Commercial operating overperformance in the fourth quarter, a little less than one-third was favorable development from the first nine months of the year, with most of the remainder reflected in the continuing run rate cost trend improvement. Our Government segment operations benefited from another strong quarter of performance in our MAPD business, primarily driven by cost rate improvements arising out of the continued success of our 15% solution.

Turning now to full-year Government segment results, our 2010 Government segment pre-tax income increased by approximately \$150 million versus 2009. As noted on the slide, there are four items that are included in this \$150 million net improvement:

First, we benefited in the Government segment from \$182.4 million of greater-than-anticipated prior years favorable medical claims development in 2010.

Second, we incurred about \$77 million of additional SG&A expenses associated with the Humana-Walmart PDP plan launch, which was \$40 million, and with the change in the 2011 Medicare Advantage enrollment period, which was \$37 million. With respect to the Medicare enrollment season, 2010 was unique in that we incurred first quarter marketing and selling expenses associated with the 2010 enrollment season and then also absorbed what we would normally have spent in the first quarter of 2011 into the fourth quarter of 2010, because of the mandated shortening of the enrollment period for 2011.

Third, the portion of the Humana Foundation contribution that was attributable to the Government segment was \$26 million.

Finally, then, the remaining pre-tax improvement of approximately \$70 million results primarily from the growth of our Medicare Advantage membership, our SG&A cost efficiencies, and the benefits of scale that come with being a larger competitor. You will recall that we discussed on Investor Day that we

reset our overall Medicare pre-tax margin to 5% for 2011, and continued to pursue the beneficial effects related to the 15% solution. We also continue to expect to record between \$50 million and \$75 million of charges in the fourth quarter of 2011 related to the assumed termination of the current TRICARE contract on March 31, 2012. Approximately \$50 million of these charges relate to goodwill, and the remainder relate to the transition of the contract. These are the same assumptions that we originally used with respect to 2010.

Moving on to our full-year 2010 Commercial segment results. While we benefited from much lower-than-expected medical cost trends, as well as some greater-than-expected favorable development of prior years' medical claims, we also incurred some significant expense items, most notably the new health insurance reform law mandated \$147.5 million write-down of deferred acquisition costs on our individual major medical block of business in the second quarter, as well as the previously described long-term care reserve strengthening during the fourth quarter. With respect to the medical cost trends, for pricing purposes, we've assumed a return to historical levels for 2011, which is reflected in our guidance for this year.

Turning next to our 2011 earnings per share update, we have raised our full-year earnings per share guidance by \$0.25 to reflect the impact of two items: First, higher membership in both our Medicare Advantage and stand-alone PDPs. This increase in Medicare membership represents about \$0.15 per share. Second, we are reflecting some of the 2010 lower commercial medical cost trends, which will result in a lower medical cost base, which will benefit 2011. This \$0.10 per share increase primarily relates to our large group business, which is much less encumbered by the new health insurance reform minimums for medical loss ratios than are our small group and individual blocks of business. Accordingly, we have also increased our 2011 Commercial segment pre-tax income forecast by approximately \$50 million to reflect this large group cost trend improvement, as well as the inclusion of Concentra's expected accretion of \$0.10 per share, announced at the time of its acquisition in December.

Moving next to selling, general, and administrative costs. We expect that our solid progress in 2010 will continue to 2011. As mentioned in our third quarter earnings conference call, we achieved our \$100 million of cost savings in 2010 and have entered 2011 with \$200 million run rate savings goal that we set for ourselves at this time last year. Our cross-functional administrative cost committee has developed processes which assure that these administrative cost reduction efforts are not just one-time events, but rather an ongoing source of both improved cost competitiveness and savings-funded initiatives, which allow us to continue to transform Humana to both meet the requirements of health insurance reform and also to implement the corporate strategy we outlined in detail on Investor Day. Our current 2011 SG&A ratio forecast, which includes all Concentra expenses, shows how we expect the payback of our cost reduction and savings reinvestments to lower our core administrative expenses, as represented by the blue bar on the slide.

Turning next to our expected 2011 quarterly earnings pattern. This slide shows the timing of the major items that we expect will impact our earnings from quarter to quarter this year. These items include our annually discussed seasonality factors, such as, for example, the quarterly effects of our PDP benefit designs and the ongoing migration of our commercial membership into high-deductible health plans. The only change in this slide from last year is the elimination of the Medicare selling season for the early part of the year. And as previously discussed, this elimination results in the concentration of our Medicare marketing and selling expenses for the entire 2012 selling season into the fourth quarter of 2011. Thus, other than the

timing of the expenses associated with the fourth quarter Medicare selling season, we do not anticipate any significant 2011 differences from our 2010 quarterly earnings pattern. Accordingly, our first quarter 2011 earnings per share guidance range of \$1.15 per share to \$1.20 per share is approximately 20% of our current full-year EPS guidance range, which is consistent for each of the last two years.

Turning last to operating cash flows and capital deployment. Our capital deployment efforts remain focused on effectiveness-building capital expenditures, potential acquisitions in strategic investments, as well as continuing to repurchase our shares. Based on record 2010 operating cash flows, we were able to do all three to an increasing extent in 2010 versus 2009, as outlined in this morning's press release.

Our 2011 guidance range for operating cash flows was increased by \$200 million today to reflect the increase in our Medicare membership, the improved Commercial segment pre-tax outlook, and the Concentra acquisition. This morning's increases in our 2011 guidance points for capital expenditures as well as depreciation and amortization expenses, primarily are due to the inclusion of the 2011 Concentra capital budget and asset ledgers, respectively. As we move further to 2011, we continue to believe that having and conserving ample capital and liquidity provides us with the financial flexibility needed to compete effectively in the new environment as it continues to unfold.

So to conclude, we're pleased with our financial and operating results for both the fourth quarter and for the full-year 2010. Our increased 2011 full-year earnings guidance range of \$5.70 to \$5.90 per share reflects our organizational competence and confidence, as well as our disciplined and intentional approach to the current operating environment.

With that, we'll open the phone lines for questions. We request that each caller ask only two questions in fairness to those still waiting in the queue. Operator, will you please introduce the first caller?

Q&A

Operator:

And your first question comes from Josh Raskin from Barclays. Your line is open.

<Q - Joshua Raskin>: Hi, thanks. Good morning. Just a question - I guess, Jim, just staying on that line of reasoning around the 2011 guidance. So, I guess, your 2010, was I guess, basically in line with your estimates from a couple months ago. But that included \$0.52 from the reserve boost for the long-term care and then the foundation of \$0.13, and Concentra-based cents. And I guess even if you took out the favorable development of \$0.14, I'm still getting a net improvement of \$0.59. So I guess I'm looking at guidance up \$0.25, but then the core operating in the fourth quarter alone is \$0.59. So I'm just curious, what's the disconnect? Was there fundamental - was it just some of the upside can't come back next year because of MLR minimums on the Commercial side, or what's sort of the difference there?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: There's two principal differences, and again, this is sort of what we talked about on Investor Day, too. So it's a good question. As both Mike and I said, we reset our Medicare margin to 5% every year. And then as Mike pointed out, we use, when we do better than that - and the organization works very hard all year to improve on that and, again, give better outcomes at lower costs to our members. But as we improve on that, then when we go to next year, we take that and put that back into the benefits and premiums,

particularly in light of what's happened in the last couple years with respect to reimbursement. So that's made us very competitive. And then also on the idea of the - just to get to the other part of your question - the Commercial side. As you know, this is the year where the 80% minimum MLR kicks in for small group and individuals. So basically the only real improvement we get to show there comes from the larger group. So those are the two things that sort of help us, but also really - you don't to really get to start all over again where you left off the prior year.

<Q - Joshua Raskin>: I guess, Jim, on the Medicare margin, I understand you guys put your bids in eight, nine months ago, I guess the first week in June. So if you're seeing better improvement in the fourth quarter, are you saying you're going to augment benefits in 2011 as we go? You can still do that now? Is that the idea?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: No, it just has to do with - again, when we do it back in June, again, looking at where we were for 2010 with an economic 10% problem of basically a 5% rate cut and a 5% trend, and having - the legislation having froze us out of really increases, that we priced according to that 5% margin and then we did better. And so now as we get into '11, we've got a competitive price offering. And as the year goes by, we'll continue to look at and report what happens to us vis--vis that target 5% operating margin.

<A - James E. Murray>: I think this is one month into the year. And as we see claim payments and other clinical measures support what we saw in the fourth quarter, then we would obviously anticipate it and report it at that time. But we're going to wait until we see the favorable claim payments play themselves out a little bit furtherer into 2011.

<Q - Joshua Raskin>: Got you, Jim. So that makes sense. Just more extra prudence. And then hopefully this counts as the second question, but any expectations for the 45-day notice next week? Where do you guys think 2012 reimbursement will start at?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: We've seen a couple of write-ups by folks on the phone that would suggest that the range is somewhere between a negative 2% and a positive 1.5%. And as we've looked through those documents, I can't find anything that I would take umbrage with. I think that that would probably be a reasonable guesstimate as to where that will turn out.

<Q - Joshua Raskin>: Okay. And do you think the RADV stuff gets included?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: No. I don't believe so.

<Q - Joshua Raskin>: Okay.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: Remember, Josh, we always go last.

<Q - Joshua Raskin>: Right. I know.

Operator:

Your next question comes from the line of John Rex with JP Morgan. Your line is open.

<Q - John Rex>: Thanks. Over the course of the reporting period, a few of the companies have noted they've made some, as it relates to RADV, some accruals for repayment during the 4Q. I think you guys have early on said you don't view it as estimable right now, so you wouldn't be doing that. Was there anything in your 4Q?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: This is Mike. No, we have nothing in there for that.

<Q - John Rex>: Okay. So I mean, until you get a methodology, I suppose your point of view would be you couldn't put down accrual?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: No, I don't know how you could, frankly. I think we're far from understanding where this methodology is going to come out. And CMS's note last week confirms the fact that it's a work under way. So until we know specifics of how it's going to work, it's not appropriate to be setting aside reserves.

<Q - John Rex>: Okay, great. And then can you talk through the gross adds and losses in the Medicare banners book?

<A - James E. Murray>: Sure. This is Jim Murray. Just a few points. We sold a total of about 500,000 gross sales, which includes plan-to-plan changes. So our MarketPOINT organization, led by Patrick O'Toole, did an incredible job in a short period of time.

Were you to strip out the plan-to-plan changes of around 200,000, you would come up with net sales of around 290,000, which was an incredibly good result against what we thought was going to be around 270,000. So we exceeded our sales targets by around 20,000.

In addition to the sales results, we also enjoyed some good retention. We had terminations of around 163,000 net against a target of around 210,000. So about a 50,000 or 47,000 favorable retention against our goals. Some of that came from what we refer to as true terminations, and some against the better job we did on selling members that we reported to you prior - that were in exit - private fee-for-service exit states. We did a much better job of selling those folks.

The other thing that I would point out is that the 200,000 plan-to-plan sales that we made, 80,000 were in the 115,000 that we reported to you that we would have to resell, which was a really good result. And in addition to that, about 120,000 were from conversions into network-based options, further demonstrating the point that we've been talking about for a long time, that people are more willing to buy network plans than had been thought of in the past.

So we feel very, very good about what's happened in this AEP, and we look forward to 2011.

<Q - John Rex>: Great. And just - on the last point that you had answered previously, just on the 45-day notice. So ex the 45-day notice, have you estimated the impacts in '12 just from the transition to the new reform rules? So as we start phasing those in, what kind of increment you'd expect on that?

<A - James E. Murray>: Yeah. This is Jim Murray again. Included in the 1.5% to negative 2% that we talked about earlier, there were some guesstimates as to what the implications would be for the health reform phase-in. And so if

you use that as a starting point - and I'm just going to talk from 100,000 feet - let's pretend the range is a negative 2% to a positive 2%. Okay? So that's the money we would receive from the government.

What's not included is our MRA work that we do and we talk about with you regularly. Some of the reports that we've read anticipate that there's a negative 2% in the range that I talked about earlier related to risk factor changes. So if you assume that our MRA work offsets that - which we've said for a long time that that's a zero-sum game - so minus 2% to a positive 2%. Then you would add 2 percentage points for MRA.

Then - we talked with you a long time about the 15% solution. So let's identify or estimate that's anywhere from a 2% to a 4% improvement because of what we do that we call trend-benders, that goes to support that 15% solution.

And then against all of that, you have to step back and think about what trend really is. We believe, and we've told you for a long period of time, that we think trend is anywhere from 4% to 5% year after year.

So if you take all of those ranges that I've given you, you come up to about a negative 2% to a positive 3%. And we feel very good about our ability to manage within that kind of an environment -to continue to provide an economic benefit to the members that we serve. And feel very good about our prospects for our 2012 bid season.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: Let me just add to that, John. We talk about this, and I'm not sure how much credibility you all give it. But this idea of getting better value for money and better clinical results is actually a very big deal in all this.

Because you've heard me say for the last decade what a mess the traditional Medicare program is, and how uncoordinated it is. And what an opportunity there is to clean all that up, get better treatment for people, get it better organized and get better cost. That's what keeps us, really, in a nice position. This is not just a pure insurance sort of model here. This is all about healthcare, clinical organization, and clinical integration, and improving productivity.

And across every metric we measure relative to our membership, from the sickest to the walking healthy, things are continuing to get better. And that's really what props up everything here.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Justin Lake with UBS. Your line is open.

<Q - Justin Lake>: Thanks. Good morning. First question, just a follow-up on the RADV commentary.

Your 10-Q has a great risk statement that gives a lot of clarity on the issues you see with these RADV audits, and specifically, it talks to the potential of not only taking a reserve if and when CMS comes out with a final methodology, but also talks to the potential for accruing or changing the way you accrue for risk scores in the current year, depending on how the methodology comes out.

Can you talk to us about how that, from an accounting standpoint, would work? And what are the two or three factors we should be focused on, as far as that methodology, as to whether you would need to change your accruals and potentially change your revenue recognition for this, in the current year,

not just taking a reserve for 2007?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Right. Well, I think that the primary thing - and again, we appreciate your reference to the risk factor because we - it's been out there for a long time. And we think it adequately describes where we are right now.

But with respect to the methodology itself, we believe that the methodology is incorrect and flawed and actuarially invalid. So until that situation changes, to me, there would not be a reason to accrue. And Mike made that comment just a few minutes ago. And I think that's the principal reason why it's inappropriate at this time.

In addition, we - CMS put out the notice that we've all referenced that they're looking at this carefully and they're understanding better now what the comments are. So we'll wait to see what that is. But in the meantime, we think that the risk factor disclosure that we've made that you've referenced is very important for everybody to understand, and that this is an important issue for our industry. And so, as we move forward, we'll take a look at the facts and circumstances as they develop to decide what we're going to do. And one of the other things that you mentioned that's also important is that this is really a revenue recognition issue, and not so much a contingent liability. And the accounting rules that govern revenue recognition are different than those that surround contingencies and losses. So, anyway, I'll stop here.

<Q - Justin Lake>: Jim, maybe you can just specifically carve that out for us. I mean, I really want to understand the 2011 impact rather than the audit impact on 2007.

So CMS comes to you and says, we want a dollar back for 2007 from these risk score audits. Is that going to change the way you accrue for risk score revenue in 2011 as well? Meaning you'll have to lower your revenue guidance for 2011 and increase your MLR?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: If ultimately - and I say ultimately - that these matters were definitively to come out the way the original December 21st notice was, then after the final judgment and after the final consideration by everybody, including the agency and the courts and everybody else, then you might get to that situation.

But again, we're going to watch this very carefully as it evolves. Right now, we believe we're appropriate - we've discussed it appropriately in the risk factor and we've appropriately not accrued anything or reduced revenue for 2011 for this.

<A - James E. Murray>: Just I - go ahead.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: Let me just say this one more time. The proposed methodology they have out there is absolutely actuarially wrong. It is incorrect. And therefore we're not sitting around here wringing our hands at this point, because at the end of the day, we think we end up in a different place.

<Q - Justin Lake>: No, that makes perfect sense. And, Jim, just one last point of clarification. As far as your - if CMS comes out with this methodology and says we're not changing it, you wouldn't change your accruals until after it's been vetted by the courts?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Yes, I believe that would be the appropriate thing, because then again, we would have all the redress avenues that we have for the incorrect methodology that Mike just mentioned.

<Q - Justin Lake>: Okay. And I'll throw my - just ask my second question quickly, around Medicare Advantage membership.

Can you talk about the - this aging-in of the population is obviously going to be very significant over the next couple of years - or the next decade or two, I should say. I'm just trying to understand - the Medicare penetration overall, the 45 million, 46 million that are out there, are somewhere in the 20%, 25% range. I'm just curious, have you seen or can you talk to what the take-up rate is of the 65-year-old population as they age in each year? Is it materially different than that 20% to 25% of the overall population?

<A - James E. Murray>: This is Jim Murray. I believe that we've done analysis in the past - but I'd have to go and dust that off - that would suggest that when people do turn age 65 here lately, they are at a bigger percentage than the current market shares that we're seeing. And that's because people are more used to a network-based PPO kind of an option, which is what we're providing them. And we're seeing an increase in share as time goes on.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: I think the other thing to remember is, until recently, there really - were not really any national players in this business. So there were huge swaths of the United States that had no Medicare Advantage even being offered.

So we've got two things going on. People are seeing these products for the first time, as Humana and others are expanding across the country. And then they're having to deal with their experience, or lack thereof, with network plans and that sort of thing.

So whatever the data would tell you today, I'm not sure it says much about the future. I think these plans are going to continue to grow because they do have a very high value proposition.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Sarah James from Wedbush. Your line is open.

<Q - Sarah James>: Thank you. I had a - my first question was on Concentra. It looked like in the slides that there was a 225 basis point G&A boost from the expenses, which works out to be about \$832 million on the midpoint of your revenue guidance. And prior guidance was for about \$800 million of Concentra revenue.

So I was just wondering if there are some one-time G&A pieces in there or non-Concentra items contributing to the 225 basis point move. And then what the long-term margin on that business looks like.

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Well, Sarah, you've pretty well, I think, accurately recapped what it is. You can see that the other revenues guidance went up by \$850 million, and these expenses probably by \$825 million, and that \$25 million to \$27 million difference is the \$0.10 EPS that the accretion is based on. When we look at 2011, we're going to have integration expenses. We're looking

at different ways, as Mike said, to take what Concentra does and move it from our commercial populations and toward our Medicare and our Humana membership. And so those will be the expenses that sort of weigh down '11 with respect to Concentra.

But we're very optimistic over time that this type of business fits both strategically and financially.

<A - James E. Murray>: And all of Concentra's expenses are included in administrative costs, including the physician salaries.

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Correct. Correct.

<A>: That makes sense.

<A>: Correct.

<Q - Sarah James>: Got it. Okay. That makes sense. And then I guess on the enrollment guidance, it looked like the January numbers you reported were a little bit above where guidance was. So I was just wondering if there are some factors leading to your conservatism or if that guidance could then come up to at least the January numbers or above?

<A - James E. Murray>: Yes, this is Jim Murray again. We're currently sitting at around a net 130,000-member increase, and I think we've guided to the midpoint being around 100,000.

And we're being prudent. We've looked at some of the members that have stuck with us. They didn't term. And we've looked at some of the premiums that those folks have been delivered. We talked earlier that generally speaking, our premiums that we've delivered across the entire block stayed about the same. And that's one of the reasons why we were successful in this open enrollment period.

But certain parts of the United States, certain geographies, did get some premium increases. So we're prudently looking at those geographies and stepping back and wondering whether or not those folks are going to be able to pay those premiums. And as time goes on and we see whether or not they're able to pay those premium increases, that 100,000 could move closer to the 130,000. But time will tell.

<Q - Sarah James>: Got it. Thank you.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Charles Boorady from Credit Suisse. Your line is open.

<Q - Charles Boorady>: Thanks, good morning. On Medicare Advantage enrollment, are you able to tell yet what percent of your gross new adds were age-ins versus share gains? And do you have any sense for roughly what percent of the age-ins are moving into Medicare Advantage?

<A - James E. Murray>: That's difficult to tell with this AEP enrollment gain. What we'll be able to do better - as the rest of the year plays itself out, we'll see how the age-ins are as a percentage to the earlier question that was asked. We can't tell whether or not an individual who's joined us at

this time was with a plan prior.

<Q - Charles Boorady>: Got it. You're able to know their age, I suppose, to see if they've recently turned 65?

<A - James E. Murray>: Sure. We haven't pulled that together yet, but we can pull that together fairly easily. That's - that's a -

<Q - Charles Boorady>: Got it. On the star ratings, do you have a goal for ultimately reaching four stars or some certain level of stars, and over what timeframe? And can you talk about whether your opportunity is really mostly on the clinical side or on the admin side, for what you would need to improve to get to higher average star rating?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: This is Mike, Charles. The goal's - is pretty straightforward: It's five stars everywhere.

Now, having said that, we have a lot of different product designs, and some are more tightly managed than others. And so we're always going to have varying degrees of performance against this.

I think that the clinical - it may seem counterintuitive, but I think the clinical side may be easier to handle than the other side. Because the clinical is going to be something we're going to have data on and understand exactly what's happening with these people and have an ability, through messaging and other techniques, to give better quality and hit those stars. The service side, to me - frankly, I think they ought to eliminate those stars anyway. I think a lot of that stuff is not really powerful in terms of measuring how well this program works. But they are what they are for the time being. And until changed, we'll work to make those better as well. But to the extent you're dependent upon downstream providers for customer service kind of implications, that gets a little trickier.

So I think we'll have varying performance all over the country. It'll depend on the type of structure of the plan. It'll depend on the concentration of membership we have. And so we'll have a lot of moving parts, but you'll see us progressively improve across the entire book of business we have over time. And I think we're going have our fair share of very highly rated plans over time.

<Q - Charles Boorady>: Five is a theoretical goal, I understand that. But just to get a rough sense of timeframe, Mike, are you thinking - is it two years, three years, four years, to get to four-star average? And then how long to get to five?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: Again, I think the clinical side, we can probably measure and be a little more predictable around. We're not talking a six- or seven-year journey here. Our people realize they need to be on this, we need to figure out how to improve these scores, and we'll move as quickly as we can.

<Q - Charles Boorady>: Should we expect to see any special investments, more downstream risk sharing, or anything else as you strive to achieve that goal?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: All of those things. I mean, we're looking for providers that are interested in working closely, being driven by metrics. Some will want to take some risk sharing; some will not. It's not critical they go either way. But the more tightly integrated you have, and if they have any kind of

risk-sharing relationship with us, they tend to be much more focused on the quality of health care, as well as things like service metrics and this sort of thing. So as far as we can move down the path as fast as we can with any provider that's interested in doing better, seeking better value for money, providing a higher level of service, and participating in the improved payment methodology that results from all that, we're ready. So we're looking nationwide as we speak right now, and there's a lot of interest out there.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Doug Simpson from Morgan Stanley. Your line is open.

<Q - Doug Simpson>: Hi, good morning, everyone. Just walking through the one G&A slide, just trying to come at this a little bit of a different way. If we think about it being 13.8% in '09 coming down to 13.2% in 2010, and then if you strip out Concentra, you're at, call it, the midpoint 12.5%. If we were to look ahead into 2012, just trying to wrap all the comments you've made, including potentially the investments to support the star ratings in the MA book, how would you see that sort of core G&A tracking, looking out 12 months from now?

And then just maybe on the Concentra side, the 225 you're showing this year, it sounded like there was some - maybe some one-time type stuff in there for 2011. So just trying to get at how that progresses this year and what the run rate might look like coming into 2012?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Well, as you've pointed out, we try to divide this into two things, and that's what the slide's trying to get at. What's the core rate - what's the SG&A ratio on the core expenses? And again, we're transforming the company. So we're not only getting more cost competitive, but we're using some of those savings to reinvest in the other things we need for our corporate strategy. So there's two things we're always looking at. So it makes it hard, kind of, to look at it from the standpoint of, well, what's it going to be in 2012? I think if you look at the blue bar on those slides, the dark-blue portion, you can see that the trend is clearly down, and that's really what we're about. Now, we need to reinvest. We need to get to it to do the strategy that we talked about. We need to do that reinvesting.

As far as Concentra is concerned, we just have acquired that, and we're looking to see all the different things that can be done with that. There'll be some investment in there. The investments that we're going to make in 2011 that cause that sort of 225 comes from the fact, as was mentioned before, all the Concentra expenses are in there. And we have to do the integration, really, we have to bring the two organizations closer together and figure out how we can really get the synergies that we think are available to us through Concentra.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: I would add that trying to figure out SG&A is going to be a little difficult for you all over time, as our business mix continues to shift, and things like Concentra is a good example. But what we know internally here is that admin has to be very, very low in this new MLR world we're going to live in across all these products. So higher productivity internal is what we're focused on. And to the extent the mix changes some, it may be harder for you to see on a consolidated basis. But we are all over the idea that scale

matters, our IT investments have to be smart, and our SG&A internally on our core businesses has to be very low.

<Q - Doug Simpson>: That's helpful. Maybe just some color on the Concentra deal and how you see the spending in longer term, I guess on two fronts. One, just in general with provider contacting in the markets that have overlap? And then secondly, how do you see this positioning you with respect to, call it the employers and the 1,000- to 2,000-employee count? How do you envision structuring products leveraging the Concentra assets?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: There's a number of possibilities. I mean, I'll go back to what we said when we bought Concentra. This was about acquiring a platform with good management and a basic position capability to locate offices, staff them, build metrics about performance, hire and recruit and retain, and that sort of thing. So you can take our company and you can start looking at all sorts of spots where the ability to do that will be meaningful. But it's important to note that it's going to vary dramatically by location. In some cases, we may only have a few of these. In some cases, they may be concentrated. In some cases, they may be the core of an insurance product. In some cases, they may strictly be strictly be a relationship with employers across wellness and well-being and this sort of thing, work-site clinics. So we look at the company from a number of perspectives, and we think strategically it fits into a lot of little corners of what we do. We like the idea of having them be a key component in our Medicare strategy long term. Because the primary care piece is critical in Medicare. And I think we've got a situation here where we have the capability to really have a tool that can be used in a lot of different ways. So it's not a simplistic view of it. In the meantime, it's a well-run company that's contributing to our EPS.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Tom Carroll from Stifel Nicolaus. Your line is open.

<Q - Tom Carroll>: Hey, good morning. Just want to follow back up on some of the enrollment numbers that we talked about. So it's really two things. I guess first of all, what kind of dis-enrollment are you expecting? And I think it goes back to Sarah's question on your increase year-to-date on MA versus your guidance. So there's a 30,000 roughly person difference there. I guess, does this mean you expect 30,000 folks to dis-enroll? And what kind of dis-enrollment behavior have you seen year to date?

<A - James E. Murray>: This is Jim Murray again. The 30,000 that we referenced earlier was our stepping back, looking at what happened during the ADP and the pockets of members that stuck with us and the premium levels that we delivered to them and us stepping back and saying, is it likely for these folks to continue to pay these premiums? And what would prudence tell you in terms of establishing a target? And that delta was the 30,000 that we've come up with. To the extent that as we go throughout the course of the year, those folks are paying the premiums that were a part of their plan benefits for 2011, it's possible that that 100,000 midpoint would go closer to the 130,000.

For the remainder of this year, except for that, we would hope that our age-in opportunities would offset the terminations that occur as folks die

and choose to leave the program. So we would think, other than that 30,000, that we would be generally flat for the remainder of the year. And as I said in my earlier remarks, we were very, very pleased with our persistency that we saw during the AEP. We did a lot of work to message folks in terms of those that were getting premium increases, any kind of benefit changes, messaging them about the possibility that we wanted to move them from a private fee-for-service offering to a network-based option. Lots of connections, lots of relationships. And we were pleased with how we ended up in terms of keeping significantly more members than we had anticipated.

<Q - Tom Carroll>: So thank you for your follow-up on that. My second question: Do you have a sense of maybe how much did your Walmart arrangement contribute to your strong MA gains this year? So in terms of people having conversations about the Part D product, how much of that do you get a sense of translated into full-blown MA sales?

<A - James E. Murray>: We haven't connected the dots exactly. But I will tell you the opportunity to be in 3,000 Walmart locations throughout the United States and having an opportunity to talk with seniors in terms of their needs and talk to them about the - not only the Walmart plan, but also whether or not there's other kinds of products that would better suit their needs - likely contributed nicely to the improved enrollment that we experienced. There's probably a really direct correlation to that. And we really enjoy the relationship that we've developed with Walmart. We look to do more with them in the future.

<Q - Tom Carroll>: Will you be sitting down with Walmart to do kind of a debrief on how things went this year?

<A - James E. Murray>: Not only on how the prescription drug plan worked, but a lot of other good ideas that they and us are developing as a partnership.

<Q - Tom Carroll>: Great. Thank you.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Christine Arnold from Cowen & Company. Your line is open.

<Q - Christine Arnold>: Hey, there. I just wanted to probe your guidance a little bit with respect to the Medicare book. You're saying that your guidance incorporates a 5% Medicare margin, true?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: True.

<Q - Christine Arnold>: Okay. And you did better than that in 2010? True?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: True.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: And '09.

<Q - Christine Arnold>: I'm sorry?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: And '09.

<Q - Christine Arnold>: And '09. Okay.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: And '08.

<Q - Christine Arnold>: Right, right. Okay. So I guess what I'm getting at here is you've historically taken that which you've done better and tried to incorporate it in benefits and premiums, and yet you've still done better. Can you tell me in 2010 if my 83.8% Medicare MLR is reasonable?

<A - James E. Murray>: Well, again, I think you have the basic thing, because we've done it - as Jim mentioned, we've done it year after year. We start with 5%, and then we work very hard as an organization to improve. And we've been successful in doing that the last few years, but we still end up with having to start all over again. Now, what helps us to do that, as Mike and as we've said in Investor Day and really all through the last three or four years, the 15% solution is the reason that enabled - that's one of the primary reasons that enables us to do that. Because we continue to deliver better outcomes at lower costs to those who are the most chronically ill and have the greatest morbidities among our membership. So that's the primary reason that we're able to go. When we get to this time of the year, as Jim mentioned earlier, too, with only six weeks gone in the year, it's hard to really say, well, now it's time to raise that up. We wait until we see that, and then we say, this is where we are. And this is the pattern that we've done every year.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: Let me add to that. We're heading to an 85% MLR world in Medicare. And when you're there, the way you win, and the way you grow, and the way you have better value for people in the program is through cost management and low admin, and you plow your margin above 5% back into those things every year. And this is going to be a top-line growth story for a very long time for Humana. And I think the winners are going to be those who get better value for money and turn it right around and give it back. And we're positioned pretty well in an 85% MLR world. We don't have to go much further than where we are right now to be there.

<Q - Christine Arnold>: Right. And my ballpark that you did about 100 basis points better than the 5%, and that's what you're plowing into benefits and premiums?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: Well, I mean, the math is simple. We ran something just north of 6%.

<Q - Christine Arnold>: Okay.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: So we moved it back to 5%, and I said from the beginning, we had no intention of running 5% in 2011, but that's the math as we sit here. And so we're working very hard today with everything I've talked about from a clinical perspective, to get better value, more productivity, and whatever that works out for '11, so be it. We'll plow that back in in '12, and grow

the top line again.

<Q - Christine Arnold>: Okay. Thank you.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Chris Rigg from Susquehanna. Your line is open.

<Q - Chris Rigg>: Good morning. Thanks for taking my questions. I was wondering if you could give us an update on the longer-term status of the TRICARE contract, and where that process stands at this point?

<A - James E. Murray>: Well, the government has come back to us and negotiated two six-month extensions. We wish we knew more about when they're going to make their final decision. The folks in the TRICARE organization tell me that the government could take as long as up to May before there's an issue with the terms of the timing. We're hopeful that smarter heads prevail and we are successfully put back into the program, but time will tell. And I can't tell you much more than that. It's frustrating, but that's all we know.

<Q - Chris Rigg>: Got you. Okay. And then was hoping - if you could help me better understand what determines the contribution to the Humana Foundation? And then on top of that, was there anything in the Walmart expenses in the fourth quarter that would be ongoing rather than nonrecurring? And I'll leave it at that.

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: This is Mike McCallister. On the foundation, we try every year to put something in there as part of our overall social responsibility agenda. In five of the last 10 years, we didn't put anything in. In the other five, we put something in. So what you're looking at is a bit of a catch-up over time, and we think it's a key component of what we do as a company, and we want to be good citizens everywhere we do business. And we do it both directly from the company as well as through the foundation. So you're seeing a number that's a bit of a catch-up over basically a decade.

<A - James E. Murray>: On your Walmart question, there was some amount of continuing costs related to telesales operations and advertising programs that we thought would be similar year over year. The amount that Jim highlighted in his remarks is totally related to incremental costs that we don't think will recur next year.

<Q - Chris Rigg>: Okay. Thanks a lot.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Ana Gupte from Sanford Bernstein. Your line is open.

<Q - Ana Gupte>: Thanks. A couple questions. The first one's on the Part D book, and you've enrolled 500,000-plus members. And as you're looking at the health profile of these people across low-income subsidy retail, enrolled in

Walmart or otherwise, are you seeing anything that gives you pause relative to your expectations actuarially from all your claims experience, and is there any possible upside and/or downside to your margins with this new formulary design?

<A - James E. Murray>: This is Jim Murray. I expected this question. We looked at risk scores, and they're very good. We've looked at scripts PMPM; they look good. We've looked at generic dispensing rate; it looks good. We've looked at member risk share; we had that problem a couple years ago that I won't ever bring up again on member risk share. That looks good. Mail utilization, that's one of the reasons why we wanted to do this program. It was our Right Source and the mail that we could do as a result of this program. That looks strong. And the allowed costs look very good. So we're very, very pleased with the way the Walmart plan looks in its first six weeks.

<Q - Ana Gupte>: Thanks. It looks like more upside than downside if anything. Okay. So then on Medicare Advantage, you mentioned that your group sales went pretty well. Is this a shared margin with Cigna for 2011?

<A - Michael B. McCallister, Chairman of the Board and Chief Executive Officer>: No. No. No. We didn't say that. We didn't have any significant group sales we reported. So we're not expecting things to come out of our Cigna relationship probably till next year.

<Q - Ana Gupte>: Okay. I thought I saw something in your press release. Sorry, I was probably mistaken. Then switching gears, I was looking at some of the components on MA rates going forward, 2012 and beyond. There was a letter from MedPAC to - I believe, to Donald Berwick on the \$1.3 billion demo project and how that was not budgeted for. So as you're having conversations and consulting with them, do you see that piece at risk? And are you including that potential in the 2012 rate?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: I think that it's included in there in that range that Jim mentioned from minus 2% to plus 2%. It's one of those myriad of factors that really kind of goes into what they believe the trend piece is. But again, I think it's a relatively small piece of that. But again, we'll wait and see when it comes out in terms of what the final is. We want to make sure that we're talking about the flemary rate book here, and every year we have our own bid/ask as to what's going to be in there. But again, we still have the days afterwards to think about it and to comment on it, and then when it becomes final in April, then we go to work. So it's still a long ways away in terms of whatever these numbers turn out to be.

<A - Regina C. Nethery, Vice President of Investor Relations>: This is Regina. We're running really long on the call. And we've still got a few more people in the queue, so we're going to ask that you limit it to one question at this point, and we'll take as many as we can before we have to conclude the call. So next question, please?

Operator:

Your next question comes from the line of Scott Fidel from Deutsche Bank. Your line is open.

<Q - Scott Fidel>: Thanks. My question is just relative to the commercial MLR guidance. And it looked like that ticked up by around 50 basis points from

the guidance you had issued in November at the Investor Day. But it doesn't sound like you've changed any of your views on med cost trends. So maybe you can just talk to the change in the commercial MLR guidance?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Again, I think what we've looked at is the large group piece. Because remember, we have the 80% in our small group and our individual. And those are a large part. And we've also signaled that, given the large group piece, there's a smaller number of members. As we approach the 80% - so we've ticked up by 50 basis points, as you point out, from when we did it last time. So, again, it's all a matter of the mix. We want to tell you that we've given some weight to the low trend that we had last year and now it's going to affect this year. But, again, that basically follows mostly to the large group. And that's why it's a \$0.10 piece.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Kevin Fischbeck from Bank of America. Your line is open.

<Q - Kevin Fischbeck>: Okay. Thank you. I was wondering if you could maybe help provide a cash flow bridge to the parent for 2011? If you didn't do any buyback or acquisitions, where do you think that cash balance might end up at the year-end?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Generally we give a very strong indication of that in our second quarter call, which would be in August. And that would be after we've visited all the states, extracted dividends, in conjunction with consultations with them, and also visited the credit rating agencies. I would say this, qualitatively: We had an excellent year this year, as we've talked about all morning, and so we would expect the dividends to be higher than the \$750 million we took last year.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of David Windley from Jefferies. Your line is open.

<Q - David Windley>: Hi. On the SG&A ratio, it looks like ex the Concentra, that is down, I think, 50 basis points. And I was wondering if I'm looking at that apples to apples and what the drivers were of that?

<A - James H. Bloem, Senior Vice President, Chief Financial Officer, and Treasurer>: Again, you are looking at it apples to apples, and again, the 50 basis points, again, looks at as we crossed over the threshold from November 18, it went over year-end, we now have all our budgets in place. That's where the 50 basis points is.

<A - Regina C. Nethery, Vice President of Investor Relations>: Next question, please?

Operator:

Your next question comes from the line of Carl McDonald from Citigroup. Your line is open.

<Q - Carl McDonald>: Thanks. Recognizing we're only a few weeks into the year, anything that you can point to at this point that would suggest that cost trends are accelerating relative to the trends you saw in 2010?

<A - James E. Murray>: It's Jim Murray. It's very early in the year, so it's very difficult to make any predictions based upon the claim payments that we've seen. Nothing significantly favorable or significantly negative.

<Q - Carl McDonald>: Thank you.

<A - Regina C. Nethery, Vice President of Investor Relations>: Thank you. And we've got time for one last question, please.

Operator:

Your last question comes from the line of Peter Costa with Wells Fargo Securities. Your line is open.

<Q - Peter Costa>: Thank you. I wanted to take another shot at the question of converting to the PPACA rates. What portion - and maybe you can answer a couple specific components of it - what portion of your business will be under a two-year conversion as opposed to a longer conversion? And then secondly, what percentage difference would there be between the PPACA rate and your bid-plus-rebate payment that you got in 2010, if it was to convert 100%?

<A - James E. Murray>: Well, I can answer the first question. I'm not sure what the second question was specifically. The year phase-in is two years is 34%, four years is 29%, and six years, 27%. But I need help with some acronyms and specifically what you're asking with your second question.

<Q - Peter Costa>: Okay. The rate under PPACA that has the variation from 95% of fee for service to 115%, if we were to take the average for your book of business as to what that rate would be compared to what you were paid on an average payment from the government in terms of - it's not the benchmark, but what your payment was in 2010?

<A - Regina C. Nethery, Vice President of Investor Relations>: So the old payment versus fee for service versus what we think the new payment under - versus fee for service would be post-health insurance reform? Is that - ?

<Q - Peter Costa>: Yes. If you had 100% of your business convert.

<A - James E. Murray>: I'm not as smart as a lot of people, so I need remedial training. Can you help me with exactly what - ?

<A - Regina C. Nethery, Vice President of Investor Relations>: Peter, this is Regina. I take it you're asking about where MedPAC, I believe it does, does the study that says, for instance, in 2010 assuming the doc fix had happened, we were like 113% of fee for service. If they'd done the doc fix properly, we would have been at 107%. Is that where you're headed?

<Q - Peter Costa>: Correct.

<A - Regina C. Nethery, Vice President of Investor Relations>: Okay. I don't

-

<A - James E. Murray>: Well, I can just talk about my broad feelings as respects any kind of what is referred to as an overpayment. When a lot of folks were here for Investor Day, we shared with you a slide that demonstrated that trends, as they restate over time, typically run in the 4% to 7% range. So I'll use 5%. And as many of you know, over the last two or so years, we've gotten either a flat or a negative trend estimate. And so, if it were me, I would say that those were reductions from this theoretical overpayment.

And then when you layer in the doc fix, which I've been told is valued somewhere around 4%, when you put all those pieces together, I would proffer - but this is me - that we're nowhere near being overpaid the amount that we're hearing that there's an overpayment out there. And so, over time, it's our strong belief that as trends restate to their proper levels, that that will self-correct itself as time goes on. And that it's been very good management for us to get through the last several years not getting the trend increases that were appropriate. And so I think we're really close to the 100% of Medicare fee for service that you know is designed by the healthcare reform.

Now, I know I didn't answer your question.

<A - Regina C. Nethery, Vice President of Investor Relations>: But I think that's as good as we can get for you today, Peter. Go ahead, Mike.

Michael B. McCallister, Chairman of the Board and Chief Executive Officer: Okay. Let me just close. Thanks for joining us this morning. We had a good quarter, and we're pretty excited about where we are for 2011, especially relative to our Medicare results here in the AEP. So we're positioned well, we're happy with that. I want to thank the Humana associates that are on the call for making this all possible. And with that, we'll say goodbye.

Regina C. Nethery, Vice President of Investor Relations: Have a good day.

Operator:

Ladies and gentlemen, this concludes today's conference call. You may now disconnect.

This transcript may not be 100 percent accurate and may contain misspellings and other inaccuracies. This transcript is provided "as is", without express or implied warranties of any kind. Bloomberg retains all rights to this transcript and provides it solely for your personal, non-commercial use. Bloomberg, its suppliers and third-party agents shall have no liability for errors in this transcript or for lost profits, losses, or direct, indirect, incidental, consequential, special or punitive damages in connection with the furnishing, performance or use of such transcript. Neither the information nor any opinion expressed in this transcript constitutes a solicitation of the purchase or sale of securities or commodities. Any opinion expressed in the transcript does not necessarily reflect the views of Bloomberg LP

LAW OFFICES
OF
MARK S. JOFFE

1800 K STREET, N.W.
SUITE 720
WASHINGTON, D.C. 20006-2202
FAX (202) 457-6636

MARK S. JOFFE
(202) 457-6633

KELLI D. BACK
(202) 457-6632

ADMITTED IN DC & MD

ADMITTED IN DC

March 13, 2009

Alissa Fox
Senior Vice President
Office of Policy and Representation
Blue Cross and Blue Shield Association
1310 G Street, NW, Twelfth Floor
Washington, DC 20005

Dear Ms. Fox:

I am responding to your request for an opinion regarding whether CMS is legally required to assume that the Medicare physician fee schedule will be reduced by 20 percent, as provided by current law, for purposes of developing the national per capita MA growth percentage.

As background, in the "Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies," CMS announced its proposed 2010 national per capita growth percentage. One component of that growth percentage is the 2010 Trend Change, which was estimated at a negative 1.1 percent. The principal reason for the negative trend change was the assumption by CMS that the Medicare physician fee schedule will be reduced by about 20 percent, as provided for under existing law. The issue you have asked me to consider is whether CMS is obligated to assume that the physician fee schedule will be reduced by that percentage notwithstanding the widely held expectation that Congress will nullify the fee reduction, as it has done in previous years.

Section 1853 of the Social Security Act specifies the payment methodology used by CMS to develop the Medicare Advantage payment rates. The national per capital MA group percentage is a factor that affects the change in the MA benchmark amount from one year to the next. Section 1853(c)(6) of the Social Security Act defines national per capital MA growth percentage as follows:

(A) In general. In this part, the "national per capita MA growth percentage" for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate

determinations may be made for aged enrollees, disabled enrollees, and enrollees with end stage renal disease.

Under this language, the Secretary is directed to develop an “estimate” of the growth rate. The language of the statute does not specify how that estimate is to be made. Thus, the statute on its face does not require that the Secretary assume that existing law will continue in effect in making this projection. CMS’ implementing regulations and its corresponding manual provisions repeat the reference to developing an “estimate” without elaborating on how CMS is to determine the estimate. See 42 CFR §422.308 and Section 20.1 of Chapter 8 of the Medicare Managed Care Manual (Payments to Medicare Advantage Organizations).

Because the statute and regulations do not explicitly require that CMS assume that existing law will continue, it is clear that there is no explicit legal obligation for CMS to estimate the growth percentage based on existing law. Thus, the key issue is whether a reasonable estimate of this growth percentage implicitly requires acceptance of existing law.

Because the estimates are developed through actuarial analysis, it is appropriate to consider the standards established by the Actuarial Standards Board in examining this issue. There are two standards that have been adopted by the Actuarial Standards Board in its Actuarial Standard of Practice No. 8 “Regulatory Filings for Health Plan Entities” that are directly relevant to this issue. These two standards are as follows:

3.2.4 Use of Past Experience to Project Future Results. When setting assumptions, the actuary should adjust past experience for any known or expected changes that, in the actuary’s professional judgment, are likely to materially affect expected future results.

3.2.9 Reasonableness of Assumptions. The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary’s professional judgment, using relevant information available to the actuary. This information may include, but is not limited to, business plans; past experience of the health plan entity or the health benefit plan; and any relevant industry and government studies that are generally known and reasonably available to the actuary. The actuary should make a reasonable effort to become familiar with such studies.

Standard 3.2.4 is clear that an actuary has the obligation to consider “expected changes” that are likely to materially affect expected future results. In addition, Section 3.2.9 requires that the assumptions used be “reasonable.” Given that there is widespread, or perhaps even universal, agreement that Congress will be compelled to nullify the 20 percent reduction in the Medicare physician fee schedule, the “expected change” is that this fee reduction will not go into effect. Thus, in my opinion, CMS would clearly have the authority to factor in that expected change in estimating the national per capita MA growth percentage. Moreover, I believe that CMS’

actuaries, who would have the same responsibility to follow these actuarial standards, should factor in legislation to nullify the fee cuts in making their growth projections.

In addition, a conflict exists between CMS' view that it lacks the authority to assume that Congress will nullify the physician fee cuts and CMS' position allowing MA organizations to assume a rescission of the cuts in projecting their MA bid costs. CMS has permitted MA organizations to assume that Congress will nullify previous reductions in the Medicare physician fee schedule as part of the projections of its costs for purposes of its MA bids. Because the national per capita growth percentage directly impacts the revenue assumptions that an MA organization uses in its bids, there is a clear inconsistency in CMS allowing potential future legislation to be factored into cost projections, but not allowing that same factor in projecting revenues. It would appear that both projections would be governed by sound actuarial principles and those principles dictate acceptance of "expected changes" whether those expected changes are legislative or otherwise.

A final point to note is that in a related context CMS has exercised its administrative discretion to make a decision in anticipation of Congressional action to nullify a physician fee schedule reduction. Under Original Medicare, CMS' contractors are obligated by law to pay clean claims within 30 days of receipt. See 42 CFR §405.922. Notwithstanding, CMS directed that its contractors delay for 15 days until July 15, 2008, payment of claims in order to avoid paying physicians at a lower rate while legislation was pending to rescind the reduction in physician fees. This example illustrates the flexibility that CMS has been willing to exercise on this issue prior to Congressional action. Moreover, if CMS was willing to assume that Congress would nullify a 10.6 percent fee schedule reduction in 2008, it is at least equally reasonable to conclude that Congress would negate physician fee cuts of twice that size.

As explained above, in my opinion neither the MA statute nor its implementing regulations compel CMS to assume that the 20 percent fee cut will occur as part of its estimate of the national per capita growth percentage. The unprecedented level of this cut level warrants a change from past practice. Based on actuarial standards, I believe that CMS has the responsibility to use assumptions based on expected changes. Given the universality of the expectation that the payment cuts will be nullified, CMS arguably not only may, but has the responsibility to, assume the statute would be amended in these unique circumstances.

Feel free to contact me if you would like to discuss this issue further.

Sincerely,



Mark S. Joffe

MA coding pattern differences – Advance Notice and Announcement text

2008 Advance Notice, published 2/16/07

Section B. Adjustment for MA Coding Intensity

Section 1853(k)(2)(B)(iv)(III) requires CMS to reflect in its risk adjustment for Part C payment “differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.” The Conference Report for the Deficit Reduction Act of 2005, which added section 1853(k), calls upon the Secretary to “conduct an analysis” in order to attempt to identify such differences in coding patterns, and that “[t]he conferees intend that any adjustments made for differences in coding patterns be made for differences resulting from inaccurate coding.” The Report further provides that “[t]o the extent that the Secretary identifies any differences, they are to be incorporated into calculations of the risk rates and the budget neutrality factor in 2008, 2009, and 2010.”

CMS calibrates the risk factors under the CMS-HCC model on the diagnoses and expenditure data of fee-for-service Medicare beneficiaries. Risk scores are then developed for each Medicare beneficiary (including those in managed care) using their own diagnoses. These individual risk scores are used to adjust Part C payments to MA organizations for each plan enrollee. An upward trend in fee-for-service coding results in average risk scores that are greater than 1.0 after the calibration year. Increases in risk scores over time are a result of changes in diagnostic coding over time which, in turn, can be a result of more specific coding, increased illness, or more severe manifestations of illness. In order to keep the average risk score at 1.0, CMS adjusts the CMS-HCC risk scores for these changes in fee-for-service coding patterns using a fee-for-service normalization factor (in 2007, this factor is 1.45 percent per year). A key reason for normalizing risk scores is to keep them tied to the county ratebook, which is standardized with the average county FFS risk scores.

Because the CMS-HCC model is calibrated on fee-for-service data and the resulting risk scores are adjusted for fee-for-service normalization, MA coding patterns that differ from patterns in fee-for-service may result in risk scores that are not equivalent to the risk scores of the FFS beneficiaries used to calculate the county rates.

CMS is conducting studies designed to assess the degree of coding patterns differences that may be identified between FFS and MA and the extent to which any differences could be appropriately addressed by an adjustment to the CMS-HCC risk scores. Below is a description of two pending studies.

1. Differences in disease progression between MA and FFS. The goal of this study is to assess any differences in coding patterns by comparing overall changes in risk scores and the disease component of the risk scores for beneficiaries in FFS and in MA. This study is being conducted to test the hypothesis that MA plans code more thoroughly and, therefore, similarly situated beneficiaries appear sicker. To conduct this study, CMS will analyze the change in risk scores from 2004 to 2006 among beneficiaries in FFS and MA. We will also explore the extent to which changes in risk scores are attributable to case mix in FFS and MA plans by separately analyzing changes among continuing enrollees (stayers), leavers, and joiners. The analysis of case mix will allow us to decompose the overall trends in risk scores into the effect of changes in enrollee composition versus changes due to differences in coding patterns.

2. Differences in persistence. The goal of this study is to assess any differences in coding patterns by comparing the differences in the ‘persistence’ of HCCs among continuing enrollees in FFS and in

MA. This study is being conducted to test the hypothesis that greater coding in MA is reflected in greater persistence in of diseases (HCCs) across years. To conduct this study, CMS will analyze rates of persistence and changes in the rates of persistence for specific diseases in the CMS-HCC model from 2004 to 2006 among beneficiaries in FFS and MA. We will explore whether persistence rates differ between FFS and MA. This analysis will specifically address rates of persistence among those who remain continuously enrolled in FFS and MA over time.

CMS will use the results of these studies and additional analysis (if any), once completed, to determine the necessity for, and if necessary the magnitude of, an adjustment to the Part C risk scores based on differences in coding patterns between MA and FFS. To the extent that these studies produce valid results that identify differences in coding prior to the April 2, 2007 Announcement, that Announcement will reflect any warranted adjustments based on these differences. If there are no conclusive results as of that date, no adjustment will be made for 2008. We invite public comment on the relative strengths of each of these studies as well as suggestions for alternative studies that could help identify differences in coding patterns.

Section C. MA Coding Intensity Adjustment

As required by the Deficit Reduction Act (DRA), we have analyzed whether there are coding pattern differences between Medicare Advantage and fee-for-service. As discussed in the Advance Notice, we conducted two studies to assess the extent of coding differences.

Persistence Analysis. The first study looked at how well Medicare Advantage and fee-for-service consistently identify beneficiaries with ongoing, chronic conditions from year to year. Because some beneficiaries have conditions that we know persist from year to year, e.g., diabetes, we would expect a beneficiary who has been identified as diabetic in one year to also be identified as diabetic in the following year. The intent of this analysis is to assess the extent to which any coding differences between MA and FFS can be attributed to a higher rate of year-to-year “persistence” in diagnosis coding in MA. In our analysis, we looked at beneficiaries enrolled in an MA plan over a two-year period (either 2004-2005 or 2005-2006) to see if diagnosis codes from the first year were reported in the following year. Our results indicated that by 2006 there were no notable differences in persistence coding between MA plans and FFS providers.

Disease Progression Analysis. For this second study, we looked separately at risk score trends for various groups of enrollees in MA and FFS: specifically, we looked at the risk scores of those who joined FFS or enrolled in MA plans (“joiners”), those who disenrolled from FFS (either due to death or because they enrolled in an MA plan) or from an MA plan (either due to death or because they returned to FFS) (“leavers”), and those who stayed in an MA plan from one year to the next or who stay in FFS (“stayers”).

Findings Regarding Risk Score Trends. We found that, over the period from 2004-2006, MA risk scores increased faster than FFS risk scores. FFS risk scores increased approximately 2 percent per year, while MA risk scores increased approximately 4.5 percent per year. We found two dynamics that explained this differential growth in risk scores. The first dynamic was enrollment patterns.

- **Joiners:** The risk scores of those who enroll in MA plans are, on average, higher than the risk scores of those who enroll in FFS – new enrollees in FFS are largely newly-eligible beneficiaries who have just turned 65 years old; among new enrollees into MA plans, more than twice as many have switched from FFS than are newly-eligible for the program; and
- **Leavers:** Those who disenroll from MA plans -- either decedents or those who are switching to FFS – have an average risk score that is lower than the average risk scores of disenrollees from FFS, who are largely decedents.

With FFS losing higher risk beneficiaries than MA, and with MA enrolling higher risk beneficiaries than FFS, MA risk scores were pushed up at a faster rate than risk scores in FFS.

The second dynamic is related to those who stayed enrolled in an MA plan or in FFS from one year to the next (“stayers”). We looked specifically at the disease (HCC) portion of stayers’ risk scores so that we could isolate the effect of coding and exclude the effect of demographic changes, such as aging, on risk scores. The disease portion of the MA stayers’ risk scores increased more than the disease portion of those stayed in FFS.

We found that part of the difference in the increase between MA and FFS risk scores is due to the effect of different enrollment patterns in MA versus FFS and changes in the demographic

characteristics of enrollees (such as aging into brackets with higher relative factors or obtaining Medicaid eligibility). We would not want to adjust payment for such factors since they are unrelated to coding patterns.

We also found that part of the differential increase in risk scores is due to the increase in the disease component of MA stayers' risk scores. However, we have not been able to measure the possible causes of this differential. For example, it is unclear how much of the increase in risk scores is due to changes in coding patterns versus changes in health status. In addition, to the extent that the increase is due to coding, it is unclear how much is due to catch-up (MA plans increasing their coding to "catch up" to the level of FFS) versus coding patterns that exceed FFS. This overall industry pattern can be seen to varying degrees on a plan-by-plan basis – some MA plans have experienced significantly high changes in the disease portion of the risk scores of the enrollees who stay enrolled in their plan while some have experienced very little.

Given that we cannot yet definitively attribute the difference in MA and FFS risk scores to underlying coding patterns differences, we will not make a coding intensity adjustment to MA payment for 2008. We will continue to study this issue, with particular focus on the plans that have experienced significant increases in risk scores, in an effort to determine what the appropriate adjustment might be for 2009 and 2010.

Comment: Several commenters thought it would be inappropriate to make adjustments related to activities that serve to improve beneficiaries' health and quality of life, and to coding patterns that are derived from the historical period 2004-2006, since coding patterns could have since changed. Commenters also suggested various factors that could explain differences in MA and FFS coding patterns: selection bias, differences in local coding practices across particular markets, differences in the urban/rural mix of MA enrollment to beneficiaries in the fee-for-service program, emphasis placed by MA plans on preventive care and early diagnosis, techniques such as discharge planning, health risk assessments and medical management that contribute to improved care coordination, under-reporting of claims at start-up and subsequent improved coding practices. One commenter recommended that CMS release detailed methodology and data to support all coding pattern adjustments to MA rates and payments and provide MA plans with an opportunity to review and comment.

Response: We appreciate the input of the commenters. We look forward to future discussion regarding our ongoing analysis of differences in coding patterns between MA and FFS.

Section E. Adjustment for MA Coding Intensity

Background

As promulgated by the Deficit Reduction Act (DRA), Section 1853(k)(2)(B)(iv)(III) requires CMS to reflect in its risk adjustment for Part C payment “differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.” The DRA further instructs that results of the analysis will be “incorporated into the risk scores only for 2008, 2009, and 2010.” In order to comply with this section of the DRA, CMS has studied the changes in MA and FFS risk scores, the differences between those changes, and the coding patterns behind these changes.

From our research for the 2008 payment year, CMS found that MA risk scores increased approximately twice as much as FFS risk scores did for our study population between 2004 and 2006. There are a number of key reasons why risk scores in the MA and FFS sectors may rise at different rates. The composition of enrollment in each sector can have an effect on the change in the average risk score. Initially, some MA plans may have had difficulty gathering and reporting diagnosis codes as completely as FFS, so part of the differential risk score growth could be due to “catching up” to FFS. MA plans may be finding and diagnosing disease at a higher rate than FFS providers. Or, it is possible that beneficiaries enrolled in MA plans may be getting sicker faster than beneficiaries in FFS.

Our preliminary research on coding patterns, which was conducted prior to the release of the 2008 Rate Announcement, was unable to clarify enough about the coding pattern differences that result in MA and FFS risk score differences. Therefore, we did not make an adjustment for coding patterns differences in payment year 2008. We stated that we would continue to study this issue, with particular focus on the plans that have experienced significant increases in risk scores, in an effort to determine what the appropriate adjustment might be for 2009 and 2010.

CMS has continued its analysis of the coding patterns that result in differences in the MA and FFS risk scores. The findings below are based on diagnoses reported for payment years 2004-2006. CMS will update these figures by adding the (currently unavailable) 2007 risk scores to the analysis, prior to the publication of the Announcement on April 7, 2008.

Study Results

Composition effects: In order to analyze the gross difference between the change in FFS and MA risk scores, we examined the change in risk scores for three categories of enrollees: stayers, leavers, and joiners. **Stayers** were those enrollees who remained in the same sector (either FFS or MA) over the study period, **leavers** were those who left either the MA or FFS sector, either to go to the other sector or who died, and **joiners** were those who came into FFS or MA, either from the other sector or who were newly eligible to Medicare. We found that indeed some of the difference in the change in risk scores between MA and FFS was due to composition effects. Specifically, we found that:

- A significant portion of the beneficiaries who join MA are beneficiaries who are switching from FFS. In FFS, the vast majority of beneficiaries who join are newly-eligible to Medicare. The risk scores of beneficiaries who are newly eligible to Medicare tend to be very low and these low risk scores depress FFS risk score growth relative to MA.

- Of the leavers, decedents (who have high risk scores) are a slightly larger fraction of FFS beneficiaries than of MA enrollees and, thus, the exit of high-risk score decedents restrains the year-to-year growth of average FFS risk scores by slightly more than it does MA scores.

Because most new enrollees in FFS are newly-eligible to Medicare and FFS is losing higher risk beneficiaries, overall average MA risk scores are pushed up at a faster rate than risk scores in FFS. Over the two-year period, approximately 50% of the difference between the MA and FFS sectors in the growth of risk scores is due to enrollment patterns and approximately 50% is due to the more rapid growth in risk scores for beneficiaries who stay in the same sector in consecutive years.

Focus on “stayers:” Focusing on the stayers allows us to examine differences in risk score changes that are not due to the changing composition of the enrolled population. In our analyses of the impact of coding patterns on stayers’ risk scores, we did the following:

- We focused on two cohorts of stayers: those who were stayers in 2004-2005, and those who were stayers in 2005-2006. We weren’t able to add the 2006-2007 cohort to the analysis prior to the release of the Advance Notice, but will do so before the release of the Announcement in April 2008.
- For each cohort, we defined MA stayers as those enrollees who were in the same contract in the July of each cohort year, as well as in each data collection year. For example, for the 2004-2005 stayer cohort, we include enrollees who were in the same contract in July 2004 and July 2005, and in all of 2003 and 2004. This criterion resulted in the exclusion of enrollees who would have been new enrollees in the data collection years, as well as those enrollees who switched contracts.
- We found that the overall risk scores of MA stayers increased by 0.032 more than those of FFS stayers over the two-year study period. As discussed below, we then broke down the change in aggregate risk scores into the changes in the disease component of the CMS-HCC risk score (the “disease score”) versus the demographic component.

Focus on the disease score of stayers: The disease score is the HCC component of the risk score that plans (and FFS providers) affect by their reporting of diagnosis codes. Among stayers, we found that MA disease scores increased more quickly than FFS disease scores and that change in the disease component of the risk score accounted for approximately 90% of the difference in the change in MA versus FFS risk scores.

We found that, on average, disease scores for stayers in MA plans increased 20% faster than stayers in FFS over the two years in the study period. Specifically, FFS disease scores for stayers increased by 0.145 over the two-year period between 2004 and 2006, while the average disease score among beneficiaries who remained enrolled in a single MA contract for at least two data collection years increased by 0.174 over the same time period for a two-year difference of 0.029.

Dynamics behind changes in disease scores: CMS also analyzed the reasons why the change in MA and FFS disease scores differed among stayers. A significant portion of the difference in disease score changes is attributable to the reporting of 26 HCCs (of the 70 HCCs in the model) that fall into one of seven hierarchies: diabetes (5 HCCs), cardiovascular disease (4 HCCs), coronary artery disease (3 HCCs), cancer (4 HCCs), quadriplegia and other central nervous system disease (4 HCCs), liver disease (3 HCCs), and dialysis/renal disease (3 HCCs). Approximately one-third of the difference in disease score change is due to increases in severity within these hierarchies, particularly within the diabetes hierarchy. The remaining difference results primarily from greater retention of reported

diagnosis codes within certain hierarchies from one year to the next, especially the coronary artery disease, liver, diabetes, and renal hierarchies.

Variation among contracts: CMS research has also revealed a large amount of variation among MA contracts in the disease score change among stayers, and in the dynamics behind contracts' changing disease scores. As described above, on average, disease scores for MA stayers increased by 0.174 over the 2004-2006 study period, or 0.029 greater than the average increase of 0.145 for FFS stayers. We found that approximately 40% of the contracts in our study – those operating continuously during the 2004, 2005, and 2006 payment years – had changes in stayer disease scores that were less than the changes in FFS stayers' disease scores. Looking at enrollees, we found that 25% of the MA stayers in our analysis were enrolled in contracts where the difference between the two-year increase in stayers' disease scores and the FFS increase was at least twice the industry average.

Catch-up to FFS levels of coding: Although CMS cannot definitely determine whether “catch up” to FFS coding occurred or not, CMS recognizes that plans may have experienced some catch up, particularly during initial years of operation. In order to take any such catch up into account in our adjustment, we are proposing to:

- Adjust for MA coding only in 2009 and later (not adjust for previous year's coding patterns differences).
- Make an adjustment for contracts that have existed since at least 2005.
- Adjust risk scores for enrollees in contracts that have significant coding pattern differences from FFS.
- We are proposing to weight the impact of coding differences on disease scores in more recent years (when plans would have caught up to FFS) differently than coding patterns differences in earlier years.

More complete coding: We do not assume that the coding pattern differences that we found in our study are the result of improper coding. As discussed above, CMS understands that MA plans have made efforts to identify enrollees' conditions and may be coding more completely than FFS. However, because MA coding patterns differ from FFS coding patterns, the normalization factor (which is calculated based on FFS coding) does not currently adjust for these different coding patterns.

Impact of health status on risk score changes: As noted above, it is possible that beneficiaries enrolled in MA plans may be getting sicker faster than beneficiaries in FFS and this could be driving faster risk score growth for MA enrollees. Given the care coordination and disease management activities of MA plans, however, we do not find it reasonable to assume that MA stayers' underlying health status is getting worse at a faster rate than stayers in FFS. CMS analysis has found that MA mortality rates during the study period do not explain rising risk scores; when applying expected mortality rates to the MA population, risk scores are expected to decrease, not increase. (In our analysis, we adjusted mortality rates for age, sex, county, Medicaid status, and institutional status.)

Calculation and Application of a Coding Intensity Measure

While our research supports the finding that MA plans have coding patterns that differ from FFS, we only have a few years to observe the differences in MA and FFS coding patterns. Therefore, for 2009 we propose to apply an MA coding adjustment factor as follows:

- Apply an adjustment to the risk scores of enrollees in those contracts for which the difference between the change in stayers' disease scores and the change in the FFS stayers' disease scores is two or more times the industry average; this threshold is approximately the same as a threshold at the plans enrolling the 25% of MA stayers with the largest change in disease score. We considered a few other options for applying an adjustment:

- We considered applying an adjustment to those contracts above two standard deviations above the mean difference in disease score change, but the variation among plans is so great that such a threshold would eliminate most contracts.
- We considered applying an adjustment on a contract-by-contract basis, but decided instead to apply a relatively high threshold in order to focus on the contracts that have experienced the largest changes in their stayers' disease scores, relative to FFS stayers' disease scores.

CMS is requesting comments on the criteria for determining the threshold used to determine those contracts' payment to which we would apply an adjustment factor.

- Exclude those contracts that were not in existence until after 2005 (came into existence in 2006 or later). Contracts that existed in 2005 and earlier have at least two years of experience reporting to CMS stayers' diagnosis codes that have been used to calculate risk scores.
- Exclude contracts with under an average of 1,000 enrollees during 2005-2006. CMS considers these contracts too small to provide enough data to make reliable estimates of their coding patterns.

CMS proposes to calculate the 2009 MA coding adjustment as follows:

1. *Calculate the average annual difference between the increase in MA and FFS stayers' disease scores.* The average annual change in stayers' disease scores for a contract is calculated as the change in average disease score, averaged over as many cohorts of stayers that a contract has, e.g., CMS would calculate the annual average change in disease score for contracts that have been in existence since 2003 or earlier as the average of the change in disease score for the 2004-2005, 2005-2006, and the 2006-2007 stayer cohorts. We would then subtract the FFS annual average change in stayers' disease score to obtain the differential increase in stayers' disease scores. Changes in disease scores would be adjusted for age and survivor status.
2. *Calculate this average annual difference in the change in stayers' disease scores within that group of contracts that would fall above the threshold for applying the adjustment.* For example, we would calculate the annual average difference between MA and FFS stayers' disease score increase based only on MA data from those contracts where the difference between the change in stayers' disease scores and the change in FFS stayers' disease scores was two or more times the industry average. We would calculate the average disease score change for the set of contracts by weighting each contract's disease score change by the number of beneficiaries in each contract. We would then subtract the FFS disease score change from this weighted average. Based on the two years of data that were included in our analysis to date, the difference in the change in stayers' disease score for the contracts in this group and the FFS average is 0.050.
3. *Adjust the annual average difference in disease score change for the average percent of MA plan enrollees in the payment year who were enrolled in the same plan in the data collection year.* CMS currently estimates that this percentage of enrollees is approximately 75%, but will finalize the percentage after we add 2007 risk score data to our analysis. Based on our current estimate of 75% for the proportion of MA enrollees who are stayers, the adjustment for the contracts with the top 25% of MA enrollees with the largest difference between their change in disease score and the FFS change in disease score would be 0.0375. CMS (1) will update this calculation with 2007 data, (2) proposes to convert the adjustment amount into a percent change to risk scores in the Announcement, and (3) will consider whether to apply a straight average across the year-to-year differences, or whether to give more weight the disease score

change differences in the most recent years. CMS requests comment on how we calculate the adjustment factor.

The average change in MA stayers' disease score, the change in MA stayers' disease scores for the top group of contracts, the FFS average change in disease score, the difference between MA and FFS, and the proportion of stayers we project to be enrolled in MA contracts in 2009, along with other calculations, will be updated in the Announcement.

Section E. Adjustment for MA Coding Intensity

In the 2009 Advance Notice, CMS summarized findings from our analysis of risk scores in FFS and Medicare Advantage over the 2004-2006 time period and proposed to apply a coding difference adjustment to contracts whose disease scores for stayers exceeded FFS by twice the industry average. We proposed to apply an adjustment calculated based on those contracts that fell above our threshold.

In response to the Advance Notice, CMS received a significant number of comments on the proposed adjustment for MA coding differences, most of which disagreed with our view that we had identified differences in coding patterns between MA and FFS Medicare. Based on our analysis of the comments received, and our further consideration of the question of whether differences in risk scores can be attributed to differences in coding patterns, we have again decided not to make a coding intensity adjustment for 2009.

We hope to be able to reach a more definitive conclusion as to whether differences in risk scores are attributable to differences in coding patterns prior to the Rate Announcement for 2010. In the Advance Notice, we identified differences between the risk scores of MA and FFS Medicare enrollees. However, we did not have available comprehensive information from medical records to support our hypothesis that risk score differences were driven by coding pattern differences, rather than by the health status of MA enrollees. For 2010, we intend to use the results of the first year of plan-level annual MA plan audits (see section F below) to further inform our study of coding pattern differences. Moreover, CMS will collect additional utilization data from MA organizations to increase the accuracy of our risk-adjusted payments.

Below, we summarize and respond to the comments received on the proposed coding intensity adjustment.

(i) Legal Justification for the MA Coding Intensity Adjustment

Comment. Twenty-nine of the 30 commenters on the Advance Notice expressed views on our coding intensity proposal, and all but one of these 29 commenters opposed the adjustment as proposed. The commenter who supported the adjustment was encouraged by CMS' efforts to implement the Deficit Reduction Act (DRA) provision, but argued that CMS had too narrowly defined the subset of plans targeted to have their risk scores adjusted, and felt that CMS' effort to correct upcoding was minimal and unacceptable. Twenty eight commenters opposed the adjustment. Many contended that CMS has not demonstrated that conclusive evidence of coding differences exists, and contended that CMS had not met the requirement in the Deficit Reduction Act (DRA) that the Secretary must identify differences in coding patterns in order to adjust capitation payments to "reflect [...] differences in coding patterns between Medicare Advantage plans and providers under part A and B..." Some commenters suggested that CMS defer implementation of the DRA provision pending completion of further research and analysis to determine the extent of coding inaccuracies by MA organizations.

Response. As noted above, CMS has determined that for CY 2009, we will not make an adjustment to risk scores when calculating 2009 plan payments. We believe that the results of the Audits discussed below in Section F will result in an ability to determine more conclusively whether the differences in risk scores we have identified are attributable to differences in coding patterns.

Comment. Authority under the DRA. Many commenters cited the Deficit Reduction Act (DRA) requirement directing CMS to adjust capitation payments to “reflect [] differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences” and contended that CMS has not demonstrated that evidence of such differences exists. Further, numerous commenters also cited the Conference Report for the DRA, which states that “The conferees intend that any adjustments made for the differences in coding patterns be made for differences resulting from inaccurate coding.” These commenters interpret the conferees’ use of the term “inaccurate” to refer to “improper” or fraudulent coding, and noted that, in the 2009 Advance Notice, CMS stated that “We do not assume that the coding pattern differences that we found in our study are the result of improper coding.” The commenters thus argued that CMS does not have the authority to make adjustments based on the coding pattern differences that CMS found. Some commenters suggested that CMS defer implementation of the DRA provision pending completion of further research and analysis to determine the extent of coding inaccuracies by MA organizations.

Response. CMS believes that the statutory language in the DRA provision at issue provides for a payment adjustment if CMS establishes that there are “differences in coding patterns between Medicare Advantage plans and providers under part A and B.” The Conference Report language necessarily must be read in light of the statutory language that Congress actually enacted.

Given the fact that the MA payment methodology is based on fee-for-service payments, and that the risk adjustment methodology is designed to compare the risk scores of MA plan enrollees to other plan enrollees and beneficiaries not enrolled in MA plans, for this comparison to be valid, MA plans must code the way Medicare Part A and B does. This would result in the MA plans’ coding “accurately” reflecting the fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared. In this sense, “differences” in coding patterns, regardless of the source, would make the MA plan coding “inaccurate” for purposes of implementing risk adjustment.

This reading of the word “inaccurate” is supported by floor statements made by Senator Grassley, Congressman Barton, and Congressman Thomas. Senator Grassley made the following floor statement; the other two committee chairs made very similar statements:

Section 5301 and the joint statement which accompanied the conference report in the Senate requiring adjustments for differences in coding patterns is intended to include adjustments for coding that is inaccurate or incomplete for the purpose of establishing risk scores that are consistent across both fee-for-service and Medicare Advantage settings, even if such coding is accurate or complete for other purposes. This will ensure that the goal of risk adjustment—to pay plans accurately—is met.

Comment. Several commenters contended that the DRA provision requiring a coding intensity adjustment did not provide for an adjustment that would be applied to a subset of plans, as opposed to the MA program generally.

Response. The DRA requires that, in “applying the adjustment under [section 1853(a)(1)(C)(i)] for health status to payment amounts, the Secretary shall ensure that such adjustment reflects. . .differences in coding patterns between the Medicare Advantage plans and providers under Part A and B to the extent that the Secretary has identified such differences.” Section 1853(a)(1)(C)(ii)(I). The adjustments to capitation rates made under section 1853(a)(1)(C)(i) generally are specific to a particular MA organization. In the case of adjustments based on an enrollee’s risk score, they are specific to the plan’s individual enrollees. In the case of adjustments made to reflect working aged enrollees, they are made at the plan level based on that plan’s enrollees.

We believe, therefore, that if we had made a final determination that an adjustment for 2009 was justified, we would have had the authority to make adjustments where we found the greatest differences in coding patterns (and where such adjustments arguably would be more necessary in order for risk scores to have the same meaning for MA enrollees and original Medicare enrollees), while not doing so where there are no such differences, or where the difference is of a smaller magnitude.

(2) Purpose of coding differences adjustment and informing of public of final methodology

Comment. One commenter contended that the Advance Notice did not make clear precisely the purpose of the proposed coding intensity adjustment, other than citing the Deficit Reduction Act (DRA). Other commenters felt that CMS had not adequately demonstrated the need for such an adjustment for coding pattern differences, and had not identified with any certainty the reasons for the difference. Commenters suggested that there were other explanations of coding pattern differences, such as regional coding pattern differences, other than those identified by CMS.

Response. The DRA requires that CMS adjust payments to reflect “differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.” While we have reconsidered our view that the differences that we found were conclusively the result of coding pattern differences, if we had reached such a conclusion, an adjustment would have been appropriate without regard to the findings cited by commenters.

(3) Impact of plans, markets, beneficiaries

Comment. While some commenters felt that CMS too narrowly limited the number of contracts to which the adjustment would be applied, and a few others agreed with the CMS proposal to apply the adjustment to plans whose risk score change relative to FFS Medicare is significantly above the average change relative to FFS Medicare, many commenters expressed concerns that applying an adjustment to a subset of contracts was inequitable and had anti-competitive implications.

Several commenters felt that the adjustment penalized MA organizations that have been in the program longer and are now operating more efficiently. A number of commenters posited that the coding adjustment could discourage providers from contracting with plans that received the coding intensity adjustment, since MA organizations, especially those that pay providers a percent of revenue, may have to lower provider payments, which might lead to difficulty in maintaining provider networks and accessibility of care, instability in beneficiary access to care, and consumer dissatisfaction if their physicians leave the plan. Commenters also expressed concern that a coding intensity adjustment would lead to increased premiums and cost sharing and decreased benefits, and possibly cause disruption for beneficiaries who may then feel that they have to disenroll from their plan, and who may then have to switch providers. One commenter suggested that plans will lack incentive to enroll sicker, higher-risk patients. Several commenters expressed concern about the ability of plans to continue to provide appropriate care.

Response. We appreciate commenters’ concerns regarding their perceptions of inequity in applying a coding differences adjustment to a subset of contracts and the market implications of such a targeted approach. Because we have decided not to make an adjustment for 2009, the above issues are moot for the 2009 bidding process.

(4) Methodological Questions and Concerns

Comment. Commenters disagreed with CMS's proposal to use the average stayer percentage to adjust the adjustment factor, in order to apply it to all enrollees, noting changes in enrollment over the time period of the study, and variations in stayer percentages among contracts as a result of different enrollee populations. Other commenters felt that an adjustment would disadvantage MA organizations with sicker enrollees. Several commenters suggested that an adjustment for coding pattern differences would discourage initiatives to improve coding, or to maintain thorough coding, since increased coding might risk a revenue reduction in future years. Several commenters disagreed that CMS had taken into full account the degree of "catch up" and felt that a number of MA organizations would face the possibility of being penalized for these efforts.

Response. We appreciate commenters' concerns about the methodology of our approach to calculating and applying an MA coding differences adjustment. Because we are not making an adjustment for 2009, these comments are moot for this year.

Comment. One commenter suggested that CMS identify strategies for improving coding accuracy in FFS to reduce the variance in coding patterns directly related to differences in financial incentives between MA and FFS – strategies such as risk-adjusting FFS payments.

Response. CMS does make adjustments to FFS payments for diagnosis coding that is not in synchronization with a provider's case mix. We have applied an adjustment to long term hospitals that is projected to total \$430 million over five years (FY 2009-FY 2013) and to home health providers that is projected to total \$6.53 billion from 2008-2012.

Section F. CMS Audits

In CY 2007, CMS' payments to MA plans were 100 percent risk-adjusted for the first time because the transition from demographic-only to risk-adjusted payments was completed. Given this milestone, CMS has determined that our Risk Adjustment Data Validation, starting with CY 2007 payments, will be conducted using a sampling frame that generates statistically valid plan-level payment error estimates for those plans selected for review.

CMS will audit a subset of MA plans each year. The audit will include randomly-selected plans and targeted plans. Targeted plans will be selected based on how their risk score growth compared to FFS.

Findings from our validation studies from CY 2007 onward may inform CMS why plan average risk scores did or did not grow rapidly. This analysis will allow us to further refine our MA coding intensity adjustment. In addition, because we will have statistically-valid plan-level error estimates, we will make plan-level payment adjustments rather than adjustments to payments for specific beneficiaries whose risk scores were not supported by the medical record reviews, as we have done previously.

Section D. Adjustment for MA Coding Pattern Differences

BACKGROUND.

Section 1853(k)(2)(B)(iv)(III) requires, that in risk adjusting Part C payments in 2010, CMS make an adjustment to reflect “differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.” In order to comply with this requirement, CMS has conducted extensive research to analyze changes in MA and original fee-for-service Medicare (FFS) risk scores, differences between those changes, and coding patterns behind these changes.

RESULTS OF CODING PATTERN DIFFERENCE ANALYSIS:

Based on our careful and in depth review of the data, CMS has found that MA risk scores have increased more than twice as much as FFS risk scores. This trend was established based on our study data from 2004 and 2007 and our preliminary 2008 risk score data shows that this trend is continuing.

As discussed in previous Advance Notices, part of the differential in FFS and MA risk score increases can be attributed to changes in the population of enrollees, i.e., the risk scores of beneficiaries leaving (“leavers”) or joining (“joiners”) either FFS or MA plans have an impact on the overall average risk score in each sector. Specifically, we found that:

- A significant portion of the beneficiaries who join MA are beneficiaries who are switching from FFS. In FFS, the vast majority of beneficiaries who join are newly-eligible to Medicare. The risk scores of beneficiaries who are newly eligible to Medicare tend to be very low and these low risk scores depress FFS risk score growth relative to MA.
- Of the leavers, decedents (who have high risk scores) are a slightly larger fraction of FFS beneficiaries than of MA enrollees and, thus, the exit of high-risk score decedents restrains the year-to-year growth of average FFS risk scores by slightly more than it does MA scores.

Because most new enrollees in FFS are newly-eligible to Medicare, and FFS is losing higher-risk beneficiaries, there has been downward pressure on the average FFS risk scores compared to those in MA. Approximately 50% of the difference between the MA and FFS sectors in the growth of risk scores is due to enrollment patterns and approximately 50% is due to the more rapid growth in risk scores for beneficiaries who stay in the same sector in consecutive years.

We have continued to analyze coding pattern differences with a particular focus on “disease scores” and “stayers.” The “disease score” is the HCC portion of the risk score that plans and FFS providers affect by their reporting of diagnoses codes. “Stayers” are those beneficiaries who remained in MA for at least two years and, therefore, (1) whose risk score in a payment year was calculated using diagnoses submitted by an MA plan in the previous year and (2) whose change in disease score is due entirely to MA diagnosis reporting. We compared the coding patterns of these beneficiaries with those who stayed in FFS for at least two years. Based on our careful consideration of this data, we have concluded that there exists a difference in coding patterns between MA and FFS.

CMS has found that MA stayer disease scores increase faster than FFS stayer disease scores, even after adjusting for age distribution and survivor status. The absolute difference in disease score growth between MA and FFS was about 0.015 in 2004-2005 and in 2005-2006. This difference in disease score growth increased to 0.025 in 2006-2007. We will have the results for the 2007-2008 cohort prior to the publication of the 2010 Announcement.

In compliance with Section 1853(k)(2)(B)(iv)(III), we are planning to use the methodology specified below to make an adjustment to Part C risk scores in 2010.

CALCULATION OF THE 2010 CODING PATTERN DIFFERENCE ADJUSTMENT FACTOR:

CMS intends to apply a coding pattern difference adjustment in 2010 that takes into account differences in disease score growth. We are planning to adjust for differences in disease score growth for the period 2007-2010, which constitutes three years of growth (2007-2008, 2008-2009, and 2009-2010) and is consistent with the payment years specified in statute for which CMS must adjust risk scores.

CMS is planning to calculate the 2010 MA coding pattern difference adjustment as follows:

1. Calculate difference factor. The difference factor is calculated as the average annual difference in MA and FFS stayer disease score growth. CMS calculates this average difference across as many stayer cohorts as are available.
 - ▶ Create Stayer cohorts
 - For each cohort, we defined MA stayers as those beneficiaries who were in a Part C plan in the July of each cohort year, as well as in each respective data collection year. For example, for the 2004-2005 stayer cohort, we include beneficiaries who were in a Part C plan in July 2004 and July 2005, and in all of 2003 and 2004 (the respective data collection years).
 - Similarly, we defined FFS stayers as those beneficiaries who were in FFS in the July of each cohort year and in each of the respective data collection years.
 - We have created MA and FFS stayer cohorts for 2004-2005, 2005-2006, and 2006-2007.
 - The data to allow us to create a 2007-2008 cohort will be available after the Advance Notice is released. We plan to add these data to our calculations of the MA coding pattern difference adjustment factor.
 - ▶ Calculate the difference in disease score growth between MA and FFS for each cohort: We calculate the change in the average disease score change for each MA and FFS cohort, and then subtract the FFS disease scores growth from the MA disease score growth. The following adjustments are made in calculating the difference in disease score growth:
 - We rebase each disease score so that the 1.0 in any given year is the FFS average. For example, we divide the 2004 FFS and MA disease scores by the 2004 FFS average risk score, and the 2005 FFS and MA disease scores by the 2005 FFS average risk scores. Rebasing puts the MA and FFS disease scores on the same scale so that comparisons can be made across years.
 - We adjust the resulting difference for age and survivor status: Because the age distribution in FFS is not the same as that in MA, and because disease score growth varies by age, we are adjusting the results to account for age differences between the two sectors. We then recalculate the average change in disease score.
 - ▶ The average annual difference in disease score growth is calculated as the average across each cohort's difference in disease score growth, weighted by the number of MA stayers in each cohort year. We turn the average annual difference into a percentage by dividing through by the average of the rebased risk score in year 2 of each cohort year.
 - ▶ The average annual difference factor based on the three existing cohorts is 1.75%. We plan to add the results of the 2007-2008 cohort to the analysis and announce the updated difference factor in the 2010 Announcement in April 2009.

2. Calculate MA enrollment duration factor (EDF)
 - ▶ The EDF is the average length of time that beneficiaries have been enrolled in the MA program as defined below.
 - ▶ The EDF accounts for the fact that MA enrollees have been enrolled in Medicare Advantage for varying lengths of time.
 - ▶ Tabulate the EDF over the past three (3) years. Ideally, we would make these calculations for those beneficiaries who are enrolled in MA in payment year 2010. Since the enrollees in the payment year are unknown at the time of calculation of this factor, we approximate this count by tabulating the EDF over three (3) years for those enrolled in the January prior to the payment year.
 - ▶ In order to tabulate the EDF, we start with the number of full risk enrollees in MA in the current year (in this case, 2009) and count the number who were also in an MA plan for at least seven (7) months in the previous (data collection) year (in this case, 2008). We then add to this count the number of beneficiaries who were enrolled in MA in 2009, at least seven (7) months in 2008, and at least seven (7) months in 2007. We continue this summation back for a total of three (3) years to obtain the aggregate years of MA enrollment.
 - ▶ We then divide the total number of enrollment years by the number of full risk enrollees in the starting year who were enrolled at least seven (7) months in the year before the starting year to obtain the average enrollment length of time, or EDF.
 - ▶ The preliminary EDF for three (3) years, tabulated for enrollees in January 2009, is 2.45.
3. Apply the EDF to the difference factor to obtain MA coding pattern difference factor
 - ▶ Based on calculations using the three existing cohorts, the coding difference adjustment factor for three years would be 4.29% ($1.75\% \times 2.45$). We will update the MA coding pattern difference factor when we obtain results from the 2007-2008 cohort and will announce the final adjustment factor in the 2010 Announcement.
4. Operationalize MA coding pattern difference factor in order to apply factor to all enrollees in the payment year.
 - ▶ We will adjust coding difference factor by the percent of enrollees who are stayers in the year prior to the payment year (to approximate the proportion in the payment year), in order to obtain an adjustment factor which we can apply to all enrollees in the payment system.
 - ▶ The stayer percentage that we are planning to use is the percent of stayers enrolled in Part C plans in January 2009. The preliminary percentage is 87.3%.
 - ▶ **The adjustment applied to Part C risk scores, using data from the existing three cohorts, would be a reduction of 3.74%.** We plan to update this MA coding pattern difference adjustment factor with data from the 2007-2008 cohort and announce the final adjustment factor in the 2010 Announcement in April 2009.

While we are planning to adjust for differences in disease score growth for the three-year period 2008-2010, we also are considering other possible alternative approaches that would involve adjusting for disease score growth over a different numbers of years.

For payment year 2010, we considered an adjustment for differences in disease score growth since 2004, the first year of comprehensive risk adjustment. This would represent disease score growth over a six year period, i.e., 2004 to 2010. An adjustment on this basis would represent the broadest measure of differences in coding patterns. In our 2009 Advance Notice, we proposed to base an

adjustment, that we ultimately did not make in that year, on just one year's worth of differential disease score growth.

We invite comments on our decision to adjust for differences in disease score growth for the three-year period 2008-2010, as well as alternative approaches involving a greater or smaller number of years. We will consider all comments carefully, and may adopt any of these approaches in the final notice.

The MA coding pattern difference adjustment will be taken into account when we calculate budget neutrality for 2010.

We consider the MA coding pattern difference adjustment as a needed statutory correction to payments for 2010, as required by the DRA. In the future, the adjustment will no longer be needed once we have enough years of encounter data from Part C plans so that we can calibrate the Part C risk adjustment model on plan data. Once we are able to calibrate the Part C risk adjustment model on plan data, we would also develop the model normalization factor based on plan coding trends, which we anticipate will be adequate to maintain an average risk score of 1.0. We will be releasing guidance in 2009 regarding the collection of encounter data from Part C plans.

Section E. Adjustment for MA Coding Pattern Differences

In the Advance Notice, we proposed a coding difference adjustment of 3.74%. This adjustment was based on adjusting for three years of differential coding between MA and FFS, i.e., from 2007 to 2010. This adjustment factor was calculated based on beneficiaries who were enrolled for seven months or more in any given year, using data for three cohorts (2004-2005, 2005-2006, and 2006-2007). In the Notice, we stated our intention to update the adjustment factor with data for an additional cohort (2007-2008) for the Rate Announcement.

Our analysis of the 2007-2008 cohort showed that coding pattern differences have accelerated and this finding has strengthened our conclusion that coding pattern differences between MA and FFS are having a notable impact on payment. Because this is the first year that CMS is implementing this MA coding adjustment under the provisions of the DRA, however, CMS is taking a conservative approach and implementing an adjustment factor using a coding difference factor based on the earliest three cohorts (2004-2005, 2005-2006, and 2006-2007). CMS will consider the 2007-2008 data and later cohort data for future MA coding pattern difference factors.

CMS received a number of comments suggesting that the stayer percentage and enrollment duration factor used to calculate the MA coding pattern difference adjustment factor should be based only on beneficiaries who are enrolled in MA for a full 12 months in any given year, rather than seven months or more. CMS concurs with these comments; in finalizing the 2010 MA coding pattern difference adjustment factor, CMS is basing the stayer percentage and enrollment duration factor on 12 months of continuous MA enrollment.

Based on these changes in methodology, the final 2010 MA coding intensity adjustment will be 3.41%. Table 1 summarizes the calculation of the adjustment.

Table 1: Calculation of Difference Factor

Calculation of difference factor for 2010 Cohorts between 2004 and 2007 EDF = 2.38 Stayer percentage = 81.8%	
Weighted average of Year 2 MA risk scores	0.9806
Weighted average differences in disease score growth	0.0171
Difference factor as a percent of risk score	1.75%
Apply EDF to obtain adjustment factor (2.38)	4.16%
Adjust for percent of stayers to allow application of adjustment factor to all enrollees' risk scores (81.8%)	3.41%

Comment: A number of commenters offered CMS strong support for our determination in the Advance Notice that we were required to apply a coding pattern difference adjustment in 2010. Several commenters cited several reasons why the adjustment was appropriate. They agreed with CMS that the adjustment will improve payment accuracy, reduce unnecessary Medicare expenditures, and better assure financial neutrality between FFS and MA. Some commenters opined that the adjustment was long overdue. Commenters noted that MA organizations had an incentive to identify and code diseases, whether the diseases were treated or not, and that as a result unadjusted

risk scores show MA enrollees to be sicker than they actually are. Several commenters noted that the increased MA payments resulting from coding pattern differences are in addition to the 14% payment differential resulting from MA benchmarks being set above Medicare FFS levels. One commenter noted that because physicians in FFS do not have a financial incentive to code as intensely, MA plan risk scores can increase at a greater rate than FFS risk scores, making MA enrollees look less healthy and more costly without any change in their actual health status.

Response: We concur with these comments.

Comment: Several commenters argued that the coding pattern difference adjustment was being made on the assumption that coding observed in the FFS program is accurate, and argued that CMS should not penalize MA organizations for differing from FFS coding patterns if, in fact, these FFS patterns were somehow inaccurate or inadequate. One commenter expressed concern that the adjustment would penalize many organizations for doing what CMS and Congress intended when they implemented risk adjustment payments (invest resources to improve data collection and educate providers on proper documentation). One commenter contended that a significant differential should be expected between FFS and SNPs for SNPs that code accurately. Another commenter claimed that risk scores of beneficiaries in Original Medicare are depressed by the inadequate coding of chronic conditions on FFS claims. One commenter does not believe that it is in keeping with Congressional intent for CMS to make a negative adjustment to all plans regardless of whether improper or inaccurate coding has been identified; another commenter thought that an across-the-board adjustment conflicted with Congressional intent to adjust payments for “differences resulting from inaccurate coding.”

Response: As we stated in the 2009 Advance Notice, we do not assume that the coding pattern differences that we found in our study are the result of improper coding. As documented in the 2009 Announcement, CMS believes that the statutory language in the DRA provision at issue provides for a payment adjustment if CMS establishes that there are “differences in coding patterns between Medicare Advantage plans and providers under part A and B.”

Given the fact that the MA payment methodology is based on fee-for-service payments, and that the risk adjustment methodology is designed to compare the risk scores of MA plan enrollees to other plan enrollees and beneficiaries not enrolled in MA plans, for this comparison to be valid, MA plans must code the way Medicare Part A and B providers do in order for risk adjustments to be valid. This means that MA organizations are coding “accurately” when they are coding in a manner similar to fee-for-service coding used on the beneficiaries to whom MA plan enrollees are being compared. In this sense, “differences” in coding patterns, regardless of the source, would make the MA plan coding “inaccurate” for purposes of implementing risk adjustment.

This reading of the word “inaccurate” is supported by floor statements made by Senator Grassley, Congressman Barton, and Congressman Thomas. Senator Grassley made the following floor statement; the other two committee chairs made very similar statements:

“Section 5301 and the joint statement which accompanied the conference report in the Senate requiring adjustments for differences in coding patterns is intended to include adjustments for coding that is inaccurate or incomplete for the purpose of establishing risk scores that are consistent across both fee-for-service and Medicare Advantage settings, even if such coding is accurate or complete for other purposes. This will ensure that the goal of risk adjustment—to pay plans accurately—is met.”

Comment: One commenter argued that, since CMS did not make adjustments in 2008 and 2009, this necessarily must mean that data available to CMS as late as April 2008 did not demonstrate that the changes in risk scores were the result of differences in coding patterns, and that CMS accordingly should not apply an adjustment based on 2007 to 2008 data. Under this argument, CMS cannot now state that a change in risk score trends can be conclusively attributed to differences in coding patterns based on pre-April, 2008 dates. This commenter argued that CMS can adjust the capitation rates only to compensate for that one year of differential. In other words, the commenter argued that CMS implicitly had previously found that prior years of risk score trends can be explained based on factors other than coding patterns, and thus should not rely on the data to make an adjustment. Another commenter opined that the information in the 2010 Advance Notice fails to present substantive new evidence free of technical concerns.

Response: While, in previous years, CMS has delayed the application of a coding patterns difference adjustment in order to conduct further research, this did not mean that we had concluded that risk score trends were caused by factors other than coding pattern. Our most recent analysis – discussed below – has resulted in our decision to apply a coding pattern differences adjustment in 2010. We believe that, having concluded that the differences we have observed are in fact attributable to differences in coding patterns, it is appropriate to use data from the beginning of the program, as deemed necessary to better ensure appropriate and accurate payments.

Comment: Several commenters, noting that CMS had indicated in last year's Announcement that we would use the results from the risk adjustment data validation (RADV) audits to inform our assessment of whether risk score differences were driven by coding pattern differences, rather than by the health status of MA enrollees, inquired about our findings and how they supported the coding pattern difference adjustment. A number of commenters were concerned that CMS would be making an adjustment twice for the same coding effects if it applied both a coding pattern difference adjustment and made adjustments as a result of its RADV audits. Several commenters expressed concern that a prospective coding intensity adjustment in combination with future 2010 risk score audits could result in duplicate adjustments. A few commenters asked if CMS was adjusting the 2007 risk scores used in developing the MA coding pattern difference adjustment factor for adjustments made as a result of the RADV audits. Some commenters suggested that, instead of implementing a coding pattern difference adjustment, we rely on the RADV audits. They contended that the current risk score validation audit process was the appropriate system to determine coding accuracy and payments should only be adjusted for the subset of plans in which coding problems can be documented.

Response: CMS' strategy for determining the correct MA coding pattern difference for 2008 and 2009 was to ensure that we thoroughly understood the dynamics behind the coding pattern differences between MA and FFS. In this spirit, we agreed to assess whether the new annual medical record audits would be able to inform our study of MA coding pattern differences. Medical record audits serve the purpose of determining whether diagnosis codes submitted to CMS for risk adjustment payment purposes have a basis in the documented medical record, while our study of MA coding pattern differences has resulted in a better understanding of the differential growth in the number of diagnosis reported by MA plans and FFS providers. The results of the medical record audits supported our approach to calculating the MA coding pattern differences adjustment by failing to show a systematic correlation between coding pattern differences and errors in the reporting of documented coding.

Comment: Several commenters argued that CMS was not authorized to make a retroactive coding pattern difference adjustment. Another commenter asked if the adjustment would be used for 2010

alone, or would also be used to make retroactive adjustments. Several commenters opined that the DRA did not require a retroactive adjustment and that, since the MA payment methodology is fundamentally a prospective system, that absent an explicit statutory direction to impose a retroactive adjustment, CMS should not apply adjustments it now deems appropriate for 2008 and 2009 into 2010 payments. A couple commenters argued that the DRA established coding intensity to be a single annual adjustment made for each coverage year, if supported by the data, and felt that the MA coding pattern difference adjustment described in the Advance Notice was intended to retroactively apply an adjustment for 2008 and 2009. One commenter felt that this was not the intent of Congress and the other commenter felt that this adjustment would be made for years when CMS found that it did not have adequate information to justify an adjustment.

Response: CMS is not making a retroactive adjustment. We estimated the cumulative coding pattern difference in MA and FFS stayers' disease scores in 2010. We calculated this adjustment by applying a three-year enrollment duration factor (EDF) to the annual average difference in disease score growth, essentially calculating the adjustment to account for three years of coding pattern differences. As a result, the coding adjustment is an estimate of how much lower risk scores would be in 2010 if they rose at the same rate as FFS risk scores over the period 2007-2010. We note that some commenters supported using six years (2004-2010) in the calculation based, taking into account all measured differences since risk adjusted payments were begun.

Comment: One commenter believed that using a 2-year stayer cohort captures a large proportion of MA stayers that are new to MA with no coding history in year-one with potentially larger coding increases in the second year as the plan gains accurate diagnosis data. Another commenter opined that the calculation of the adjustment does not seem to acknowledge a trend observed by MA organizations in which a beneficiary's risk score increases more quickly during the second year that the beneficiary is enrolled in an MA plan and that, therefore, the enrollment effect that the agency attempts to isolate may be larger than assumed in the notice. One commenter suggested studying 3- and 4-year stayer cohorts; they also recommend that CMS study the cohort of individuals that would not qualify as stayers due to being in MA or FFS for only a single year over the examined time period.

Response: The method by which CMS constructs its two-year stayer cohorts ensures that the experience of beneficiaries newly enrolled in MA are not included in the difference measurement. Requiring enrollees to have been enrolled for thirty months results in first-year disease scores that were coded exclusively by either MA plans or FFS providers and, thus, CMS is comparing year-after-year disease scores that were coded exclusively by a single sector. These cohorts will capture some enrollees' second and third years in MA, but it will also capture differential disease score changes for enrollees who have been enrolled in either sector for longer periods of time. Therefore, the difference factor is calculated over all beneficiaries who have been enrolled in a sector over varying periods of time, thereby obtaining an average difference across all continually-enrolled beneficiaries.

The use of cohorts over more than two years would result in smaller cohorts of non-representative beneficiaries in that they were alive much longer and they were enrolled in their respective sector for longer than beneficiaries in the two-year cohorts. For example, beneficiaries who are in MA for at least 3 or 4 years are not identical to those who are enrolled for at least two years. Two-year cohorts capture the information needed while keeping the largest number of enrollees in the cohorts.

Comment: One commenter stated that, since CMS acknowledges that a significant portion of Medicare beneficiaries who join MA plans are switching from FFS, and that the vast majority of beneficiaries joining FFS are newly eligible and have very low risk scores, basing an adjustment of

risk scores on a comparison of FFS to MA enrollees will overstate the differences between the two groups.

Response: CMS constructs the cohorts in such a way that “joiners” and “leavers” – beneficiaries who switch from one sector to the other – are excluded from the population on whom we calculate the difference factor. The cohorts only include beneficiaries who have been in MA or FFS for several years – at least 30 months.

Comment: A couple commenters expressed interest in having CMS recognize that MA plans’ effort to “catch up” with FFS in the coding pattern difference adjustment factor. One commenter felt that changes in coding due to “catch up” fell outside the purview of the DRA and strongly suggested that the agency consider changes to the calculation of the adjustment to exclude “catch up” to more directly address the statutory requirement. Another commenter felt that, after seeking to take “catch up” into account last year, CMS should recognize it in the 2010 adjustment factor. One commenter offered an example of a way to adjust for “catch up” that involved applying a ratio of the amount by which the average MA risk score was below the FFS 1.0 when risk adjusted payments started, relative to the amount by which the average MA risk score was greater than the FFS 1.0 in later years.

Response: While we are using cohorts starting with 2004-2005 to calculate the average difference factor, we are only taking into account three years of experience in the enrollment duration factor (EDF). Any catch up occurring in the first three years (2004-2007) of risk adjusted payments is not factored into the duration factor and, therefore, not included in the coding pattern difference adjustment. In other words, by adjusting the annual average difference by the average enrollment over the past three years, CMS is only adjusting 2010 risk scores by the cumulative effect of coding pattern differences over three years, and not over all six years since the start of risk adjusted payments.

Comment: One commenter stated that the enrollment duration factor (EDF) seems intended to reflect the number of beneficiaries to whom a coding intensity adjustment would have been appropriately applied in 2008 and 2009 (if the agency had made a determination to apply such an adjustment in time to affect payments in those years) and prospectively in 2010. Another commenter questioned why CMS was using an enrollment duration factor and felt that an adjustment based on the disease scores would take differences into account. This commenter argued that CMS had not established that there was a link between length of MA enrollment and higher risk scores or explained how the EDF meets with the intent of the DRA.

Response: The enrollment duration factor (EDF) is used to adjust the annual difference factor in order to approximate the experience of stayers in 2010. In other words, the EDF creates a single year, prospective estimate of cumulative difference between MA and FFS disease scores (not just the marginal growth in the difference from the previous year). A less nuanced way to calculate the cumulative difference would simply be to multiply the average annual difference (the difference factor) times the number of years being taken into account. The EDF allows CMS to adjust the annual average difference by the estimated enrollment experience of the beneficiaries in MA during the payment year.

Comment: Several commenters recommended that the adjustment incorporate an analysis of coding pattern differences in four cohorts available at the time the Announcement is published: 2004-2005, 2005-2006, 2006-2007, and 2007-2008. They felt that doing so would permit the agency to more precisely determine the appropriate magnitude of the adjustment while considering data from the 2004-2005 data collection year, when risk adjustment was first a significant component of MA plan payments. One commenter felt that, since the coding difference experience seems to be volatile and

unpredictable, using four cohorts would add some stability to the calculation. They cited OACT's use of 5-year moving averages of the ratio of the county FFS per capita costs to national per capita costs when estimating the FFS costs in each county.

Response: Because 2010 is the first year that CMS is applying the MA coding pattern difference factor under the provisions of the DRA, we have decided to take a conservative approach and calculate the difference factor using only the first three cohorts, as described in the Advance Notice. After applying the new enrollment duration factor (EDF) (see below), the MA coding pattern difference factor for 2010 is 3.41.

Comment: Several commenters disagreed with the use of seven months enrollment in the prior year to determine whether someone is a stayer for purposes of the enrollment duration factor (EDF) and felt that twelve months would be a more appropriate measure. Commenters contended that an MA organization needed at least one full year of enrollment experience with a beneficiary to credibly calculate a member's risk score and that 12 months was in alignment with the idea that the adjuster should be applied to "stayers." One commenter understood that the EDF makes the assumption that the adjustment factor would be the same for members with between 7 and 30 months of plan membership, and believed that this was highly unlikely, and that the effect of relative coding intensity are likely to increase over time. One commenter asked how CMS had validated that a 7 month time period is sufficient to capture the HCC diagnoses for a member.

Response: The objective of the enrollment duration factor (EDF) is to capture the average number of years a population of enrollees has had their diagnoses submitted by the MA sector; for this factor, we are not trying to capture change in disease score, but exposure to MA coding patterns. In response to industry concerns regarding the adequacy of seven months of enrollment in capturing and reporting enough diagnoses codes to establish a pattern, CMS will use twelve months in previous years as a criteria for calculating the EDF. Using twelve months, applied to the same time period as in the Advance Notice – 2007-2010 – the EDF that CMS will use in calculating the adjustment factor will be 2.38.

Comment: One commenter noted that plans with more turnover will have lower EDFs. Other commenters asked if an analysis had been done to see how much variance there is in enrollment duration from plan to plan.

Response: CMS recognizes that enrollment duration may differ among plans. Because we have determined that it is most appropriate to apply an industry-wide adjustment, the EDF used in the calculation will, by its construct, be an industry average.

Comment: One commenter wanted CMS to use the same definition of "stayer" when determining the stayer percentage as we do when developing the cohorts used for measuring the coding pattern difference (30 months of continuous enrollment).

Response: Because CMS will apply the adjustment to all enrollees' risk scores, not just stayers, we need to reduce the adjustment proportionately so that the aggregate effect is the same, whether we applied the adjustment to stayers only or to all enrollees. To calculate the actual adjustment to use in payment, we reduce it by the proportion of stayers in MA for the most current period available. In applying the twelve month enrollment criteria in calculating previous-year enrollment for the EDF, we also changed the calculation of the stayer percentage that we will use to reduce the adjustment factor for application in payment. The stayer percentage we will use is 81.8%.

Comment: Commenters suggested a number of additional factors that they thought CMS should adjust for in calculating the coding pattern difference adjustment factor. The additional factors suggested are: age, gender, originally disabled, Medicaid eligibility, institutional status, hospice status, beneficiaries with multiple chronic conditions, duration in managed care, health status, type of plan, plan size, socio-economic status, racial/ethnic differences, and enrollment in the Veterans Affairs or Department of Defense health programs. A number of commenters requested that CMS adjust for regional differences in FFS coding differences. One commenter felt that plans with a high proportion of recent FFS members or in regions where MA coding changes are not greater than FFS are disadvantaged. One commenter suggested that possible anti-selective effects in MA were resulting in an overestimate of MA's rising risk scores. One commenter asked how CMS knew that measured differences in coding changes between MA and FFS were really coding pattern changes and not changes in health status.

Response: CMS did take into account factors that we believed would have an important influence on the rate of change in disease score growth between MA and FFS. For example, we adjusted the difference factor (the annual average difference in disease score growth between MA and FFS) for age and survivor status variations between MA and FFS. Because a greater proportion of disabled beneficiaries are enrolled in FFS than in MA, and because disabled beneficiaries risk scores tend to grow more slowly than aged beneficiaries' risk scores, adjusting for age reduced the differences in disease score growth between the two sectors. In addition, the enrollment duration factor (EDF) takes into account the average duration of enrollment in the MA sector of those who are present in the year prior to the payment year. We believe that age and survivor status are correlated to the differential change in disease scores between MA and FFS, and that duration of enrollment in the MA sector directly affects how long a beneficiary's disease score has been exposed to this differential. It is not clear that other factors would affect differential changes in disease score.

Comment: One commenter inquired about which version of the CMS-HCC model we used to calculate the coding pattern differences.

Response: CMS used the version of the CMS-HCC model that was used in payment from 2004 through 2006 to calculate the difference factor. We ran all cohorts through the same version of the model, so that measurements of differences would not be affected by model changes.

Comment: One commenter wanted CMS to establish an appeals mechanism that would allow plans to demonstrate that their coding patterns are correct.

Response: As discussed above, the MA coding pattern difference adjustment is not adjusting for coding that is incorrect, but for coding that differs from FFS and is therefore inaccurate for payment. Further, the industry-wide adjustment factor will not be modified for individual plans.

Comment: In the 2010 Advance Notice, CMS invited comments on the decision to adjust for differences in disease growth for the three-year period prior to 2010, as well as on alternative approaches involving a greater or smaller number of years. A number of commenters wanted CMS to adjust for one year instead of three. One commenter states that using the annual rate going back to 2004 would be the most reasonable approach. One commenter stated that CMS should make an adjustment on a prospective basis only, which they took to mean a single year adjustment. Several commenters argued that the DRA requires CMS to adjust for all differences in coding patterns, and suggested that CMS should adjust for all measured and projected differences, including those attributable to the excluded period for 2004-2007. Another commenter noted that, while one alternative was to make an adjustment for all years during which comprehensive risk adjustment has

been in place – that is, 2004 to 2010 -- on balance they were inclined to think that the methodology described in the Advance Notice was appropriate.

Response: The difference factor, which takes into account coding pattern differences from 2004 to 2007, is an average annual difference in the growth of disease scores between MA and FFS. Based on the data that we have, it is clear that coding pattern differences have continuously grown since 2004 and that 2010 risk scores will incorporate repeated years of coding pattern differences. We have decided to maintain for 2010 the use of three cohorts as proposed in the Advance Notice.

Comment: One commenter expressed concern that the MA coding difference adjustment would reduce the disease score, causing a greater portion of the risk score to be based on demographic factors, which would introduce limitations and problems of the old AAPCC approach.

Response: CMS is calculating the MA coding pattern differences adjustment factor based on disease scores because that is the portion of the risk score that plans have control over. However, the adjustment is being applied simply as an overall proportional reduction to the risk scores, leaving the proportion of the risk score that is determined by diseases intact.

Comment: One commenter suggested that FFS normalization and MA coding pattern difference adjustment should be subtractive, not additive, or plans will be penalized twice for coding practices observed in the FFS program.

Response: The two adjustments address two different measures of coding changes: the FFS normalization factor adjusts risk scores for underlying changes in FFS coding and the MA coding pattern difference adjustment factor adjusts for coding patterns above and beyond the FFS changes.

Comment: One commenter asked if the three-year adjustment discussed in the Advance Notice would lead to a restatement of the historical budget neutrality adjustments for those years.

Response: As discussed above, the 2010 MA coding pattern differences adjustment is not a retroactive adjustment, but an estimate of the cumulative difference between MA and FFS stayers' disease score in 2010. CMS will take the projected reduction in 2010 risk scores into account when calculating the 2010 budget neutrality factor.

Comment: One commenter expressed concern that the extent of the adjustment may cause health plans to consider withdrawing from the market given the short time to prepare the 2010 bids. A couple commenters expressed concern that the proposed across-the-board 3.74% reduction would have a major negative effect and is a departure from last year's proposal to gather plan-specific coding changes through targeted audits.

Response: While we appreciate that the application of the MA coding pattern difference adjustment will need to be taken into account in MA plan bids, we believe that the final 3.41 percent adjustment is an appropriate correction that will result in more accurate payments. In addition, the adjustment is consistent with the statutory requirement that we study whether there are different diagnoses coding patterns between MA and FFS and, if we find differences, that we adjust MA risk scores accordingly.

Comment: A number of commenters did not support an industry-wide coding pattern difference adjustment and either wanted CMS to implement a more targeted adjustment or delay or phase in the adjustment. Some commenters wanted CMS to apply the coding pattern difference adjustment to a defined subset of plans that fail the risk validation audit or plans with larger differences in risk score growth. Commenters felt that an industry-wide adjustment would be unfair to plans that have

under-coded and create an incentive of promoting coding intensity by those plan that have previously under-coded. Commenters suggested that CMS use a plan-specific EDF, or apply an adjustment in tiers to take into account different levels of turnover. A few commenters felt that SNPs would be at a disadvantage because there was an increased volume of encounters for their members and because the percent of stayers was likely to be less than the average MA plan rate. A number of commenters supported an industry-wide adjustment; one commenter cited the following advantages: (1) industry-wide adjustments were the practice in other sectors of Medicare, (2) all MA plans should be paying close attention to coding and documentation and it was reasonable to expect coding changes to be widespread, (3) coding behavior of a particular provider does not necessarily affect just one plan, (4) beneficiaries move from one plan to another and retain the diagnosis codes assigned; and (5) when using MA data, a system-wide adjustment will ensure that baseline information is accurate.

Response: In addition to the reasons given by commenters, CMS was also persuaded by comments on the 2009 proposal – which proposed an adjustment on a subset of contracts – that an industry-wide adjustment provides an even playing field when plans compete: newer plans may be able to code just as intensely as older plans, but would not have been in existence long enough for CMS to calculate an adjustment factor for them. Further, applying an adjustment factor to a subset, or tiered adjustment factors across contracts, results in cut offs that can potentially appear unfair, especially if one contract falls just above and another just below a cutoff. To avoid these problems, as well as for the reasons cited by the more recent comments, we have decided that an industry-wide adjustment is the most efficient and effective approach to making an adjustment for MA coding pattern differences.

Comment: One commenter suggested that CMS should review and compare samples of MA plan member medical records with a FFS control group and that the difference in risk scores derived from the medical records could support an across-the-board coding pattern adjustment in a subsequent year.

Response: While a comparison of diagnostic coding captured on medical records in MA and FFS would indicate differences in documentation of diagnoses coding in the medical record, there are two key shortcomings of this approach in calculating an MA coding pattern difference adjustment factor. The key comparison in studying the impact on payment of differences in coding patterns between MA and FFS is the codes that are submitted and codes that are reflected in the model. In addition, CMS is taking into account changes in disease scores over time and taking a sample of medical records will not provide that information.

Comment: One commenter did not agree that CMS should calculate coding pattern differences for each individual and, instead, recommended that the difference be calculated by dividing the MA growth in risk scores by the FFS growth in risk scores for each age and survivor status grouping in each cohort.

Response: CMS did not calculate individual differences in disease score growth; we calculated the difference between the average growth in disease scores among MA stayers and the average growth in disease scores among FFS stayers for each cohort. This difference calculation was adjusted for each age and survivor grouping in each cohort. It is not clear how CMS would use the ratio of MA growth to FFS growth in applying an adjustment.

Comment: A number of commenters requested that CMS release all relevant information and calculations concerning the MA coding pattern difference adjustment factor in order to make sure that the adjustment is fully explained and transparent to the public to the same extent that they are for the FFS program through regulation. A couple commenters believed that CMS has not provided

enough transparency in the methodology used to calculate the coding pattern differences for the public to properly evaluate the calculation CMS has completed.

Response: We would be happy to provide addition information about the steps and results of our MA coding pattern differences analysis to interested stakeholders.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Wednesday, June 08, 2011 3:33 PM
To: Scott, John A. (CMS/CM); Creighton, Sean M. (CMS/CPC); Kornfield, Thomas (CMS/CPC)
Cc: Rice, Cheri M. (CMS/CPC)
Subject: RE: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)
Attachments: MA coding in Advance Notices and Announcements.doc

(b)(5)



Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

From: Scott, John A. (CMS/CM)
Sent: Wednesday, June 08, 2011 3:29 PM
To: Creighton, Sean M. (CMS/CPC); Paul, Rebecca (CMS/CM); Kornfield, Thomas (CMS/CPC)
Cc: Rice, Cheri M. (CMS/CPC)
Subject: Fw: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)
Importance: High

(b)(5)



From: Stickell, Michele W. (CMS/CM)
Sent: Wednesday, June 08, 2011 03:24 PM
To: Scott, John A. (CMS/CM)
Subject: FW: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)

(b)(5)



From: Jones, Tavonia L. (CMS/OSORA)
Sent: Monday, June 06, 2011 2:05 PM
To: Jones, Tavonia L. (CMS/OSORA); Ahern, Robert (CMS/CM); Altman, Jessica (HHS/OCIIO); Andrews, Danielle Y. (CMS/OCSQ); Aragona, Elizabeth A. (CMS/OFM); August, Kimberly J. (CMS/CM); Aversa, Cheryl A. (CMS/CPC); Bauer, Christian J. (CMS/CM); Borys, Carol M. (CMS/MC); Boutte, Jeffrey P. (CMS/COO); Brewer, Ryan (CMS/OIS); Brown, Angela (CMS/OCSQ); Brown, Deborah J. (CMS/OL); Brown-Jones, Shanterri M. (CMS/OCSQ); Carmichael, Wanda E. (CMS/OFM); Cocchiara, John V. (CMS/CMHPO); Cones, Kenneth (CMS/OL); Cording, Kristina (CMS/OIS); Curtis, Catherine A. (CMS/OACT); Dibella, Michael E. (CMS/CM); Dinicola, Kelly A. (CMS/OEA); Farran, Patti A. (CMS/CMM); Francis, Shelis

V. (CMS/OFM); Franey, Maribel R. (CMS/OIS); Gange, Laura K. (CMS/OESS); Gelzer, Heidi J. (CMS/OFM); Gleimer, Anita (CMS/CPC); Grant, Monica (CMS/CPI); Grayson, April (CMS/CPC); Gurule, Roman (HHS/OCIIO); Held, William J. (CMS/CM); Helphenstine, Patricia J. (CMS/CMCS); Holmes, Tawanda (CMS/CM); Hughes, Paul J. (CMS/OSORA); Hutchinson, Barbara A. (CMS/OOM); Israel, Stormie (CMS/CPI); Johnson, Twanda B. (CMS/OEA); Johnson-James, Denise A. (CMS/CM); Jones, Greg A. (CMS/OL); Kelahan, Jean (CMS/CMHPO); Kerr, James T. (CMS/CMHPO); Ketcham, Michelle B. (CMS/CPC); Khalid, Zunaira (CMS/OL); Koepke, Christopher P. (CMS/OEABS); Kraft, Sandra L. (CMS/COO); Land, Marni B. (CMS/COO); Malcolm, Marissa (CMS/OFM); Massey, Beverly A. (CMS/OL); McCann, Susan A. (CMS/CMM); McNeill, Serrick A. (CMS/CPC); Meyers, Anna C. (CMS/CMCS); Moreno, Cynthia E. (CMS/CPI); Mosby, Tyritta T. (CMS/OA); Nishimoto, Kristy L. (CMS/CM); Ohata, Lauren (HHS/OCIIO); Pearson, Annette M. (CMS/CMCS); Peterson, Katrina (CMS/CMMI); Porras, Jessica (CMS/OEABS); Powell, Reginald (CMS/COO); Pryor, Karla C. (CMS/COO); Reilly, Megan C. (CMS/OBIS); Rowry, Flosetta L. (CMS/CM); Scott, John A. (CMS/CM); Smith, Kathryn (CMS/CSP); Squire, Angelic M. (CMS/OA); Starinsky, Melissa (CMS/OAGM); Voorhees, John S. (CMS/OEA); Walker, Wynethea N. (CMS/OSORA); Wallace, Mary H. (CMS/OBIS); Weaver, Mary Carol (CMS/CSP); Williams, Jackson (CMS/OSORA); Worrall, Chris M. (CMS/CM)
Cc: Creighton, Sean M. (CMS/CPC); Kornfield, Thomas (CMS/CPC); Rice, Cheri M. (CMS/CPC); McNearney, Joe (HHS/ASL); Stansbury, Kevin S. (CMS/OL); Dibella, Michael E. (CMS/CM)

Subject: RE: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)

Good afternoon,

The GAO exit conference titled, ***“Medicare Advantage Diagnostic Coding”*** (Job Code 290782), has been rescheduled for a new date and time. This conference will take place **Friday, June 10, 2011 @ 2:00 PM** in conference room C-113. Please forward this email to anyone I may have missed. I do apologize for the inconvenience.

Thank you.

From: Jones, Tavonia L. (CMS/OSORA)

Sent: Thursday, June 02, 2011 2:02 PM

Cc: Creighton, Sean M. (CMS/CPC); Kornfield, Thomas (CMS/CPC); Rice, Cheri M. (CMS/CPC)

Subject: GAO Exit conference: Medicare Advantage Diagnostic Coding (Job Code 290782)

Importance: High

GAO Exit conference: **Medicare Advantage Diagnostic Coding** (Job Code 290782) **Previous title: Medicare Advantage Payments**

An exit conference has been scheduled for the GAO study titled ***“Medicare Advantage Diagnostic Coding”*** (Job Code 290782). This conference will take place **Wednesday, June 15, 2011 @ 2:00 PM** in conference room C-110 in Baltimore. Please email participants names to Tavonia.jones@cms.hhs.gov by Noon, **Thursday, June 9, 2011**. GAO's job start notice from the entrance conference is attached. Thank you.

Lead: CM-CPC

Tavonia L. Jones

Division of Audit Liaison

Office of Strategic Operations and Regulatory Affairs (OSORA)

Centers for Medicare & Medicaid Services (CMS)

Desk: 410-786-0105

Fax: 410-786-5768

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Rice, Cheri M. (CMS/CPC)
Sent: Wednesday, February 03, 2010 3:24 PM
To: Creighton, Sean M. (CMS/CPC); PAUL, REBECCA (CMS/CPC); Moseley, Deondra S. (CMS/CPC)
Subject: FW: Medicare Advantage 2011 Rate Preview
Attachments: MA_45-day_Notice_Preview_2-03-10[1].pdf

>-----Original Message-----

>From: Hill, Timothy B. (CMS/CPC)
>Sent: Wednesday, February 03, 2010 3:15 PM
>To: Rice, Cheri M. (CMS/CPC); Hutchinson, Thomas E. (CMS/CDHPC)
>Subject: FW: Medicare Advantage 2011 Rate Preview

>

>

>

>-----Original Message-----

>From: Sutton, Erin (CMS/OA)
>Sent: Wednesday, February 03, 2010 3:11 PM
>To: Hill, Timothy B. (CMS/CPC)
>Subject: FW: Medicare Advantage 2011 Rate Preview

>

>

>

>>-----Original Message-----

>>From: Hall, Amy (CMS/OL)
>>Sent: Wednesday, February 03, 2010 11:49 AM
>>To: Blum, Jonathan D. (CMS/OA)
>>Cc: Sutton, Erin (CMS/OA)
>>Subject: FW: Medicare Advantage 2011 Rate Preview

>>

> (b)(5)

>

>>>-----Original Message-----

>>>From: Brown, Ruth [mailto:Ruth.Brown@mail.house.gov]
>>>Sent: Wednesday, February 03, 2010 11:38 AM
>>>To: Hall, Amy (CMS/OL)
>>>Cc: Brooks-LaSure, Chiquita; Bjorklund, Cybele
>>>Subject: FW: Medicare Advantage 2011 Rate Preview

>>>

>>>Hi Amy - we're starting to hear noise about the Advance Notice. Can

>>>we have a quick convo about what to expect?

>>>

>>>

>>>

>>>-----Original Message-----

>>>From: Brian D. Fortune [mailto:bfortune@marwoodgroup.com]

>>>Sent: Wednesday, February 03, 2010 10:34 AM

>>>Subject: Medicare Advantage 2011 Rate Preview

>>>

>> (b)(5)

>>

>>

>>

>>>

>>> _____

>>>

>>>From: Marwood Group Research [mailto:asantangelo@marwoodgroup.com]

>>>Sent: Wed 2/3/2010 10:17 AM

>>>To: Brian D. Fortune

>>>Subject: Medicare Advantage 2011 Rate Preview

>>>

>>>

>>> (b)(5)

>>>

>>>

>>>

>>>

>>>

>> (b)(5)

>>

>>

>>

>>

>>

>>

>>

>>

>>

>>

>>

>>

>>>

>> (b)(5)

>>

(b)(5)

>>>Our attached report
>>><[http://www.capmarkets.com/ViewFile.asp?ID1=34291&ID2=210545258&ssid=3&d](http://www.capmarkets.com/ViewFile.asp?ID1=34291&ID2=210545258&ssid=3&directory=10969&bm=0&filename=MA_45-day_Notice_Preview_2-03-10.pdf)
>>>irectory=10969&bm=0&filename=MA_45-day_Notice_Preview_2-03-10.pdf>
>>>contains a detailed preview of the elements of the 45-day letter.
>>>Please contact Alison Santangelo at (212) 532-3651 with questions.

>>>Marwood Group
>>>733 Third Avenue
>>>New York, NY 10017
>>>(212) 532-3651

>>>If you experience difficulty clicking on the above link, please paste
>>>the following URL into your browser.
>>>[http://www.capmarkets.com/ViewFile.asp?ID1=34291&ID2=210545258&ssid=3](http://www.capmarkets.com/ViewFile.asp?ID1=34291&ID2=210545258&ssid=3&directory=10969&bm=0&filename=MA_45-day_Notice_Preview_2-03-10.pdf)
>>>& d i
>>>rectory=10969&bm=0&filename=MA_45-day_Notice_Preview_2-03-10.pdf

>>>The information herein is provided for informational purposes only.
>>>The information herein is not intended to be, nor should it be relied
>>>upon in any way, as investment advice to any individual person,
>>>corporation, or other entity. This information should not be
>>>considered a recommendation or advice with respect to any particular
>>>stocks, bonds, or securities or any particular industry sectors and
>>>makes no recommendation whatsoever as to the purchase, sale, or
>>>exchange of securities and investments. Reference herein to any
>>>specific commercial products, process, or service by trade name,

>>>trademark, manufacturer, or otherwise, does not necessarily
>>>constitute or imply its endorsement, recommendation, or favoring by
>>>Marwood Group
>Research, LLC ("Marwood").
>>>
>>>All information contained herein is provided "as is" without warranty
>>>of any kind. While an attempt is made to present appropriate factual
>>>data from a variety of sources, no representation or assurances as to
>>>the accuracy of information or data published or provided by third
>>>parties used or relied upon contained herein is made. Marwood makes
>>>no representations and disclaims all express, implied and statutory
>>>warranties of any kind, including any warranties of accuracy,
>>>timeliness, completeness, merchantability and fitness for a
>>>particular purpose.
>>>
>>>Neither Marwood nor its affiliates shall be liable to any other
>>>entity or individual for any loss of profits, revenues, trades, data
>>>or for any direct, indirect, special, punitive, consequential or
>>>incidental loss or damage of any nature arising from any cause
>>>whatsoever, even if Marwood has been advised of the possibility of
>>>such damage. Marwood and its affiliates shall have no liability in
>>>tort, contract or otherwise to any third party. The copyright for any
>>>material created by the author is reserved. The information herein is
>>>proprietary to
>Marwood.
>>>Any duplication or use of such material is not permitted without the
>>>author's written agreement.
>>>
>>>(c) 2010 Marwood Group Research, LLC
>>>
>>>
>>>
>>>
>>>
>>>
>>>-----
>>>This message (including any attachments) contains confidential
>>>information intended for a specific individual and purpose, and is
>>>protected by law. If you are not the intended recipient, you should
>>>delete this message. The information contained hereinafter may be
>>>proprietary, confidential, privileged and exempt from disclosure
>>>under applicable law. If the reader of this e-mail is not the
>>>intended recipient or agent responsible for delivering the message to

>>>the intended recipient, the reader is hereby put on notice that any
>>>use, dissemination, distribution or copying of this communication is
>>>strictly prohibited. If the reader has received this communication in
>>>error, please immediately notify the sender by telephone or by
>>>e-mail, and delete all copies of this e-mail and any attachments. Thank you.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Wednesday, April 04, 2012 7:09 PM
To: Decastro, Rebecca (CMS/CM)
Subject: MA coding paper & other documents
Attachments: Kronick Manuscript 10 8 09.docx; Manuscript.pdf; CMS_codingintensity_20090929.xlsx; MA coding in Advance Notices and Announcements.doc; calculating difference factor.xls

(b)(5)



Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Thursday, December 20, 2012 5:15 PM
To: Harlow, Jennifer A. (CMS/CM); Chaudhuri, Iina (CMS/CM); Decastro, Rebecca (CMS/CM); Franzel, Ashley S. (CMS/CM); Johnson, Whitney S. (CMS/CM)
Subject: MA coding in Advance Notices and Announcements.doc
Attachments: MA coding in Advance Notices and Announcements.doc

For reference, attached is my collection of MA coding discussions, as addressed in Advance Notice and Announcements over the years.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Friday, November 30, 2012 3:04 PM
To: Kapustij, Carolyn (CMS/CPC)
Subject: Advance Notice and Announcement text related to MA coding
Attachments: MA coding in Advance Notices and Announcements.doc

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: PAUL, REBECCA (CMS/CPC)
Sent: Tuesday, March 09, 2010 10:22 AM
To: Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Moseley, Deondra S. (CMS/CPC)
Subject: MA coding in Advance Notices and Announcements.doc
Attachments: MA coding in Advance Notices and Announcements.doc

For your reference... MA coding text in all Advance Notices and Announcements, updated with 2011 Advance Notice MA coding text.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Wednesday, February 02, 2011 4:13 PM
To: Moseley, Deondra S. (CMS/CPC); Kornfield, Thomas (CMS/CPC); Uebersax, Julie (CMS/CM); Hornsby, Anne M. (CMS/CM)
Subject: SGR in ratesetting
Attachments: FW: Can I see a copy of this, please? Seems like it's from sometime in March 2009; FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)

FYI to all.

Rebecca Paul
Medicare Plan Payment Group
Center for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: PAUL, REBECCA (CMS/CPC)
Sent: Sunday, January 17, 2010 6:11 PM
To: Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)
Subject: RE: coding
Attachments: MA coding in Advance Notices and Announcements.doc

(b)(5)



From: Rice, Cheri M. (CMS/CPC)
Sent: Sat 1/16/2010 2:29 PM
To: PAUL, REBECCA (CMS/CPC); Creighton, Sean M. (CMS/CPC)
Subject: coding

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Uebersax, Julie (CMS/CM)
Sent: Thursday, February 07, 2013 3:58 PM
To: Kornfield, Thomas (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

Julie A. Uebersax

Special Assistant
Medicare Plan Payment Group (MPPG)
Center for Medicare (CM)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd | Baltimore, Maryland 21244
☐: C1-13-26 | ☎: 410.786.9284 | ✉: julie.uebersax@cms.hhs.gov

Information not releasable to the public unless authorized by law: The information transmitted has not been publicly disclosed and may be privileged and confidential. It is intended only for the person or entity to which it is addressed and must not be disseminated, distributed, or copied to persons not authorized to receive it. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete it without reading it. Also, please notify the sender that you have received this communication in error. Your receipt of this message is not intended to waive any applicable privilege.

From: Uebersax, Julie (CMS/CM)
Sent: Thursday, February 07, 2013 3:47 PM
To: Rice, Cheri M. (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Julie A. Uebersax

Special Assistant
Medicare Plan Payment Group (MPPG)
Center for Medicare (CM)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd | Baltimore, Maryland 21244
☐: C1-13-26 | ☎: 410.786.9284 | ✉: julie.uebersax@cms.hhs.gov

Information not releasable to the public unless authorized by law: The information transmitted has not been publicly disclosed and may be privileged and confidential. It is intended only for the person or entity to which it is addressed and must not be disseminated, distributed, or copied to persons not authorized to receive it. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete it without reading it. Also, please notify the sender that you have received this communication in error. Your receipt of this message is not intended to waive any applicable privilege.

From: Szefflinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:13 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Don already sent this to Sean. f

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 10:35 AM
To: Szeftlinski, Francis C. (CMS/CPC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

FYI- I found it.

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:35 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

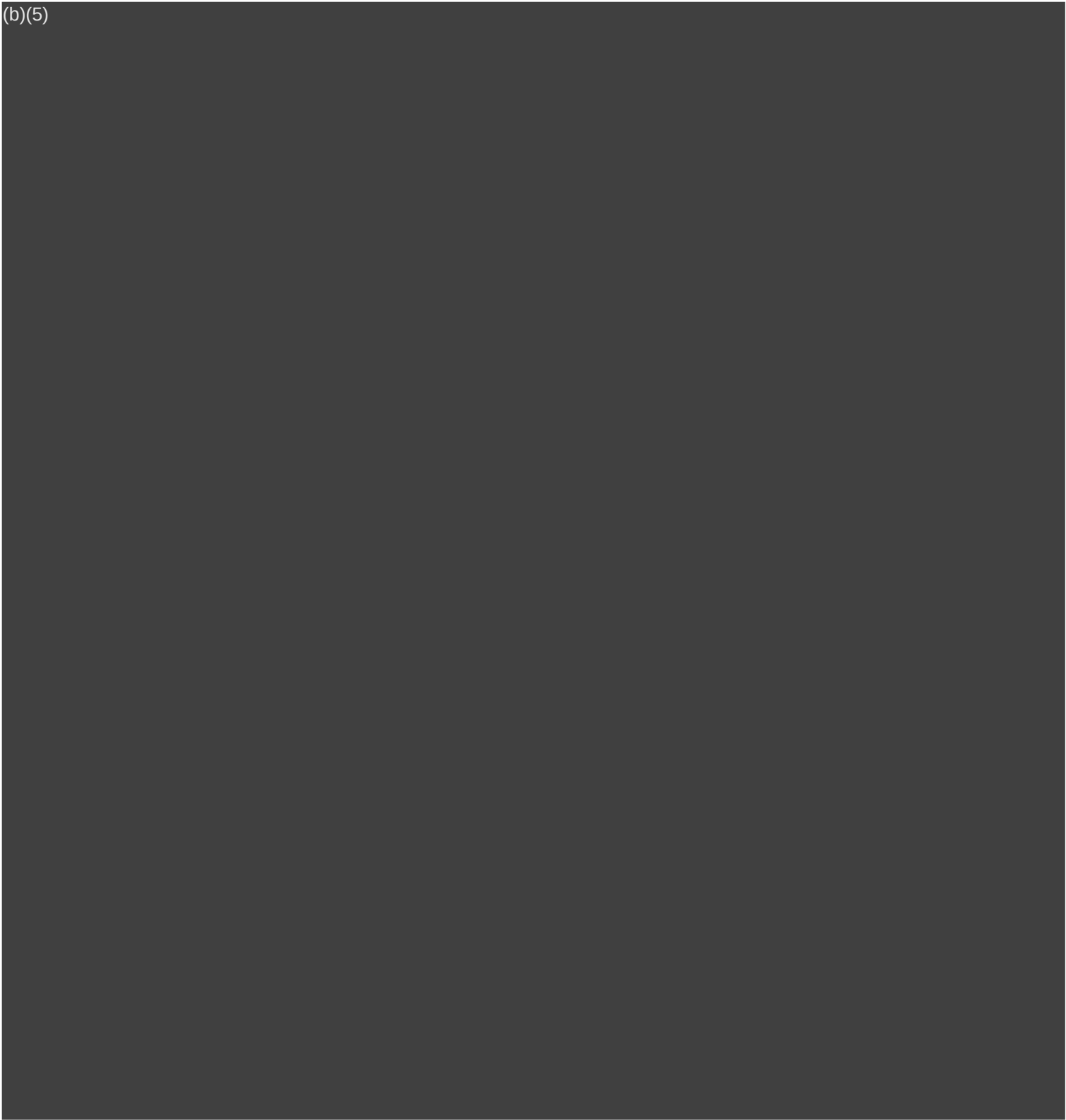


Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)
To: Don Kosin (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Sent: Wed Mar 25 17:16:34 2009
Subject: RE: 45 day notice and call letter re: MA rate adjustments

Don,

(b)(5)



Richard S. Foster
Chief Actuary

Paul I. Spitalnic
Director, PC DAG

Solomon M. Mussey
Director, MMCEG

From: Don Kosi (b)(6)
Sent: Tuesday, March 24, 2009 11:08 PM
To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)
To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6)
[Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)
Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)
Sent: Tuesday, March 24, 2009 10:47 PM
Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>
To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)
Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>
Sent: Tue Mar 24 19:29:02 2009
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Szeftlinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 2:23 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: Can I see a copy of this, please? Seems like it's from sometime in March 2009
Attachments: Joffe opinion - 3-13-09 growth assumptions and physician pay cut.pdf

From: Mark Joffe [<mailto:mjoffe@erols.com>]
Sent: Wednesday, February 02, 2011 12:22 PM
To: Szeftlinski, Francis C. (CMS/CPC)
Subject: RE: Can I see a copy of this, please? Seems like it's from sometime in March 2009

(b)(5)



From: Szeftlinski, Francis C. (CMS/CPC) [<mailto:Francis.Szeftlinski@cms.hhs.gov>]
Sent: Wednesday, February 02, 2011 2:10 PM
To: Mark Joffe
Subject: Can I see a copy of this, please? Seems like it's from sometime in March 2009

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:22 PM
To: Sands, Evan [USA]; Comer, Erin [USA]; Meyer, Mary Lynn [USA]
Cc: Jenkins, Samuel (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM); Smith, Jonathan (CMS/CM)
Subject: FW:
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 2 of 4 - CMS CY 2010 strategic planning deliverables

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Friday, October 28, 2011 12:19 PM
>To: Pulley, Tobi A. (CMS/CDHPC)
>Cc: Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM)
>Subject:

>

>Tobi,

(b)(5)

A large rectangular area of the email body is redacted with a solid black background. The text "(b)(5)" is visible in the top left corner of this redacted area.

>

>Thanks

>Sam

>

>

>Samuel B. Jenkins

>Centers for Medicare & Medicaid Services Medicare Plan Payment Group

>410-786-3261

>samuel.jenkins@cms.hhs.gov

>

>

McFarland, Bridget W. (CMS/OSORA)

From: Porter, Nancy K (IS) <Nancy.Porter@ngc.com>
Sent: Tuesday, September 06, 2011 5:15 PM
To: Hughes, Lateefah C. (CMS/CPC)
Subject: RE: CME085 audit cases.xlsx -- Please verify/clarify rules

Lateefah,

(b)(5)

A large rectangular area of the email body is redacted with a solid dark gray fill.

Nancy

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Friday, September 02, 2011 4:48 PM
To: Porter, Nancy K (IS); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :Re: CME085 audit cases.xlsx -- Please verify/clarify rules

Hi Nancy,

(b)(5)

A large rectangular area of the email body is redacted with a solid dark gray fill.

(b)(5)

Thanks,

Lateefah

Lateefah Hughes, Health Insurance Specialist
Division of Payment Validation
CMS/CPC/Medicare Plan Payment Group
410.786.2491
Lateefah.hughes@cms.hhs.gov

From: Hughes, Lateefah C. (CMS/CPC)
Sent: Friday, September 02, 2011 03:59 PM
To: 'Nancy.Porter@ngc.com' <Nancy.Porter@ngc.com>; 'Marilyn.Mattes@ngc.com' <Marilyn.Mattes@ngc.com>
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: Re: CME085 audit cases.xlsx

(b)(5)

Lateefah Hughes, Health Insurance Specialist
Division of Payment Validation
CMS/CPC/Medicare Plan Payment Group
410.786.2491
Lateefah.hughes@cms.hhs.gov

From: Porter, Nancy K (IS) [mailto:Nancy.Porter@ngc.com]
Sent: Friday, September 02, 2011 03:57 PM
To: Hughes, Lateefah C. (CMS/CPC); Mattes, Marilyn L (IS) <Marilyn.Mattes@ngc.com>
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

(b)(5)

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Friday, September 02, 2011 3:36 PM
To: Porter, Nancy K (IS); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :Re: CME085 audit cases.xlsx

Nancy,

(b)(5)

Lateefah

Lateefah Hughes, Health Insurance Specialist
Division of Payment Validation
CMS/CPC/Medicare Plan Payment Group
410.786.2491
Lateefah.hughes@cms.hhs.gov

From: Hughes, Lateefah C. (CMS/CPC)
Sent: Thursday, September 01, 2011 05:51 PM
To: Porter, Nancy K (IS) <Nancy.Porter@ngc.com>; Mattes, Marilyn L (IS) <Marilyn.Mattes@ngc.com>
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

Ok, thanks!

From: Porter, Nancy K (IS) [mailto:Nancy.Porter@ngc.com]
Sent: Thursday, September 01, 2011 5:24 PM
To: Hughes, Lateefah C. (CMS/CPC); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

Lateefah,

(b)(5)

Nancy

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Thursday, September 01, 2011 5:10 PM
To: Porter, Nancy K (IS); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :RE: CME085 audit cases.xlsx

Thanks Nancy,

(b)(5)

From: Porter, Nancy K (IS) [mailto:Nancy.Porter@ngc.com]
Sent: Thursday, September 01, 2011 4:31 PM
To: Hughes, Lateefah C. (CMS/CPC); Mattes, Marilyn L (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: RE: CME085 audit cases.xlsx

Lateefah,

(b)(5)

Nancy

From: Hughes, Lateefah C. (CMS/CPC) [mailto:Lateefah.Hughes@cms.hhs.gov]
Sent: Thursday, September 01, 2011 3:59 PM
To: Mattes, Marilyn L (IS); Porter, Nancy K (IS)
Cc: Pulley, Tobi A. (CMS/CDHPC); Smith, Jonathan (CMS/CM)
Subject: EXT :FW: CME085 audit cases.xlsx

Hello Nancy and Marilyn,

(b)(5)



Thanks,
Lateefah

McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:21 PM
To: Meyer, Mary Lynn [USA]; Comer, Erin [USA]; Sands, Evan [USA]
Cc: Hornsby, Anne M. (CMS/CM); Jenkins, Samuel (CMS/CM); Mierwald, Raymond (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Smith, Jonathan (CMS/CM)
Subject: FW: Items for the BAH meeting
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 1 of 4 - CMS deliverables for CY 2010 strategic planning

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Monday, October 31, 2011 9:22 AM
>To: Hughes, Lateefah C. (CMS/CPC)
>Cc: Pulley, Tobi A. (CMS/CDHPC); Mierwald, Raymond (CMS/CM)
>Subject: FW: Items for the BAH meeting
>
>Anne's PEDIR information is attached as well.



McFarland, Bridget W. (CMS/OSORA)

From: Harlow, Jennifer A. (CMS/CPC)
Sent: Monday, July 25, 2011 5:45 PM
To: Rice, Cheri M. (CMS/CPC); Scott, John A. (CMS/CM)
Subject: FW: request for a meeting

(b)(5)

Jennifer

From: Moreno, Cynthia E. (CMS/CPI)
Sent: Wednesday, July 20, 2011 6:33 PM
To: Harlow, Jennifer A. (CMS/CPC)
Cc: Kint, Carrie A. (CMS/CPI)
Subject: request for a meeting

(b)(5)

From: (b)(6), (b)(7)c (OIG/OI) [mailto:(b)(6), (b)(7)c@oig.hhs.gov]
Sent: Monday, July 18, 2011 6:37 PM
To: Knickman, Bobbie K. (CMS/CPI)
Cc: Martina Gilly
Subject:

Hi Bobbie,

(b)(5)

(b)(6), (b)(7)c

(b)(6), (b)(7)c

HHS/OIG/OI

(b)(6), (b)(7)c (phone)
(b)(6), (b)(7)c (fax)

Cynthia Moreno
410.786.1164

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Szefflinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:13 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

[Don already sent this to Sean. f](#)

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 10:35 AM
To: Szefflinski, Francis C. (CMS/CPC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

[FYI- I found it.](#)

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:35 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



(b)(5)

Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)

To: Don Kosin (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)

Sent: Wed Mar 25 17:16:34 2009

Subject: RE: 45 day notice and call letter re: MA rate adjustments

Don,

(b)(5)

(b)(5)

Richard S. Foster
Chief Actuary

Paul I. Spitalnic
Director, PCDAG

Solomon M. Mussey
Director, MMCEG

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6)
[Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)

Sent: Tuesday, March 24, 2009 10:47 PM

Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>

To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)

Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>

Sent: Tue Mar 24 19:29:02 2009

Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Hornsby, Anne M. (CMS/CM)
Sent: Wednesday, November 02, 2011 5:11 PM
To: Harlow, Jennifer A. (CMS/CPC)
Subject: FW: Items for the BAH meeting
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Categories: Red Category

>-----Original Message-----

>From: Pulley, Tobi A. (CMS/CDHPC)
>Sent: Monday, October 31, 2011 3:21 PM
>To: Meyer, Mary Lynn [USA]; Comer, Erin [USA]; Sands, Evan [USA]
>Cc: Hornsby, Anne M. (CMS/CM); Jenkins, Samuel (CMS/CM); Mierwald, Raymond (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Smith, Jonathan (CMS/CM)
>Subject: FW: Items for the BAH meeting

>

>Email 1 of 4 - CMS deliverables for CY 2010 strategic planning

>

>>-----Original Message-----

>>From: Jenkins, Samuel (CMS/CM)
>>Sent: Monday, October 31, 2011 9:22 AM
>>To: Hughes, Lateefah C. (CMS/CPC)
>>Cc: Pulley, Tobi A. (CMS/CDHPC); Mierwald, Raymond (CMS/CM)
>>Subject: FW: Items for the BAH meeting

>>

>>Anne's PEDIR information is attached as well.

McFarland, Bridget W. (CMS/OSORA)

From: Moreno, Cynthia E. (CMS/CPI)
Sent: Wednesday, July 20, 2011 6:33 PM
To: Harlow, Jennifer A. (CMS/CPC)
Cc: Kint, Carrie A. (CMS/CPI)
Subject: request for a meeting

(b)(5)

From: (b)(6), (b)(7)c (OIG/OI) [mailto:(b)(6), (b)(7)c@oig.hhs.gov]
Sent: Monday, July 18, 2011 6:37 PM
To: Knickman, Bobbie K. (CMS/CPI)
Cc: Martina Gilly
Subject:

Hi Bobbie,

(b)(5)

(b)(6), (b)(7)c

(b)(6), (b)(7)c

HHS/OIG/OI
(b)(6), (b)(7)c (phone)
(b)(6), (b)(7)c (fax)

Cynthia Moreno
410.786.1164

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Rice, Cheri M. (CMS/CPC)
Sent: Thursday, February 03, 2011 2:39 PM
To: Harlow, Jennifer A. (CMS/CPC); Scott, John A. (CMS/CM)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 2:37 PM
To: Blum, Jonathan D. (CMS/CM); Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Salters, Tony A. (CMS/OEA); Milgate, Karen (CMS/CSP); Brennan, Niall J. (CMS/OP)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:12 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:11 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Ashkenaz, Peter (CMS/OEABS)

Sent: Thursday, February 03, 2011 02:07 PM

To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Segal, Misha (CMS/OP)

Sent: Thursday, February 03, 2011 1:47 PM

To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)

<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Newsom, Mark (CMS/CM)
Sent: Wednesday, September 26, 2012 8:48 PM
To: Scott, John A. (CMS/CM); Abrams, Jill (HHS/OGC)
Cc: Corke, Victoria (HHS/OGC); Bucksten, William (CMS/CM); Bennett, Carol (HHS/OGC); Rice, Cheri M. (CMS/CM); Gover, Julie (CMS/CM); Johnson, Amanda S. (CMS/CPC); Chaudhuri, Ilina (CMS/CM)
Subject: RE: Fox administrative brief re: recon
Attachments: Announcement2010.pdf; 2010CallLetter.pdf; Advance2006.pdf; Announcement2006.pdf

(b)(5)



From: Scott, John A. (CMS/CM)
Sent: Wednesday, September 26, 2012 5:22 PM
To: Abrams, Jill (HHS/OGC)
Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Bucksten, William (CMS/CM); Bennett, Carol (HHS/OGC)
Subject: RE: Fox administrative brief re: recon

Jill,

(b)(5)



John

From: Abrams, Jill (HHS/OGC)
Sent: Tuesday, September 25, 2012 10:37 AM
To: Abrams, Jill (HHS/OGC); Scott, John A. (CMS/CM)
Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM); Bennett, Carol (HHS/OGC); Rice, Cheri M. (CMS/CM)
Subject: RE: Fox administrative brief re: recon

(b)(5)



From: Abrams, Jill (HHS/OGC)
Sent: Monday, September 24, 2012 4:01 PM
To: Scott, John A. (CMS/CM)
Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)
Subject: RE: Fox administrative brief re: recon

(b)(5)



From: Scott, John A. (CMS/CM)
Sent: Monday, September 24, 2012 3:54 PM
To: Abrams, Jill (HHS/OGC)
Cc: Corke, Victoria (HHS/OGC); Newsom, Mark (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)
Subject: RE: Fox administrative brief re: recon

(b)(5)



From: Abrams, Jill (HHS/OGC)
Sent: Monday, September 24, 2012 10:40 AM
To: Newsom, Mark (CMS/CM); Scott, John A. (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)

Cc: Corke, Victoria (HHS/OGC)

Subject: FW: Fox administrative brief re: recon

Importance: High

(b)(5)



From: Abrams, Jill (HHS/OGC)

Sent: Thursday, September 20, 2012 11:57 AM

To: Newsom, Mark (CMS/CM); Scott, John A. (CMS/CM); Gover, Julie (CMS/CM); Bucksten, William (CMS/CM)

Cc: Corke, Victoria (HHS/OGC)

Subject: Fox administrative brief re: recon

Importance: High

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Ceja, Kathryn S. (CMS/OEABS)
Sent: Tuesday, November 15, 2011 8:35 PM
To: Rice, Cheri M. (CMS/CPC); Jones, Greg A. (CMS/OL); Segal, Misha (CMS/CSP)
Cc: Cook, Brian T. (CMS/OEABS); Bataille, Julie (CMS/OEABS); Stansbury, Kevin S. (CMS/OL); Unruh, Patti (CMS/OEABS)
Subject: Fw: UBS (Lake): Medicare Advantage/MCOs - CMS Error Rates Incremental Positive for RADV
Attachments: UBS - Medicare Advantage Error Rates 11-15-2011.pdf; Risk Score Decisions Trump Rate For 2012.pdf; CMS May Be Looking to Calm the Waters.pdf; Thoughts on Medicare Risk Score Audits.pdf; Legal Disclaimer.txt

From: kenneth.lavine@ubs.com [<mailto:kenneth.lavine@ubs.com>]
Sent: Tuesday, November 15, 2011 08:09 PM
To: kenneth.lavine@ubs.com <kenneth.lavine@ubs.com>
Subject: UBS (Lake): Medicare Advantage/MCOs - CMS Error Rates Incremental Positive for RADV

(b)(5)



<<UBS - Medicare Advantage Error Rates 11-15-2011.pdf>>

Prior UBS Reports

<<Risk Score Decisions Trump Rate For 2012.pdf>> <<CMS May Be Looking to Calm the Waters.pdf>> <<Thoughts on Medicare Risk Score Audits.pdf>>

Please do not hesitate to call with any questions.

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

Kenneth LaVine, CFA
UBS Investment Research
Healthcare Services
(212) 713-4237
Kenneth.Lavine@ubs.com

McFarland, Bridget W. (CMS/OSORA)

From: PAUL, REBECCA (CMS/CPC)
Sent: Thursday, October 28, 2010 4:27 PM
To: Kornfield, Thomas (CMS/CPC); Moseley, Deondra S. (CMS/CPC); Uebersax, Julie (CMS/CM); Elrington, Keshanna (CMS/CM)
Subject: MA coding in Advance Notices and Announcements
Attachments: MA coding in Advance Notices and Announcements.doc

(b)(5)

Rebecca Paul
Medicare Plan Payment Group
Center for Drug and Health Plan Choice
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

McFarland, Bridget W. (CMS/OSORA)

From: Ceja, Kathryn S. (CMS/OEABS)
Sent: Thursday, February 10, 2011 4:12 PM
To: Rice, Cheri M. (CMS/CPC)
Cc: Segal, Misha (CMS/OP); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: analyst reports on RADV
Attachments: Market Insight RADV Section and MA.docx; citigroup and ma.pdf; barclays and 2012 rates.pdf; CMS May Be Looking to Calm the Waters On RADV Audits.pdf; Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf; U_S_HEALTH_CARE_MANAGED_102685386.pdf; mco_ma_radv_audits.pdf; bernstein radv.pdf; wells fargo RADV audits.pdf; humana investor transcript.pdf

Cheri,

(b)(5)

Kathy

Kathryn Ceja
Office of Communications
Centers for Medicare and Medicaid Services
Kathryn.ceja@cms.hhs.gov
202.205.9288

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 10, 2011 4:08 PM
To: Ceja, Kathryn S. (CMS/OEABS)
Subject: RE: analyst reports on RADV

Here you go...

Docs:

(b)(5)

(b)(5)

(b)(5)



McFarland, Bridget W. (CMS/OSORA)

From: Tudor, Cynthia G. (CMS/CPC)
Sent: Friday, February 04, 2011 3:05 PM
To: Rice, Cheri M. (CMS/CPC)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits
Attachments: CMS May Be Looking to Calm the Waters On RADV Audits.pdf; HPMS_Transmittal_--_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf; Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf; Preliminary RADV Methodology 12-21-2011.pdf; Legal Disclaimer.txt

FYI

From: (b)(6)
Sent: Friday, February 04, 2011 2:57 PM
To: Tudor, Cynthia G. (CMS/CPC)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

From: (b)(6)
Sent: Thursday, February 03, 2011 8:56 PM
To: (b)(6)
Subject:

From: justin.lake@ubs.com [<mailto:justin.lake@ubs.com>]
Sent: Thursday, February 03, 2011 12:33 PM
Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)

<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 2:37 PM
To: Blum, Jonathan D. (CMS/CM); Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Salters, Tony A. (CMS/OEA); Milgate, Karen (CMS/CSP); Brennan, Niall J. (CMS/OP)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:12 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)

Sent: Thursday, February 03, 2011 02:11 PM

To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Blum, Jonathan D. (CMS/CM)

Sent: Thursday, February 03, 2011 2:10 PM

To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)

Sent: Thursday, February 03, 2011 02:07 PM

To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)

Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)

Sent: Thursday, February 03, 2011 1:47 PM

To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)

Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_-_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500
Richard Mauro
High Yield- 203.719.1471
Todd Corsair
CDS- 203.719.3896
Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:12 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:11 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

(b)(5)



From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_-_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA

UBS Investment Bank

Analyst - Healthcare Services

Phone (212)-713-2765 Mobile

justin.lake@ubs.com

(b)(6)



UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 2:11 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: RE: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)

From: justin.lake@ubs.com [mailto:justin.lake@ubs.com]

Sent: Thursday, February 03, 2011 1:33 PM

Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_-_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile
justin.lake@ubs.com

(b)(6)



UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500
Richard Mauro
High Yield- 203.719.1471
Todd Corsair
CDS- 203.719.3896
Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Blum, Jonathan D. (CMS/CM)
Sent: Thursday, February 03, 2011 2:10 PM
To: Ashkenaz, Peter (CMS/OEABS); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: Re: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 02:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: justin.lake@ubs.com [<mailto:justin.lake@ubs.com>]
Sent: Thursday, February 03, 2011 1:33 PM
Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Ashkenaz, Peter (CMS/OEABS)
Sent: Thursday, February 03, 2011 2:07 PM
To: Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Rice, Cheri M. (CMS/CPC)
Cc: Ceja, Kathryn (HHS/ASPA); Segal, Misha (CMS/OP); Salters, Tony A. (CMS/OEA)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits
Attachments: CMS May Be Looking to Calm the Waters On RADV Audits.pdf; HPMS_Transmittal_--_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf; Med Adv - Thoughts on Medicare Risk Score Audits 12-21-2010.pdf; Preliminary RADV Methodology 12-21-2011.pdf; Legal Disclaimer.txt

(b)(5)



From: Segal, Misha (CMS/OP)
Sent: Thursday, February 03, 2011 1:47 PM
To: Ceja, Kathryn S. (CMS/OEABS); Ashkenaz, Peter (CMS/OEABS)
Subject: FW: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



From: justin.lake@ubs.com [<mailto:justin.lake@ubs.com>]
Sent: Thursday, February 03, 2011 1:33 PM
Subject: UBS (Lake) - Breaking News from CMS - Medicare Advantage - CMS May Be Looking to Calm the Waters On RADV Audits

(b)(5)



(b)(5)



<<CMS May Be Looking to Calm the Waters On RADV Audits.pdf>> <<HPMS_Transmittal_--
_Response_toComments_Sampling_Error_Calc_Methodology_v3.pdf>> <<Med Adv - Thoughts on Medicare Risk Score
Audits 12-21-2010.pdf>> <<Preliminary RADV Methodology 12-21-2011.pdf>>

As always don't hesitate to call with any questions.

J

Justin Lake, CFA
UBS Investment Bank
Analyst - Healthcare Services
Phone (212)-713-2765 Mobile (b)(6)
justin.lake@ubs.com

UBS Healthcare Sales and Trading Team

Cash Trading- 203.719.7400

Bernie Cooney

Brian Ritter

Al Diaz (small cap)

Options- 203.719.7330

Brendan Cusick

Converts- 203.719.8500

Richard Mauro

High Yield- 203.719.1471

Todd Corsair

CDS- 203.719.3896

Abul Rahman

McFarland, Bridget W. (CMS/OSORA)

From: Creighton, Sean M. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:55 PM
To: Rice, Cheri M. (CMS/CPC); Blum, Jonathan D. (CMS/CM); Hill, Timothy B. (CMS/CM); Larrick, Amy (CMS/CM); Fegraus, Laura (CMS/CM); Hornsby, Anne M. (CMS/CM)
Subject: Fw: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:34 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



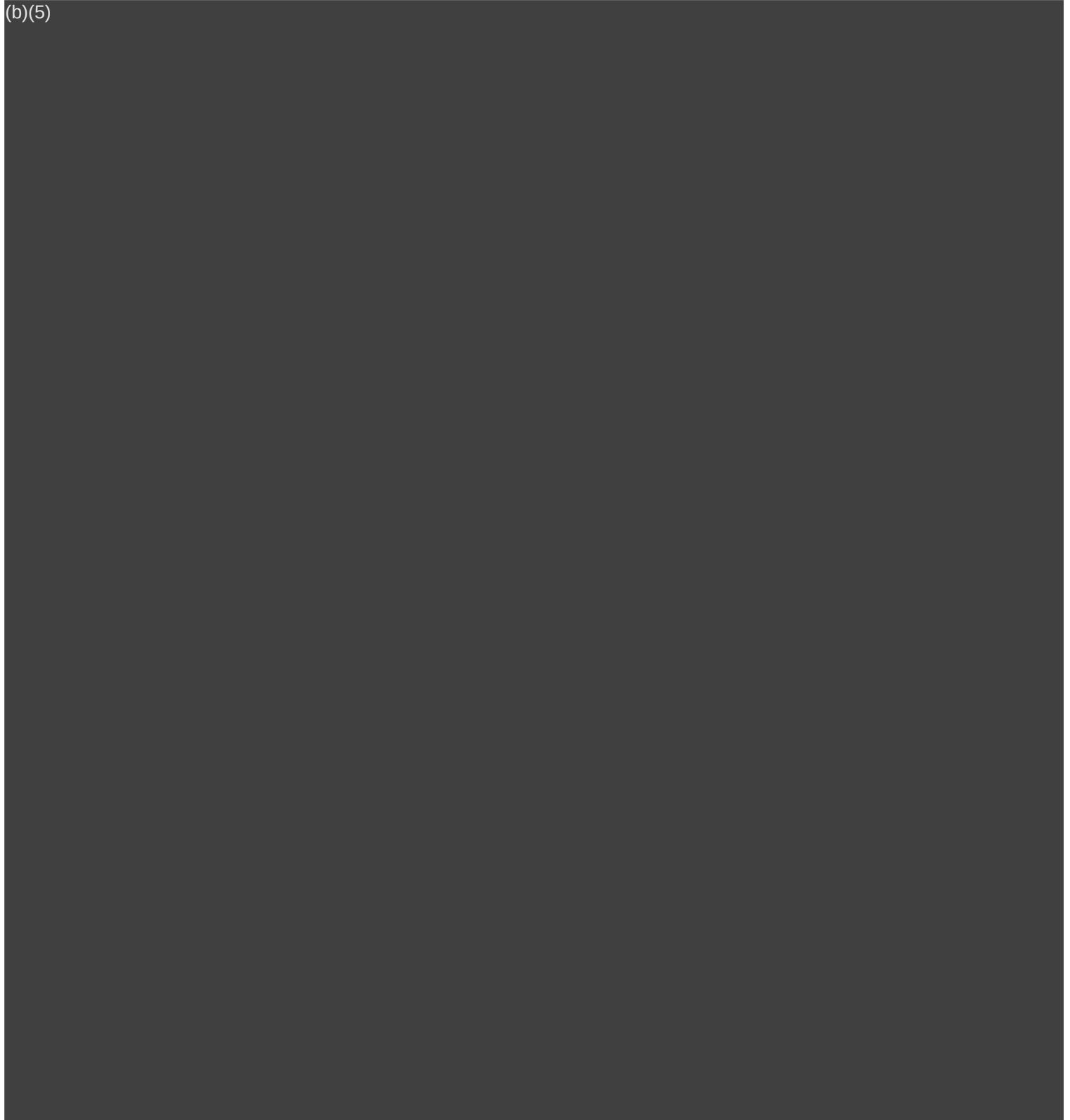
Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)
To: Don Kosin (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy

(CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Sent: Wed Mar 25 17:16:34 2009
Subject: RE: 45 day notice and call letter re: MA rate adjustments

Don,

(b)(5)



Richard S. Foster

Paul I. Spitalnic

Solomon M. Mussey

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)

----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; (b)(6)
[Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)

Sent: Tuesday, March 24, 2009 10:47 PM

Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>

To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)

Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>

Sent: Tue Mar 24 19:29:02 2009

Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Miller, Dan (CMS/CCIIO)
Sent: Monday, July 09, 2012 5:13 PM
To: Paul, Rebecca (CMS/CM); Keenan, Patricia S. (CMS/CCIIO)
Subject: RE: call with Henry on RA validation stuff

(b)(5)



Dan

Dan Miller
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
301-492-4178

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Paul, Rebecca (CMS/CM)
Sent: Monday, July 09, 2012 2:16 PM
To: Keenan, Patricia S. (CMS/CCIIO)
Cc: Miller, Dan (CMS/CCIIO)
Subject: RE: call with Henry on RA validation stuff

Hi Dan --

(b)(5)



Thanks.

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

From: Keenan, Patricia S. (CMS/CCIIO)
Sent: Monday, July 09, 2012 10:00 AM
To: Paul, Rebecca (CMS/CM)

Cc: Miller, Dan (CMS/CCIIO)

Subject: FW: call with Henry on RA validation stuff

(b)(5)



From: Miller, Dan (CMS/CCIIO)

Sent: Friday, July 06, 2012 10:40 AM

To: Keenan, Patricia S. (CMS/CCIIO)

Subject: call with Henry on RA validation stuff

Patricia,

(b)(5)



Thanks,
Dan

Dan Miller
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
301-492-4178

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

McFarland, Bridget W. (CMS/OSORA)

From: Uebersax, Julie (CMS/CM)
Sent: Thursday, February 07, 2013 3:47 PM
To: Rice, Cheri M. (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments
Attachments: announcement2010 draft v5-ogc-1.doc

Julie A. Uebersax

Special Assistant
Medicare Plan Payment Group (MPPG)
Center for Medicare (CM)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Blvd | Baltimore, Maryland 21244
☐: C1-13-26 | 📞: 410.786.9284 | ✉: julie.uebersax@cms.hhs.gov

Information not releasable to the public unless authorized by law: The information transmitted has not been publicly disclosed and may be privileged and confidential. It is intended only for the person or entity to which it is addressed and must not be disseminated, distributed, or copied to persons not authorized to receive it. Unauthorized disclosure may result in prosecution to the fullest extent of the law. If you are not an intended recipient, or have received this message in error, please delete it without reading it. Also, please notify the sender that you have received this communication in error. Your receipt of this message is not intended to waive any applicable privilege.

From: Szeftlinski, Francis C. (CMS/CPC)
Sent: Wednesday, February 02, 2011 1:13 PM
To: Paul, Rebecca (CMS/CM)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 10:35 AM
To: Szeftlinski, Francis C. (CMS/CPC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, February 02, 2011 12:35 PM
To: Creighton, Sean M. (CMS/CPC)
Cc: Choe, Ken (HHS/OGC); Hoffman, Janice (HHS/OGC); Fisher, Barbara (HHS/OGC)
Subject: FW: 45 day notice and call letter re: MA rate adjustments

(b)(5)



(b)(5)



From: Kosin, Donald (HHS/OGC)
Sent: Wednesday, March 25, 2009 5:21 PM
To: Spitalnic, Paul I. (CMS/OACT); (b)(6) McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



Sent from my BlackBerry Wireless Handheld

From: Spitalnic, Paul I. (CMS/OACT)
To: Don Kosin (b)(6); McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC); Frizzera, Charlene (CMS/OA); Snyder, Michelle (CMS/OA); Kosin, Donald (HHS/OGC)
Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL); Foster, Richard S. (CMS/OACT); Mussey, Solomon M. (CMS/OACT)
Sent: Wed Mar 25 17:16:34 2009
Subject: RE: 45 day notice and call letter re: MA rate adjustments
Don,

(b)(5)



(b)(5)



Richard S. Foster
Chief Actuary

Paul I. Spitalnic
Director, PCDAG

Solomon M. Mussey
Director, MMCEG

From: Don Kosin (b)(6)

Sent: Tuesday, March 24, 2009 11:08 PM

To: McWright, LAURA T. (CMS/OL); Blum, Jonathan D. (CMS/CMM); Hall, Amy (CMS/OL); Johnson, Donald N. (CMS/OL); Spitalnic, Paul I. (CMS/OACT); Hutchinson, Thomas E. (CMS/CDHPC); Rice, Cheri M. (CMS/CPC); Creighton, Sean M. (CMS/CPC)

Cc: Sutton, Erin (CMS/CPC); Jones, Greg A. (CMS/OL)

Subject: Re: 45 day notice and call letter re: MA rate adjustments

(b)(5)



----- Original Message -----

From: [McWright, LAURA T. \(CMS/OL\)](#)

To: [Blum, Jonathan D. \(CMS/CMM\)](#) ; [Hall, Amy \(CMS/OL\)](#) ; [Johnson, Donald N. \(CMS/OL\)](#) ; [Spitalnic, Paul I. \(CMS/OACT\)](#) ; [Hutchinson, Thomas E. \(CMS/CDHPC\)](#) ; [Rice, Cheri M. \(CMS/CPC\)](#) ; [Creighton, Sean M. \(CMS/CPC\)](#) ; (b)(6)

Cc: [Sutton, Erin \(CMS/CPC\)](#) ; [Jones, Greg A. \(CMS/OL\)](#)
Sent: Tuesday, March 24, 2009 10:47 PM
Subject: Fw: 45 day notice and call letter re: MA rate adjustments

I am not sure who has and hasn't seen this Joffe papern but here it is.

Sent from my BlackBerry Wireless Device

From: Bishop, Shawn (Finance-Dem) <Shawn_Bishop@finance-dem.senate.gov>
To: McWright, LAURA T. (CMS/OL); Jones, Greg A. (CMS/OL)
Cc: Hoffmeister, Laura (Finance-Dem) <Laura_Hoffmeister@finance-dem.senate.gov>
Sent: Tue Mar 24 19:29:02 2009
Subject: FW: 45 day notice and call letter re: MA rate adjustments

Laurie and Greg—this legal analysis by Joffe is circulating on the Hill re 45-day notice. He makes a good case for including an estimate of the SGR in the national per capital growth rate. Can you make sure the appropriate people at CMS (Jon Blum, policy staff, and GC) see this document if they don't already have it. Thanks.

Confidentiality Notice: This e-mail, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original messages.

McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:22 PM
To: Sands, Evan [USA]; Comer, Erin [USA]; Meyer, Mary Lynn [USA]
Cc: Jenkins, Samuel (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM); Smith, Jonathan (CMS/CM)
Subject: FW:
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 2 of 4 - CMS CY 2010 strategic planning deliverables

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Friday, October 28, 2011 12:19 PM
>To: Pulley, Tobi A. (CMS/CDHPC)
>Cc: Hughes, Lateefah C. (CMS/CPC); Mierwald, Raymond (CMS/CM)
>Subject:

>

>Tobi,

>

(b)(5)



>Thanks

>Sam

>

>

>Samuel B. Jenkins

>Centers for Medicare & Medicaid Services Medicare Plan Payment Group

>410-786-3261

>samuel.jenkins@cms.hhs.gov

>

>

McFarland, Bridget W. (CMS/OSORA)

From: Pulley, Tobi A. (CMS/CDHPC)
Sent: Monday, October 31, 2011 3:21 PM
To: Meyer, Mary Lynn [USA]; Comer, Erin [USA]; Sands, Evan [USA]
Cc: Hornsby, Anne M. (CMS/CM); Jenkins, Samuel (CMS/CM); Mierwald, Raymond (CMS/CM); Hughes, Lateefah C. (CMS/CPC); Smith, Jonathan (CMS/CM)
Subject: FW: Items for the BAH meeting
Attachments: CY 2010 pde-record-layout_112108.pdf; HPMS Memo 2010 PDE Submission Deadline.pdf; PEBA_2009_Data_Inventory_20111026.xlsx; RE: CME085 audit cases.xlsx -- Please verify/clarify rules; 2008_DIR_Rep_Reqs_060809.pdf; 2009 Final DIR Reporting Requirements 6-10-2010.pdf; Advance Notice Announcement2010.pdf

Email 1 of 4 - CMS deliverables for CY 2010 strategic planning

>-----Original Message-----

>From: Jenkins, Samuel (CMS/CM)
>Sent: Monday, October 31, 2011 9:22 AM
>To: Hughes, Lateefah C. (CMS/CPC)
>Cc: Pulley, Tobi A. (CMS/CDHPC); Mierwald, Raymond (CMS/CM)
>Subject: FW: Items for the BAH meeting
>
>Anne's PEDIR information is attached as well.

McFarland, Bridget W. (CMS/OSORA)

From: Paul, Rebecca (CMS/CM)
Sent: Friday, April 20, 2012 4:49 PM
To: Keenan, Patricia S. (CMS/CCIIO)
Cc: Cohen, Michael L. (CMS/CCIIO); Creighton, Sean M. (CMS/CPC); Decastro, Rebecca (CMS/CM); Keenan, Andrew K.(CMS/CM)
Subject: MA coding documents
Attachments: exhibit 1 combined 20110815.xlsx; Exhibit 1 Chart 11.09.2011.xlsx; CMS_codingintensity_20090929.xlsx; Manuscript.pdf; MA coding in Advance Notices and Announcements.doc

(b)(5)



Let me know if you have any questions!

Rebecca Paul
Medicare Plan Payment Group
Center for Medicare
Centers for Medicare & Medicaid Services
410.786.0852
rebecca.paul@cms.hhs.gov

From: Keenan, Patricia S. (CMS/CCIIO)
Sent: Friday, April 20, 2012 3:34 PM
To: Paul, Rebecca (CMS/CM)
Cc: Cohen, Michael L. (CMS/CCIIO)
Subject: FW: Analysis Standing Meeting

(b)(5)



From: Hughes, Lateefah C. (CMS/CCIIO)
Sent: Friday, April 20, 2012 12:04 PM
To: Hughes, Lateefah C. (CMS/CCIIO); Keenan, Patricia S. (CMS/CCIIO); Cohen, Michael L. (CMS/CCIIO)
Subject: RE: Analysis Standing Meeting

(b)(5)



From: Hughes, Lateefah C. (CMS/CCIIO)
Sent: Friday, April 20, 2012 12:02 PM
To: Keenan, Patricia S. (CMS/CCIIO); Cohen, Michael L. (CMS/CCIIO)
Subject: RE: Analysis Standing Meeting

(b)(5)



Lateefah

From: Keenan, Patricia S. (CMS/CCIIO)
Sent: Friday, April 20, 2012 11:58 AM
To: Cohen, Michael L. (CMS/CCIIO); Hughes, Lateefah C. (CMS/CCIIO)
Subject: Re: Analysis Standing Meeting

(b)(5)



----- Reply message -----

From: "Cohen, Michael L. (CMS/CCIIO)" <michael.cohen@cms.hhs.gov>
To: "Hughes, Lateefah C. (CMS/CCIIO)" <Lateefah.Hughes@cms.hhs.gov>
Cc: "Keenan, Patricia S. (CMS/CCIIO)" <patricia.keenan@cms.hhs.gov>
Subject: Analysis Standing Meeting
Date: Fri, Apr 20, 2012 11:23 am

Lateefah,

(b)(5)



-Michael

From: Hughes, Lateefah C. (CMS/CCIIO)
Sent: Friday, April 20, 2012 11:20 AM
To: Cohen, Michael L. (CMS/CCIIO)
Subject: RE: Analysis Standing Meeting

Michael,

(b)(5)



From: Cohen, Michael L. (CMS/CCIIO)
Sent: Friday, April 20, 2012 11:03 AM
To: Arnold, Grace C. (CMS/CCIIO); Gerrits, Diane T. (CMS/CCIIO); Davis, Jeffrey L. (CMS/CCIIO); Lauer, Johanna R. (CMS/CCIIO); Miller, Dan (CMS/CCIIO); Wu, Jeff (CMS/CCIIO); Hughes, Lateefah C. (CMS/CCIIO); McWright, Laurie (CMS/CCIIO); Doshi, Alok (CMS/CCIIO); Novick, Ariel D. (CMS/CCIIO); Sutton, Erin E. (CMS/CCIIO); Shah, Milan (CMS/CCIIO); Russell, Brigid M. (CMS/CCIIO); Grant, Jeffrey (CMS/CCIIO); Scott, Wakina L. (CMS/CCIIO); Keenan,

Patricia S. (CMS/CCIIO); Arnold, Sharon B. (CMS/CCIIO)

Subject: RE: Analysis Standing Meeting

All,

Today's analysis meeting will have the following agenda items:

1. 2013 Plans
2. Market Reform Issues
3. Catastrophic Plan Next Steps
4. Criteria for Selection of HCCs for Risk Adjustment - Upcoding

Please note additional materials will be forthcoming on the 2013 plan issue. Thanks.

<< File: upcoding Issuepkmlc.docx >> << File: MarketReforms-FM Issues (4-20-12).docx >> << File: Catastrophic -- 4-13-12.docx >>



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

MAY - 6 2013

Administrator
Washington, DC 20201

Senator Charles E. Grassley
Ranking Member
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Senator Grassley:

Thank you for your letter concerning the 2014 Medicare Advantage (MA) rates. I appreciated the opportunity to discuss these issues with you recently. As I have stated, this is a matter that I take very seriously and one in which I share your concerns. For that reason, the Department of Health and Human Services' (HHS) General Counsel referred the matter to the HHS Office of Inspector General (OIG), and that office is currently examining it.

Regarding the specific questions in your letter, there were no changes to the Sustainable Growth Rate (SGR) assumptions for the purposes of calculating MA payments after the Centers for Medicare & Medicaid Services (CMS) made the policy decision on March 15. CMS was notified at 10:47 a.m. on April 1 that the review of the rate notice had been concluded.

I appreciate your interest in safeguarding confidential and non-public information and will continue to work with you on this matter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a horizontal line.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Rick Gray
Arizona House of Representatives
Phoenix, AZ 85007

Dear Representative Gray:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to CMS's Office of the Actuary beneficiary enrollment in MA will be substantially reduced by 2017. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

We appreciate your concern about the impact possible cuts could have on MA beneficiaries in Arizona. We also recognize that you are especially concerned about the effect these cuts may have on dual eligible beneficiaries.

You noted that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

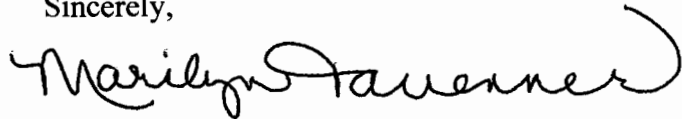
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that Arizona's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signer of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY 09 2013

The Honorable Debbie Lesko
Arizona House of Representatives
Phoenix, AZ 85007

Dear Representative Lesko:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to CMS's Office of the Actuary beneficiary enrollment in MA will be substantially reduced by 2017. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

We appreciate your concern about the impact possible cuts could have on MA beneficiaries in Arizona. We also recognize that you are especially concerned about the effect these cuts may have on dual eligible beneficiaries.

You noted that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

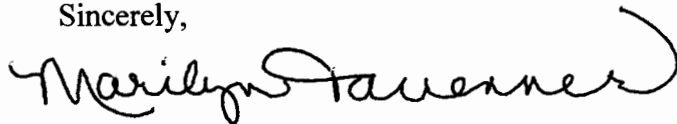
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that Arizona's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response for the co-signer of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

APR 18 2013

The Honorable Thomas Carper
United States Senate
Washington, DC 20510-0803

Dear Senator Carper:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over the word "Sincerely,".

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

APR 18 2013

The Honorable Charles Grassley
United States Senate
Washington, DC 20510-0803

Dear Senator Grassley:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a faint, circular official stamp.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 18 2013

The Honorable Robert Menendez
United States Senate
Washington, DC 20510-0803

Dear Senator Menendez:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a faint, larger version of the same signature.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 18 2013

The Honorable Marco Rubio
United States Senate
Washington, DC 20510-0803

Dear Senator Rubio:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a horizontal line.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 18 2013

The Honorable Michael F. Bennet
United States Senate
Washington, DC 20510-0803

Dear Senator Bennet:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a horizontal line.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 18 2013

The Honorable Mark Udall
United States Senate
Washington, DC 20510-0803

Dear Senator Udall:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a horizontal line.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 18 2013

The Honorable Christopher A. Coons
United States Senate
Washington, DC 20510-0803

Dear Senator Coons:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a horizontal line.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

APR 18 2013

The Honorable Martin Heinrich
United States Senate
Washington, DC 20510-0803

Dear Senator Heinrich:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services's (CMS's) February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter. I appreciate the opportunity to address your concerns about the Advance Notice and Call Letter and the potential impact on Medicare beneficiaries. On April 1, 2014, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter.

Your letter expressed concern about the impacts of the new risk adjustment model on the Program of All-Inclusive Care for the Elderly (PACE) program. In particular, you note that the removal of dementia from the model would result in a substantial reduction in Medicare reimbursements for PACE plans.

After careful consideration of the concerns you and others raised during the public comment period, we determined that we will not implement the model proposed in the Advance Notice for PACE organizations. For 2014, for the PACE program, we will retain the current risk adjustment model used for 2013 PACE payments. Accordingly, the model continues to include the dementia condition categories.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong PACE program for our nation's vulnerable seniors receiving care from these plans. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner", is written over a faint, circular official stamp.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator

Washington, DC 20201

The Honorable Ed Perlmutter
U. S. House of Representatives
Washington, DC 20515

Dear Representative Perlmutter:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Model Recalibration – You also expressed concerns about the proposed risk adjustment model changes. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concerns that have been raised regarding these risk

adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

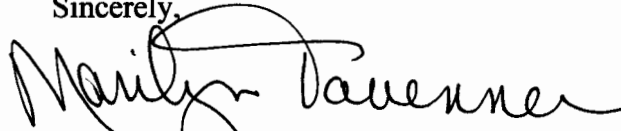
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Chris Gibson
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gibson:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" written in a larger, more prominent script than the last name "Tavenner".

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Bill Owens
U.S. House of Representatives
Washington, DC 20515

Dear Representative Owens:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important

clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

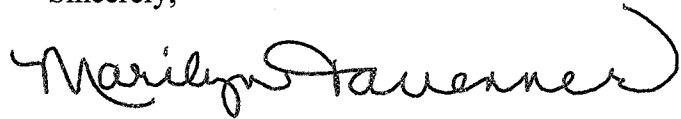
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Chris Collins
U.S. House of Representatives
Washington, DC 20515

Dear Representative Collins:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

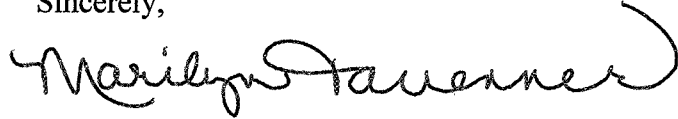
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator

5
2



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Timothy Bishop
U.S. House of Representatives
Washington, DC 20515

Dear Representative Bishop:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

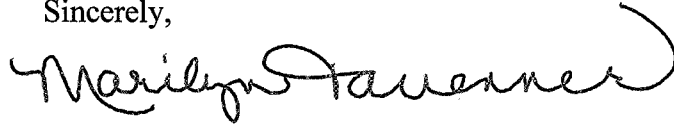
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Michael Grimm
U.S. House of Representatives
Washington, DC 20515

Dear Representative Grimm:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Richard Hanna
U.S. House of Representatives
Washington, DC 20515

Dear Representative Hanna:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

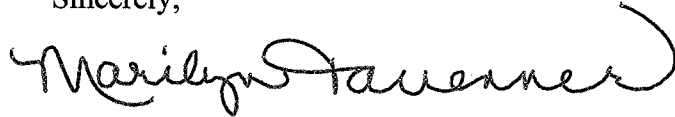
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Peter King
U.S. House of Representatives
Washington, DC 20515

Dear Representative King:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

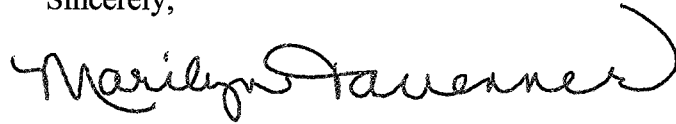
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large, sweeping loop at the end.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Sean Patrick Maloney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Maloney:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

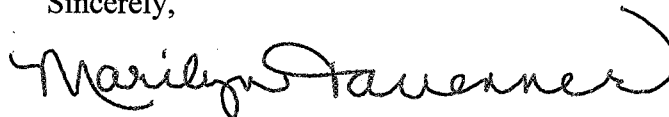
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Tom Reed
U.S. House of Representatives
Washington, DC 20515

Dear Representative Reed:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health issues. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-

service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to reconsider this assumption.

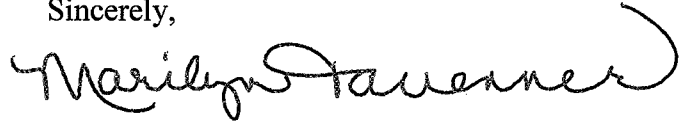
The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Mike Thompson
U. S. House of Representatives
Washington, DC 20515

Dear Representative Thompson:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Methodology Changes – You expressed concern regarding the impact on risk scores from the exclusion of certain conditions, and noted that these changes may be duplicative of the coding intensity adjustments included in the American Taxpayer Relief Act.

We received a number of comments arguing that the changes to the risk adjustment model to address coding intensity are duplicative of the MA coding adjustment factor. We understand that different model versions may affect the coding difference trend differently and, when CMS determines the MA coding adjustment factor, we take into account the version of the model that will be in use during the payment year. Since we make determinations regarding the appropriate level of the MA coding adjustment by taking into account the impact on coding of the risk model, the model adjustments made to address coding do not duplicate the MA coding adjustment factor applied to the risk scores. Nevertheless, we are transitioning to the 2014 model by blending the scores from the 2014 and 2013 model.

In the 2014 Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be substantially lower because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

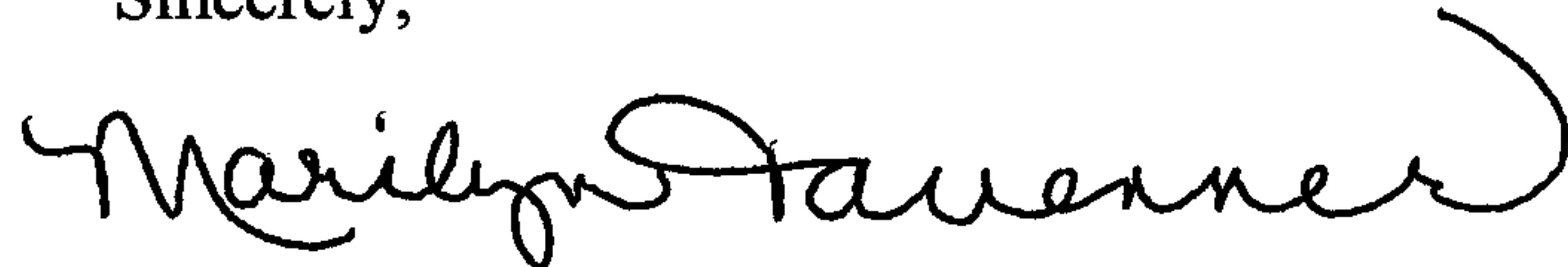
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth

Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large, sweeping loop at the end.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Earl Blumenauer
U. S. House of Representatives
Washington, DC 20515

Dear Representative Blumenauer:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Methodology Changes – You expressed concern regarding the impact on risk scores from the exclusion of certain conditions, and noted that these changes may be duplicative of the coding intensity adjustments included in the American Taxpayer Relief Act.

We received a number of comments arguing that the changes to the risk adjustment model to address coding intensity are duplicative of the MA coding adjustment factor. We understand that different model versions may affect the coding difference trend differently and, when CMS determines the MA coding adjustment factor, we take into account the version of the model that will be in use during the payment year. Since we make determinations regarding the appropriate level of the MA coding adjustment by taking into account the impact on coding of the risk model, the model adjustments made to address coding do not duplicate the MA coding adjustment factor applied to the risk scores. Nevertheless, we are transitioning to the 2014 model by blending the scores from the 2014 and 2013 model.

In the 2014 Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be substantially lower because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

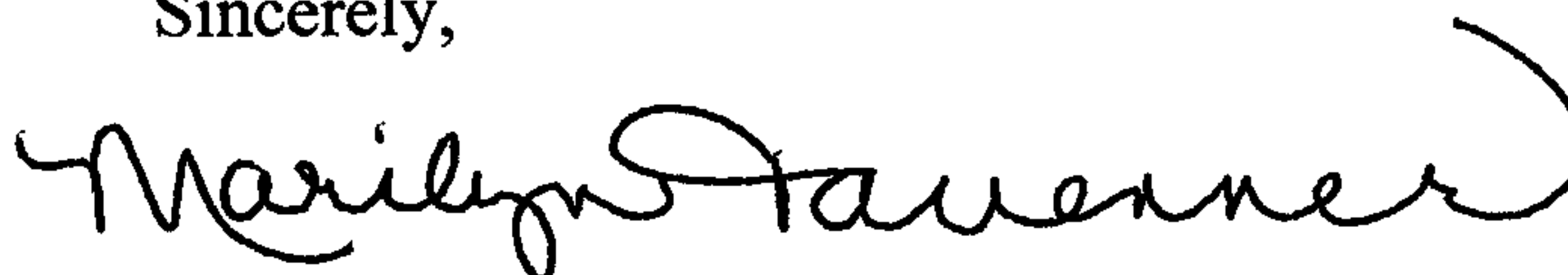
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth

Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large, sweeping loop at the end.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Joseph Crowley
U. S. House of Representatives
Washington, DC 20515

Dear Representative Crowley:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Methodology Changes – You expressed concern regarding the impact on risk scores from the exclusion of certain conditions, and noted that these changes may be duplicative of the coding intensity adjustments included in the American Taxpayer Relief Act.

We received a number of comments arguing that the changes to the risk adjustment model to address coding intensity are duplicative of the MA coding adjustment factor. We understand that different model versions may affect the coding difference trend differently and, when CMS determines the MA coding adjustment factor, we take into account the version of the model that will be in use during the payment year. Since we make determinations regarding the appropriate level of the MA coding adjustment by taking into account the impact on coding of the risk model, the model adjustments made to address coding do not duplicate the MA coding adjustment factor applied to the risk scores. Nevertheless, we are transitioning to the 2014 model by blending the scores from the 2014 and 2013 model.

In the 2014 Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be substantially lower because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

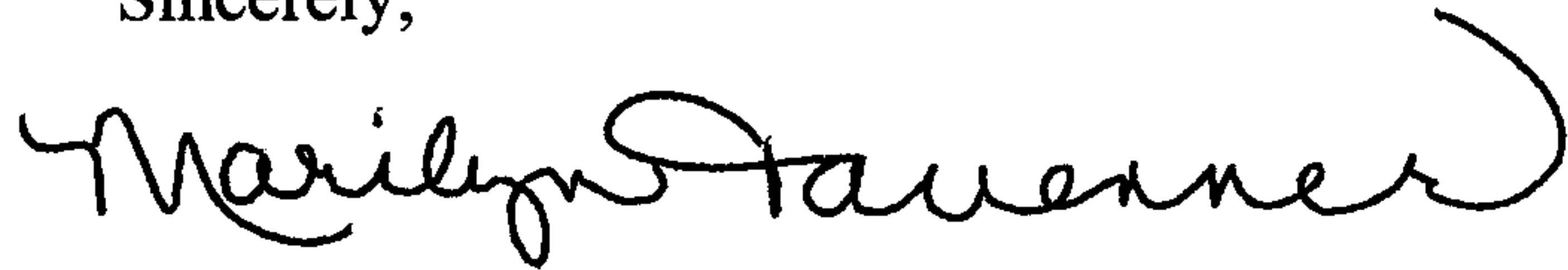
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would

be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large, sweeping loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Steve Israel
U. S. House of Representatives
Washington, DC 20515

Dear Representative Israel:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Risk Adjustment Methodology Changes – You expressed concern regarding the impact on risk scores from the exclusion of certain conditions, and noted that these changes may be duplicative of the coding intensity adjustments included in the American Taxpayer Relief Act.

We received a number of comments arguing that the changes to the risk adjustment model to address coding intensity are duplicative of the MA coding adjustment factor. We understand that different model versions may affect the coding difference trend differently and, when CMS determines the MA coding adjustment factor, we take into account the version of the model that will be in use during the payment year. Since we make determinations regarding the appropriate level of the MA coding adjustment by taking into account the impact on coding of the risk model, the model adjustments made to address coding do not duplicate the MA coding adjustment factor applied to the risk scores. Nevertheless, we are transitioning to the 2014 model by blending the scores from the 2014 and 2013 model.

In the 2014 Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Physician Payment Assumption – You note that payment rates to MA plans would be substantially lower because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

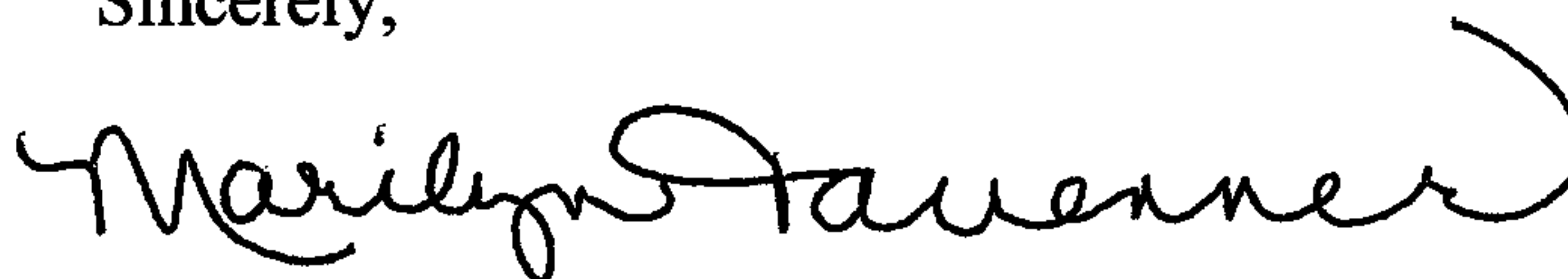
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would

be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large, sweeping loop at the end.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator
Washington, DC 20201

The Honorable Sean P. Duffy
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Duffy:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You request that CMS exercise its legal authority to establish MA payment rates based on the assumption that Congress will again act to avert the scheduled SGR cut. Allow me to respond on this issue based on our policies for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume an SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what

CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003, such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner", written over a horizontal line.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY - 9 2013

The Honorable Al Franken
United States Senate
Washington, DC 20510

Dear Senator Franken:

Thank you for your letter requesting that the Centers for Medicare & Medicaid Services' (CMS) work with Medicare Advantage (MA) plans to prevent beneficiary premium increases in light of the changes to MA reimbursement outlined in the February 15, 2013, Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 Call Letter.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comment on suggestions to address these challenges within the parameters of current law.

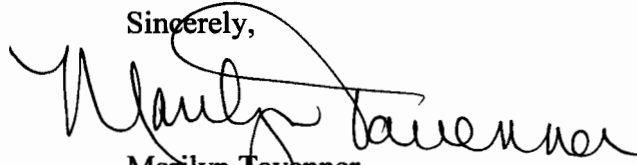
The CMS uses its authority under section 1854(a)(5)(C)(ii) of the Affordable Care Act to deny MA organization bids that propose too significant an increase in cost sharing or decrease in benefits from one plan year to the next through the total beneficiary cost (TBC) requirement. A plan's TBC is the sum of plan-specific Part B premium, plan premium, and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost-sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. We would like to note that 1) this calculation is adjusted for a plan's unique characteristics such as the benchmark changes, bonus payments, and other technical factors and 2) the measure protects beneficiaries from significant increases in cost sharing or decreases in benefits while ensuring beneficiaries have access to viable and sustainable MA plan offerings.

We received numerous comments from Medicare Advantage Organizations describing potential challenges complying with the TBC requirement, given the number of payment-related changes and the new health insurance fee. In the 2014 Final Call Letter, we established the TBC threshold at \$34 per member per month (PMPM) for CY 2014 to provide some flexibility in navigating other changes that will occur in CY 2014. The \$34 TBC threshold for CY 2014 is lower than the \$36 TBC threshold used for CY 2013 but above the \$30 TBC threshold proposed in the draft Call Letter issues on February 15, 2013. In past years, CMS has incorporated adjustments in the TBC calculation for payment rate and quality bonus changes, along with other

technical adjustments for changes in the PBP software. Consistent with that policy, we will refine the adjustment factor for CY 2014 to also account for changes in the coding intensity adjustment. Thus, a plan experiencing a net increase in benchmark, bonus payment, and/or coding intensity impact will have an effective TBC change amount below the \$34.00 PMPM requirement. Conversely, a plan experiencing a net decrease in benchmark, bonus payment, and/or coding intensity impact will have an effective TBC change amount above the \$34.00 PMPM requirement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner", written over a horizontal line.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY - 9 2013

The Honorable Mark Pryor
United States Senate
Washington, DC 20510

Dear Senator Pryor:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur*

to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner", written over a horizontal line.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator
Washington, DC 20201

The Honorable Judy Chu
U.S. House of Representatives
Washington, DC 20515

Dear Representative Chu:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter released on February 15, 2013.

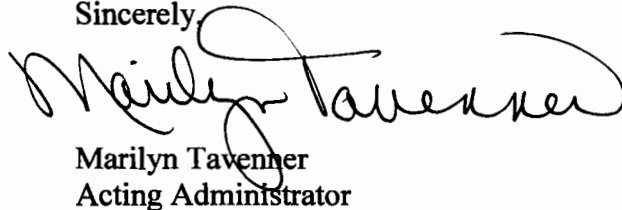
On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comment on suggestions to address these challenges within the parameters of current law.

You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health problems. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator

Washington, DC 20201

The Honorable Ron Barber
U.S. House of Representatives
Washington, DC 20515

Dear Representative Barber:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter released on February 15, 2013.

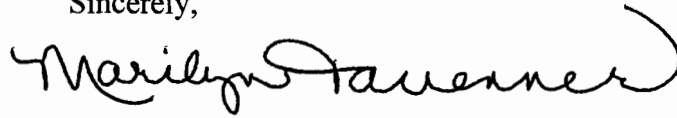
On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comment on suggestions to address these challenges within the parameters of current law.

You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health problems. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY - 9 2013

The Honorable Loretta Sanchez
U.S. House of Representatives
Washington, DC 20515

Dear Representative Sanchez:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter released on February 15, 2013.

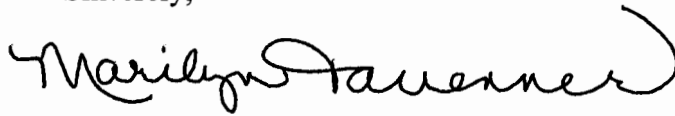
On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comment on suggestions to address these challenges within the parameters of current law.

You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health problems. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with the first name "Marilyn" written in a larger, more prominent script than the last name "Tavenner".

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator

Washington, DC 20201

The Honorable Grace Napolitano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Napolitano:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 Call Letter released on February 15, 2013.

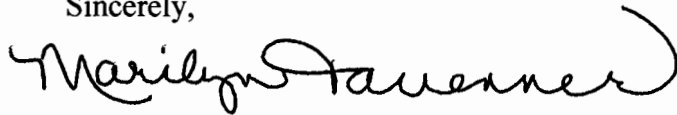
On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comment on suggestions to address these challenges within the parameters of current law.

You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with the most health problems. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Edward Markey
U.S. House of Representatives
Washington, DC 20515

Dear Representative Markey:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read 'Marilyn Tayenner', with a large, sweeping flourish extending from the end of the name.

Marilyn Tayenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Michael Capuano
U.S. House of Representatives
Washington, DC 20515

Dear Representative Capuano:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

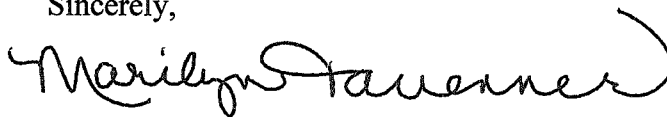
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Richard Neal
U.S. House of Representatives
Washington, DC 20515

Dear Representative Neal:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

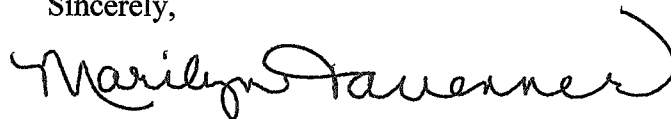
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY 9 2013

The Honorable James McGovern
U.S. House of Representatives
Washington, DC 20515

Dear Representative McGovern:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

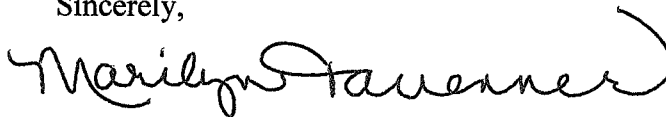
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable John Tierney
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tierney:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

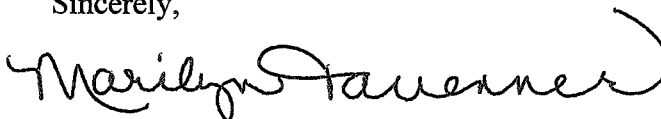
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY 9 2013

The Honorable Stephen Lynch
U.S. House of Representatives
Washington, DC 20515

Dear Representative Lynch:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

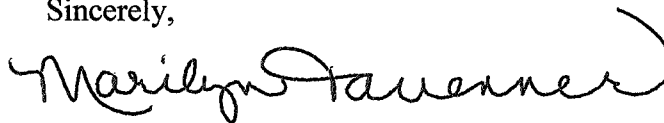
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY 9 2013

The Honorable Niki Tsongas
U.S. House of Representatives
Washington, DC 20515

Dear Representative Tsongas:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

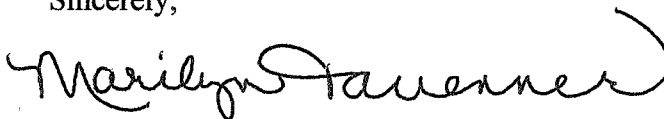
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY 9 2013

The Honorable William Keating
U.S. House of Representatives
Washington, DC 20515

Dear Representative Keating:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

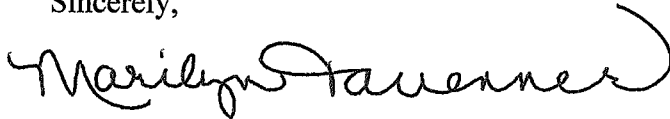
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 9 2013

The Honorable Joseph Kennedy
U.S. House of Representatives
Washington, DC 20515

Dear Representative Kennedy:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut under the sustainable growth rate formula (SGR) will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

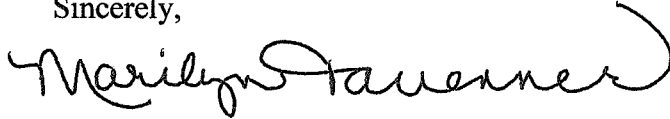
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under section 1853(c)(6)(A) of the Social Security Act from an estimate of what *would occur* to the physician fee schedule for the following year under

current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator
Washington, DC 20201

The Honorable Doris Matsui
U. S. House of Representatives
Washington, DC 20515

Dear Representative Matsui:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice) and 2014 draft Call Letter released on February 15, 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You raised the concern that CMS has assumed in the Advance Notice that the scheduled physician payment cut will occur in 2014. You have also asked CMS to consider using our authority to assume that the physician payment cut under the sustainable growth rate formula (SGR) will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (Title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of Title XVIII as in effect on the date that the rates are announced.

Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what

CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Announcement.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices.

Sincerely,



Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator

Washington, DC 20201

The Honorable Pat Toomey
United States Senate
Washington, DC 20510-0803

Dear Senator Toomey:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to the Congressional Budget Office, beneficiary enrollment in MA will be substantially reduced. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut under the sustainable growth rate formula (SGR) will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of title XVIII as in effect on the date that the rates are announced.

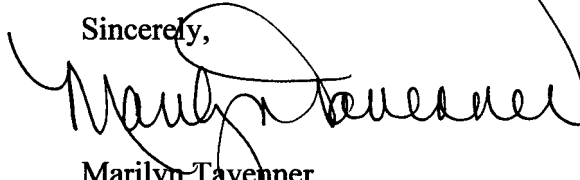
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather

than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,



Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator
Washington, DC 20201

The Honorable John Comyn
United States Senate
Washington, DC 20510-0803

Dear Senator Comyn:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to the Congressional Budget Office, beneficiary enrollment in MA will be substantially reduced. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut under the sustainable growth rate formula (SGR) will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of title XVIII as in effect on the date that the rates are announced.

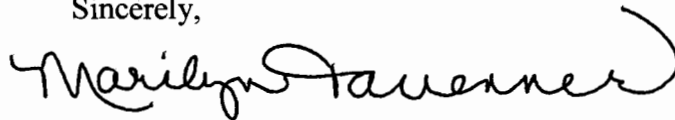
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather

than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator
Washington, DC 20201

The Honorable Dean Heller
United States Senate
Washington, DC 20510-0803

Dear Senator Heller:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to the Congressional Budget Office, beneficiary enrollment in MA will be substantially reduced. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut under the sustainable growth rate formula (SGR) will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of title XVIII as in effect on the date that the rates are announced.

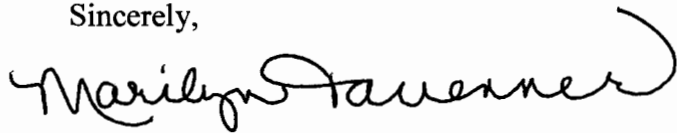
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather

than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



MAY - 9 2013

Administrator

Washington, DC 20201

The Honorable John Boozman
United States Senate
Washington, DC 20510-0803

Dear Senator Boozman:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies and 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to the Congressional Budget Office, beneficiary enrollment in MA will be substantially reduced. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Final Rate Notice) and 2014 Final Call Letter. As we had stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

You note that payment rates to MA plans would be artificially low because CMS assumed in the Advance Notice that the scheduled physician payment cut will occur in 2014. You have also asked CMS to use our authority to assume that the physician payment cut under the sustainable growth rate formula (SGR) will not occur when setting the MA rates for 2014.

The Social Security Act requires that the national MA growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title" (title XVIII). CMS historically has responded to comments urging CMS to assume a legislative SGR fix by indicating that we interpreted the use of the phrase "under this title" to mean that the estimate was to be based on the provisions of title XVIII as in effect on the date that the rates are announced.

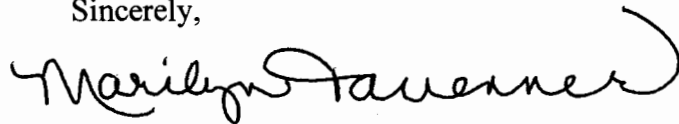
Given the increasing number of years in a row for which Congress has enacted an SGR fix after the MA rates for the upcoming year have been released in April, CMS agrees that it would be more reasonable to instead interpret the phrase "under this title" as a general reference to the nature of the expenditures, namely expenditures from the Part A and Part B trust funds, rather

than necessarily interpreting the phrase to incorporate current provisions of law into CMS's best estimate of the extent to which Medicare expenditures are actually expected to change.

Accordingly, we changed our interpretation of how we calculate the estimate of projected per capita rate of growth under this title under 1853(c)(6)(A) from an estimate of what *would occur* to the physician fee schedule for the following year under current law to a best estimate of what CMS believes *actually will* occur to the physician fee schedule for the following year based on recent history, and we revised the growth rate to assume a zero percent change for the physician fee schedule for 2014. We made this change to reflect the fact that Congress has annually changed the law every year since 2003 such that the projected SGR cut does not occur. CMS believes it is more reasonable to base the estimate of projected growth in Medicare expenditures on the assumption that a fix will occur than it would be to base the estimate on current law. The final MA Growth Percentage and the FFS Growth Percentage are calculated based on the assumption of a zero percent change for the physician fee schedule for 2014. Details on the growth percentages are contained in Attachment I of the Final Rate Notice.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator
Washington, DC 20201

MAY 9 2013

The Honorable Jack Kingston
U. S. House of Representatives
Washington, DC 20515

Dear Representative Kingston:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to CMS's Office of the Actuary beneficiary enrollment in MA will be substantially reduced by 2017. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with multiple chronic conditions. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

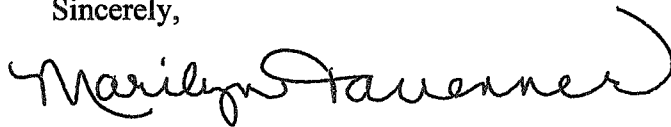
In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC

model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signer of your letter.

Sincerely,

A handwritten signature in black ink that reads "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator



Administrator

Washington, DC 20201

MAY 09 2013

The Honorable Mario Diaz-Balart
U. S. House of Representatives
Washington, DC 20515

Dear Representative Diaz-Balart:

Thank you for your letter regarding the Centers for Medicare & Medicaid Services' (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and D Payment Policies (Advance Notice), and the 2014 draft Call Letter released on February 15, 2013.

Your letter references the savings secured by the Affordable Care Act by bringing payments to Medicare Advantage plans in line with costs under Original Medicare, and that, according to CMS's Office of the Actuary beneficiary enrollment in MA will be substantially reduced by 2017. Despite the reduction in payments to MA plans required by the Affordable Care Act, I am happy to report that MA enrollment has increased to over 14 million beneficiaries as of March 2013.

On April 1, 2013, CMS released the Announcement of Methodological Changes for CY 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies (Final Rate Notice), and the 2014 Final Call Letter. As we stated in the Advance Notice, we recognize that plans face several legislatively mandated changes affecting payment for 2014. As such, we solicited comments on suggestions to address these challenges within the parameters of current law.

With respect to the issues you would like CMS to consider, allow me to respond to each in turn based on our policies for 2014:

Risk Adjustment Model Changes – You also expressed concerns about the proposed risk adjustment model changes and noted that these changes will impact plans that treat beneficiaries with multiple chronic conditions. The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. I appreciate, however, the concern you have raised regarding these risk adjustment changes being implemented at the same time as other program changes and we took these concerns into consideration as we finalized the policy for 2014.

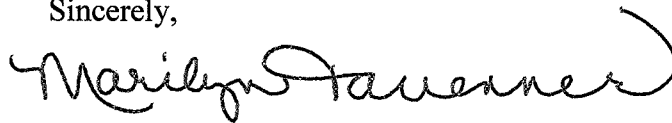
In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC

model, weighting the risk scores from the 2013 CMS-HCC model by 25 percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

Five-Star Rating System – You expressed concern regarding the proposed changes in the five-star rating system. CMS solicited comments on the proposed calculation changes to Star Ratings in the draft Call Letter. Currently, a plan's summary rating is calculated by averaging the individual measures' *stars* (1, 2, 3, 4, or 5 stars) rather than the underlying *scores* that plans achieve on each of the measures. Averaging *stars* rather than underlying *scores* (actual performance) results in a loss of information about differences between plans and increases the risk of misclassifying the plan in the summary rating. The proposed method for computing the overall/summary ratings averages using the underlying measures' *scores* would improve the correspondence between a plan's true performance in measures and its summary rating. Plans responded by requesting clarification on the calculation and a delay in implementation of the proposed changes to calculate the summary rating. In response to comments, CMS intends to delay the implementation of this change. Instead, we will conduct additional research regarding this calculation and will provide plans with advance notice of any potential changes.

Thank you for your interest in the Advance Notice and Call Letter. We look forward to working together with you to maintain a strong MA program so that our nation's Medicare beneficiaries can continue to have a wide range of quality plan choices. I will also provide this response to the co-signer of your letter.

Sincerely,

A handwritten signature in black ink, reading "Marilyn Tavenner". The signature is fluid and cursive, with a large loop at the end of the last name.

Marilyn Tavenner
Acting Administrator

5
A

U.S. HEALTH CARE- MANAGED CARE

2012 Medicare Advantage Rate Preview; All Roads Lead to FFS Parity

On Friday, February 18, we expect CMS to release the 45 day notice for the Medicare Advantage program for 2012, including the important update around reimbursement for the coming year. The preliminary rate release will be confirmed with final rates on April 5th. The rate release is typically a confusing process and this year promises to be one of the more complicated editions. Further confusing the issue is the fact that CMS has a penchant for releasing this information on a Friday evening before a long weekend, making it difficult to confirm some of the figures in the release.

In the note below we review the major components of the rate for 2012 as well as ranges for the potential outcomes. We make some additional company specific comments as well. **One major item to keep in mind is that all of the adjustments will ultimately lead to county rates that are a specific % of traditional Fee-For-Service costs as mandated by the PPACA.** While the timing of payment changes could move around, the ultimate rates to plans will still be based on a set % of FFS costs. This is probably the most important factor in the rate-setting process for 2012.

As we review below, we believe that the current law will lead to a reduction in 2012 MA rates of approximately 0.7%. While this is clearly below expected cost trends, we believe that this is at least in line with market expectations. Our estimates contain a broader range than previous years' estimates due to additional points of uncertainty. Lastly, the actual rate increases have consistently been lower than the actual revenues to the plans due to plan premium and benefit changes as well as increases in risk adjustment payments.

Overall, we believe that the currently negative short term expectations for Medicare Advantage rates are overdone. We believe that next Friday may actually serve as a positive catalyst.

INDUSTRY UPDATE

U.S. Health Care- Managed Care
1-POSITIVE
Unchanged

U.S. Health Care- Managed Care

Joshua R. Raskin, CFA
1.212.526.2279
joshua.raskin@barcap.com
BCI, New York

Joseph Kuhns
1.212.526.3302
joseph.kuhns@barcap.com
BCI, New York

Jack Meehan
1.212.526.3909
jack.meehan@barcap.com
BCI, New York

Barclays Capital does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report.

Investors should consider this report as only a single factor in making their investment decision.

PLEASE SEE ANALYST(S) CERTIFICATION(S) AND IMPORTANT DISCLOSURES BEGINNING ON PAGE 13.

CMS0001449

Summary

On Friday, February 18, we expect CMS to release the 45 day notice for the Medicare Advantage program for 2012, including the important update around reimbursement for the coming year. The preliminary rate release will be confirmed with final rates on April 5th. The rate release is typically a confusing process and this year promises to be one of the more complicated editions. Further confusing the issue is the fact that CMS has a penchant for releasing this information on a Friday evening before a long weekend, making it difficult to confirm some of the figures in the release.

In the note below we review the major components of the rate for 2012 as well as ranges for the potential outcomes. We make some additional company specific comments as well. **One major item to keep in mind is that all of the adjustments will ultimately lead to county rates that are a specific % of traditional Fee-For-Service costs as mandated by the PPACA.** While the timing of payment changes could move around, the ultimate rates to plans will still be based on a set % of FFS costs. This is probably the most important factor in the rate-setting process for 2012.

As we review below, we believe that the current law will lead to a reduction in 2012 MA rates of approximately 0.7%. While this is clearly below expected cost trends, we believe that this at least in line with market expectations. Our estimates contain a broader range than previous years estimates due to additional points of uncertainty. Lastly, the actual rate increases have consistently been lower than the actual revenues to the plans due to plan premium and benefit changes as well as increases in risk adjustment payments. **Overall, we believe that the currently negative short term expectations for Medicare Advantage rates are overdone. We believe that next Friday may actually serve as a positive catalyst.**

Figure 1: Expected 45 Day Notice Rate for 2012 MA Rates

	Low	Base Case	High
Adjusted Baseline Trend	3.25%	3.50%	3.75%
2011+Prior Error Correction	-0.25%	0.00%	0.25%
Phase out of IME	-0.30%	-0.20%	-0.10%
Health Care Code Adjs.	-2.00%	-1.50%	-1.00%
FFS Normalization	0.75%	1.00%	1.25%
County Rebasing	0.30%	0.60%	0.90%
Coding Intensity	-1.75%	-1.40%	-1.05%
FFS Premium Phase Out	-2.10%	-1.86%	-1.60%
Star Bonus Payments	0.40%	0.55%	0.70%
PPACA Impact	-1.70%	-1.31%	-0.90%
Expected 45 Day Notice	-1.70%	0.69%	3.10%

Source: CMS and Barclays Capital Estimates

Impact of the PPACA

Medicare Advantage is one of the programs most drastically changed under the PPACA, with expected savings of \$131.9 billion over 10 years to come from lower reimbursement and lower enrollment (as well as additional other savings). For starters, 2011 MA rates were frozen at 2010 levels.

Going further out, the PPACA revises the structure of payments to Medicare Advantage plans. **The underlying goal is to move the overall MA plan payments to 100% of the traditional fee for service program in aggregate.** In certain higher cost counties, the plans will receive 95% of FFS costs. On the other end of the spectrum, counties with lower costs will see payments of approximately 115% of FFS costs. Keep in mind the actual dollar amount of the payments are significantly higher in the high cost counties than they are in low cost counties; the adjusted payment structure will simply bring them closer together. Basically, the government wants to make sure that it is not paying more for MA members than for members it covers through traditional Medicare.

Under the PPACA, counties are classified into four tiers of rate structures. Although we note the number of counties in each quartile (about 800) is almost the same, more than 40% of Medicare Advantage enrollees are in the first quartile (also known as metropolitan counties). Metropolitan counties tend to have the highest costs. Plans that fall in these counties will still receive higher payments per member per month, but those payments will be the lowest reimbursement rates relative to the traditional Medicare FFS program (95% of the FFS payments). These payment structures below do not include a series of plan specific items including quality bonus payments and risk adjusters.

Figure 2: FFS Costs by Quartiles with Membership

Quartile	From	To	Benchmark % of FFS	% of MA lives 4/10	% of US counties
I	\$743.75	\$1,306.33	95%	44%	24
II	\$690.98	\$743.75	100%	21%	24
III	\$639.70	\$690.98	107.5%	15%	24
IV	\$0.00	\$639.70	115%	19%	27
Median		\$690.98			

Source: Source: CMS, Gorman Health Group and Barclays Capital Estimates.

One positive for the managed care plans is that the bill considers the market impact of making these changes too quickly. The bill calls for an elongated phase in period for the transition of payments and in some cases, this can be as long as six years from now. If the difference between the 2010 MA reimbursement (using current law) is less than \$30 above the payments that would be received in the new PPACA methodology, the payment would simply transition in 2012. For counties where the difference in the two methodologies is at least \$30 but less than \$50, the phase-in takes four years (a 25% phase-in per year in 2012, 2013 and 2014 with 100% new methodology in 2015). Last, in counties where the change would reduce payments by \$50 or more, the phase-in actually occurs over a six-year period with 100% of the new methodology not being reached until 2017.

For example, let's assume that there is a county where the MA plans are currently receiving \$1,000 PMPM on average and the Medicare FFS costs in that county average \$947 PMPM. First, we know this is a first quartile county because the MA payments are more than \$743.75 PMPM. Second, because the difference between the current plan payments (\$1,000 PMPM) and the plan payments under the new methodology (95% of the FFS costs of \$947 or \$900 PMPM) is \$100, and therefore more than \$50, we know there is a six year

phase in period beginning in 2012. Basically, the PPACA would mandate that rates are reduced for plans in that county by \$16.60 per year, through 2017.

In the chart below we give a series of examples using real data. In Dade county, Florida, we would expect a 75bps reduction in rates in each year from 2012 through 2017. **We have made the calculations for every county in the country and the straight average for the 2012 (one year) reduction in payments is approximately 1.77%.** However, that is not weighted for membership as each county has a different total. **When we adjust the impact for counties using quartiles, we arrive at an average PPACA impact of 1.86%. We believe that this is a good proxy for the overall impact of the PPACA in 2012.**

Figure 3: PPACA MA Payment Change Examples

	Dade, FL	Laramie, WY	Decatur, IN
(a) 2010 FFS Costs	\$1,236.51	\$691.49	\$636.13
(b) 2010 MA Payments	\$1,230.22	\$736.75	\$737.74
(b)/(a) MA as % of FFS	99%	107%	116%
Quartile	I	II	IV
(c) PPACA % of FFS	95%	100%	115%
(a)*(c)=(d) Implied PPACA Payments	\$1,174.68	\$691.49	\$731.55
(b)-(d)=(e) Old MA Pay vs New MA Pay	\$55.54	\$45.26	\$6.19
(f) Phase In Period (years)	6	4	1
(e)/(f)=(g) Cut to 2012 Rates	\$9.26	\$11.32	\$6.19
(g)/(b) % Impact	0.75%	1.54%	0.84%

Source: CMS and Barclays Capital Estimates.

MA Plan Quality Bonuses

A key provision in the PPACA is that it allows MA plans to earn up to 5% additional reimbursement from the government for quality metrics based on the CMS star system. This star system has historically been the sole guide on MA plans for consumers. To say that the MA plans put less than optimal resources toward star quality ratings in the past would be an understatement.

On November 10, 2010 (just 8 days after the midterm elections) CMS announced proposed changes to the star bonuses for Medicare Advantage and PDP plans for 2012. The changes were broadly a positive for the industry as more plans will qualify and payments will be larger than originally set in the PPACA. At this point, these are still proposed rules that will be vetted over the next couple months, but we expect them to be included in the 45 day notice on February 18, 2011 for ultimate inclusion in the final rule for 2012 plan payments on April 4, 2011. While these are “proposed” it is our opinion that these proposals have a very strong likelihood of eventual implementation.

Figure 4: Bonus Payment Schedule: Demonstration Project vs. Previous Method

Plan & Year	Actual Bonus* Under Demonstration			Actual Bonus Under Previous Method		
	2 Year Counties	4 Year Counties	6 Year Counties	2 Year Counties	4 Year Counties	6 Year Counties
5 Star Plans:						
2012	5.0%	5.0%	5.0%	0.75%	0.38%	0.25%
2013	5.0%	5.0%	5.0%	3.0%	1.5%	1.0%
2014	5.0%	5.0%	5.0%	5.0%	3.8%	2.5%
2015 (ACA Rules)	5.0%	5.0%	3.33%	5.0%	5.0%	3.3%
4 Star Plans:						
2012	2.0%	1.0%	0.67%	0.75%	0.38%	0.25%
2013	4.0%	2.0%	1.33%	3.0%	1.5%	1.0%
2014	5.0%	3.75%	2.5%	5.0%	3.75%	2.5%
2015 (ACA Rules)	5.0%	5.0%	3.33%	5.0%	5.0%	3.3%
3.5 Star Plans:						
2012	1.75%	0.88%	0.58%	0.0%	0.0%	0.0%
2013	3.5%	1.75%	1.17%	0.0%	0.0%	0.0%
2014	3.5%	2.63%	1.75%	0.0%	0.0%	0.0%
2015 (ACA Rules)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
3 Star Plans:						
2012	1.5%	0.8%	0.5%	0.0%	0.0%	0.0%
2013	3.0%	1.5%	1.0%	0.0%	0.0%	0.0%
2014	3.0%	2.25%	1.5%	0.0%	0.0%	0.0%
2015 (ACA Rules)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: CMS

In a recent release, CMS reported that for 2011 some 24.2% of all MA-PD plans weighted by membership reported a star ranking above 4 stars (the original threshold to receive bonus payments from CMS). **More importantly, 84.6% of all health plans weighted by membership attained at least 3 stars, which are eligible to earn a quality bonus under the new demonstration.**

Figure 5: Distribution of Overall Plan Ratings for MA-PD Plans (2011)

Overall Score	Contract Count	%	MA-PD% Weighted By Enrollment
5 stars	3	0.5%	1.0%
4 stars	74	13.2%	23.2%
3 stars	271	48.4%	60.4%
2 stars	48	8.6%	7.2%
Low Enrollment	104	18.6%	3.6%
Plan Too New	60	10.7%	4.5%
Total	560	100.0%	100.0%

Source: CMS

Using the pair of charts above, we calculate that 2012 MA payments will be increased in aggregate by 55 bps.

Perspectives on MA Components

There are approximately 8 additional components of the 2012 Medicare Advantage rate adjustment that are worth discussing. Below are comments on each of those factors:

1) The underlying expected growth in traditional Medicare for 2012

The base of all the adjustments is the simple cost trend that is expected for the Medicare fee for service program in the coming year. As the chart below shows, the average trend assumption over the past eight years has been 3.03%, ranging from a low of -1.1% in 2010 to a high of 6.1% in 2005. We note that the rates in effect for 2010 showed a baseline trend of a reduction of 1.1%. The deviation from historical standards was driven by several factors. CMS actuaries made many assumptions about 2010 including the belief that a slower economy would pressure utilization of healthcare services. Additionally, there was a material impact from the impact of the Doc Fix, which we discuss below. After a meaningful amount of pushback around the economic assumptions, it seems as though the expectations were somewhat warranted.

As noted above, a major assumption made by CMS in the past couple of years was that physicians would receive a 21% cut to their payments in the traditional fee for service program. The genesis of the problem is the Sustainable Growth Rate Formula which basically allocates funding to all parts of Medicare with the residual amounts going to the physicians. Because the funding is also below the actual costs, the formula has been kicking out a large cut to the doctors. Without a “doc fix” (a bill to restore physician payment cuts), providers in Medicare will theoretically be forced to take that 21% cut in their payments. Starting back in February 2009, CMS published the preliminary rates and at that time the “letter of the law” stated that doctors would indeed receive the cut in payments. With that, CMS actuaries were instructed to project Medicare Advantage payments under the assumption that the physician payments would see the major cut. While everyone agrees (including those at CMS that develop the rates) that the physicians would never actually see a large payment cut, those rates were used to develop the 2010 MA payments. We estimate that this reduced the 2010 baseline trend by 330 bps.

For the 2011 rates, there was again an impact from the Doc Fix as well as further assumptions of economic pressures in the preliminary rate. Because the 2010 Doc Fix only lasted one year (all of 2010 was eventually “fixed”) the impact on 2011 was exacerbated. For 2011, the physicians were facing a 25% cut. However, 2011 was unique from a timing perspective. The preliminary rate came in mid February 2010, but by the time the final rule was published in April 2010, the PPACA had passed (March 23, 2010). Because the PPACA was legislating rate cuts to the MA program, CMS then chose to zero out the trend factors and simply keep rates flat. The rationale behind this decision was that it would be best to forgo any rate increases when they would have to be rolled back in the coming years anyway. While the outcome was one of the more simple results in the history of the process, the method was very complex.

As an aside, Congress passed legislation in December 2010 that froze physician payments for all of 2011 at the same rates they were paid in the prior year. This prevented the 25% cut in fees for 2011. Obviously, this will come up again at the end of 2011 as physicians are once again going to face a large cut to reimbursement for 2012.

If we exclude 2010 and 2011 preliminary trend projections (due to CMS’ assumptions during periods of a decelerating economy), we arrive at 6 year average trend increase from 2004 through 2009 of 3.93% which is somewhat more consistent with what the Medicare Advantage plans have seen historically for a cost trend.

Figure 6: Historical Baseline FFS Medicare Trend – Preliminary Notice

	2004	2005	2006	2007	2008	2009	2010	2011	8 Yr Avg.
Preliminary Trend	3.70%	6.10%	4.50%	2.50%	3.40%	3.40%	-1.10%	1.75%	3.03%

Source: CMS

As we look at 2012, we estimate that the preliminary estimate (prior to consideration of a doc fix) will be approximately 3.50%, or slightly below the 6 year average before the economic turnaround. Unfortunately, we are faced with a similar issue for the doc fix, or lack thereof for 2012. Our fundamental belief is that physicians will never get the 25% cut in 2012 reimbursement. We don't believe that anything will happen until much later in 2011 to fix this and certainly nothing will happen before the final rates are published in April 2011. **Said another way, we are not anticipating any acts of Congress to affect these rates before Friday.**

2) Prior Year Error Correction Factors

In each year CMS goes back and looks at the prior year estimates of trend and makes an adjustment for those errors in the current year. If CMS estimated that a trend for 2011 would be 1.75% and the at the end of 2011, CMS determined that the actual trend was closer to 2.00%, CMS would add the difference (0.25%) to the current 2012 rates. As the chart below shows, there are always error corrections for several prior years. Since the change in methodology with the passage of the MMA in December 2003, the sum of the error corrections have ranged from negative (0.50%) to a positive 4.2%, with an average of a positive 1.08%. As seen below, this is typically a modest positive for the health plans.

It is very hard to know what CMS will do with the 2012 rates regarding the error correction factors. As a reminder, CMS used a 0% increase to trend for 2011 rates to account for the PPACA impact in future years. Given the complications from PPACA, we believe there will be a meaningful error factor for 2011. The big question is whether CMS includes the error correction for the 2012 rates.

We are estimating conservatively, an error correction factor of 0% in 2012 for several reasons. **First**, CMS intentionally put through a 0% increase for 2011 despite the understanding that the actual trend would be different per the actuaries. We would expect the same logic to persevere when setting the corrections for 2011. **Second**, medical costs trends in 2010 were lower than anticipated. 2010 was originally set at 1.6% and there was another 20 bps error correction factor included last year for a trend assumption of 1.8%. We would guess that the 2010 trends were not too far from that. **Third**, it is tough to see a major error correction factor for 2011 with only two months of the year passed and the major impact coming from the doc fix assumptions. **Fourth**, this is the most conservative assumption.

Figure 7: Prior Year Error Correction Factors

	2005	2006	2007	2008	2009	2010	2011	Total Average
2010 Trend Change							0.20%	N/A
2009 Trend Change						1.80%	0.56%	1.80%
2008 Trend Change					2.40%	(0.40)%	(0.30)%	1.00%
2007 Trend Change				1.90%	(0.90)%	(0.40)%	0.04%	0.20%
2006 Trend Change			1.10%	(0.50)%	0.10%	0.10%	(0.41)%	0.20%
2005 Trend Change		(0.30)%	1.80%	(0.30)%	(0.30)%	(0.10)%	(0.13)%	0.16%
2004 Trend Change	0.50%	(0.20)%	1.30%	(0.50)%	0.20%	0.60%	(0.31)%	0.32%
Total	0.50%	(0.50)%	4.20%	0.60%	1.50%	1.60%	(0.37)%	1.08%

Source: CMS

3) Phase-out of Indirect Medical Education

Indirect Medical Education (IME) amounts began being phased out beginning in 2010. As a reminder, in essence there is an additional payment that is built into MA rates for counties

that have teaching facilities. However, because those facilities also receive a higher payment from Medicare directly, they are included in the base FFS county rates they are counted twice in the payment system. Congress moved to eliminate this effect with reimbursement changes beginning in 2010. The maximum reduction that any specific county's capitation rate could incur was 0.6% of the total FFS rate in any year, as was the case in 2010. Remember, only counties with significant IME exposure would reach that cap. We estimate that the impact on the average rate for 2011 was approximately 20 bps. This was supposed to progress and be capped at 1.2% for 2011, or an incremental 60 bps. However, this was eliminated in 2011 when CMS moved to put through zero rates.

Our best guess is that CMS will resume the phase-out with another 20 bps impact on the overall program for the 2012 rates.

4) Healthcare Code (Risk Adjusters) Updates

The MA reimbursement system is now based entirely on risk adjustment payment methodology derived from specific coding of Medicare beneficiaries according to specific ailments. Plans are reimbursed for less healthy beneficiaries according to a schedule of Health Care Codes (HCCs). With this system plans with an overall risk score above 1.0 (i.e., above average) will see a positive impact. Essentially, plans receive greater payments for sicker patients. As a reminder, it was implemented in 2007. While CMS is required to update these factors no more than once every three years, CMS has tended to update them every two years. The updates had been done in 2007 and 2009. CMS was planning on implementing a new updated version for the 2011 rates (it was included in the 45 day notice) but this was tabled in the final notice. The new version was to include coefficients for the community, institutional and new enrollee segments.

We believe that CMS will implement the new system for 2012 rates. As a reminder, the HCCs represent potential categories for additional payments to the plans. For example, a beneficiary with HIV (HCC #1) receives a reimbursement of 1.945 times the standard FFS rate which is then offset by FFS normalization (see below for more detail). The updates are meant to have no overall effect (i.e. to be budget neutral to the program). However, historically, plans have suggested that these changes have had a negative effect, though it is very difficult to determine what the actual impact has been. **While we admit very little visibility into the impact on 2012 rates, we would guess it is approximately a 150 bps reduction to plan payments.**

5) The Impact of Fee-For Service (FFS) Normalization

Each year, CMS must adjust the risk adjustment payments methodology to account for population and risk coding changes for health plans relative to the traditional FFS program. In this process, CMS attempts to recalibrate the model—originally created based on 2005 data—to ensure an overall risk score of 1.0 for the overall Medicare program. Every year since then, CMS has adjusted rates down by a FFS normalization factor. In 2006 and 2007 that factor was an aggregate 2.9% over two years. In 2008, the factor was updated to 4% (or an incremental 1.1%) but included 2006 through 2008. In 2009, the FFS normalization factor decreased to 3.0% (a benefit of 1.1% in that year because CMS also updated all of the health care codes) but included just 2007 through 2009. In 2010, the normalization factor increased to 4% (another incremental 1.1%) and reflected a trend based on calculations of five years of risk score data (2004-2008). Last year, the normalization factor increased to 5.8%, an incremental impact of 1.8%. The update was made to account for the fact that CMS did not update the HCC codes. **In a nutshell, the normalization factor**

typically impacts reimbursement by reducing the HCC code to plans for the relative growth to the FFS program.

As noted above, we expect CMS to update the health care codes for 2012, which will change the typical impact for FFS normalization. **For 2012, we are expecting to see a positive 100 bps impact from FFS Normalization.** This would be relatively consistent with the recent years in which the health care codes were updated.

6) Impact of FFS County Rebasing

Every year, CMS has the opportunity to rebase the county payment rates in the Medicare Advantage program. CMS must perform this review at least once every three years. Specifically, this process allows CMS to review the prevailing FFS costs in a specific county versus previous estimates of FFS costs in the county. CMS then compares the new “rebased” FFS rates to the previous payments and reimburses for the higher amount. **In a nutshell, there is no way that this process can reduce rates and is only a potential positive for the managed care plans.** The process was done with the 2009 rates and therefore was not done for 2010 rates. While CMS is required to perform this task at least once every three years, the historical pattern had been closer to every two years. However, last year the 2011 rates were NOT updated due to the passage of the PPACA. With that, we expect the rebasing to be done for 2012. **We estimate that this will add approximately 60bps to the 2011 rates which is roughly consistent with the previous updates for rebasing.**

7) Phase-out of Budget Neutrality

We simply include this section for completeness and to contrast to prior years. As of 2011 there will be a 0% impact on the rates as the phase out was completed. Similarly, for 2012 and beyond there will be no further impact.

Budget Neutrality Background

A plan for budget neutrality was instituted to ensure that the total amount paid to the health plans under this risk adjustment system would not be reduced and that the plans with riskier members would receive greater payments. The idea here was to equate the risk adjusted payments to the demographic payment levels to ensure an even starting point. Remember, at this time, plans were struggling to operate in the MA program causing more and more seniors to lose coverage. The neutrality payments were developed in 2002 and began in 2003. Over the past several years many of the MA plans have benefited from these budget neutrality payments since it was previously believed that the members enrolled in MA were healthier than the average senior in the fee for service program.

In February 2005, the President’s Budget included a provision to phase out the increased reimbursement to health plans for budget neutrality. In 2006, 25% of those payments were eliminated. Originally, 2009 was to include the phase out with 70% of those payments eliminated, climbing to a full phase out of 100% of budget neutrality payments by 2011. On September 1, 2005 CMS announced several items that would affect MA rates in the future. A review found that the difference in health status of MA members was much closer to the traditional fee for service Medicare members than previously thought. It was recognized that the effects of the budget neutrality payments in the future would be smaller in the future. Additionally, the phase out was accelerated so that 75% of the payments would be eliminated in 2009 and by 2011 the payments would still be eliminated in total. In 2009, 25% of the Budget Neutrality factor will be applied to the risk rates. For 2010, 5% of the

Budget Neutrality factor will be applied to the risk rates. **In effect, this phase out was ultimately a reduction in MA rates for the prior years, with NO impact remaining for 2011 and beyond.**

Figure 8: Budget Neutrality Phase Payment Elimination Schedule

BN Payments Eliminated	2007	2008	2009	2010	2011
Original	40%	55%	70%	85%	100%
With Reconciliation	45%	60%	75%	95%	100%
BN Payments Remaining	2007	2008	2009	2010	2011
Original	60%	45%	30%	15%	0%
With Reconciliation	55%	40%	25%	5%	0%

Source: CMS

8) Historical Coding Correction Adjustment

This has been the biggest unknown in the process in recent years and we continue to believe the plans have some short term risk in this area. In accordance with the Deficit Reduction Act (Section 1853(k)(2)(B)(iv)(III)), CMS is required to adjust the MA rates for “differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.” Basically, CMS had to determine whether the MA plans are capturing risk adjustment codes better than providers that are simply submitting claims under Part A and B in the traditional FFS program. As a reminder, the plans get paid more for members that screen as riskier (i.e. have more HCC codes) and therefore the MA plans have a major incentive to ensure that they submit information for every potential risk adjuster. There is no such incentive for providers under Part A and B.

Not surprisingly, CMS has indeed found that the Medicare Advantage plans were coding at higher levels than the traditional FFS program. When presenting their findings last year, CMS found that the disease-scores for seniors in MA plans increased more than twice as much as rates for seniors in regular Medicare (FFS). CMS noted that some of this difference can be explained by the changes in those two populations. First, most new MA members come from FFS and are typically less healthy than the average. Conversely, most new FFS members are newly eligible to Medicare, typically younger and therefore healthier on average. Second, those that dis-enroll from MA plans typically do so “involuntarily” (i.e. pass away) and are therefore sicker. For FFS disenrollment, some can be attributed to joining MA plans. CMS estimates that these factors make up about 50% of the difference in risk scores for MA plans versus FFS Medicare.

CMS chose to analyze data for Medicare enrollees that stayed in MA for 2 years, or stayed in FFS for two years. The premise was that the changes in risk scores in the second year could be isolated as program differences. This is where CMS determined that there were still significant differences of risk scores for Medicare Advantage members compared to the FFS program.

The absolute difference in risk scores was 0.015 from 2004 to 2005 and also from 2005 to 2006. However, that absolute difference rose to 0.025 from 2006 to 2007. After the preliminary rates were released in February 2010, CMS included data from 2007 to 2008 in the final rates for 2010. In the preliminary rate notice CMS calculated that a three year average annual difference in rates was 1.75%. CMS then calculated the enrollment duration factor (EDF) which is the average length of time that beneficiaries were enrollment in MA plans over that time. The EDF was set at 2.45. If you applied the average difference (2.45) to

the EDF (1.75%), you arrive at a three year cumulative impact of 4.29%. Lastly, CMS calculated the % of stayers (members enrolled in MA) for the next year to be 87.3%. That % was applied to the 4.29% to arrive at a cumulative three year rate reduction factor of 3.74%. **In the final rates for 2010, the adjustment was amended to 3.41%** and that was the amount that is being applied to the 2010 risk scores for reimbursement reduction.

For 2011, CMS simply included another adjustment of 3.41%. Because CMS maintained the same adjustment factor, there was NO incremental impact on 2011 rates. This was consistent with the goal of maintaining a flat payment schedule for 2011 relative to 2010.

For 2012, we would not be surprised to see a higher impact than was seen in the 2011 rates (which was constant from 2010). As noted above, the more recent data appears to indicate that MA plans have been showing a larger risk score differential compared to the FFS program as time passes. We believe that each incremental year will show a larger deviation in risk scores from plans relative to FFS costs. This is not surprising as plans continue to improve their compliance and risk score coding infrastructures. **We estimate that the adjustment factor in 2012 could be roughly 4.5%-5.2%, which implies a negative impact in 2012 from coding intensity of approximately 105-175bps.**

Company Specifics

1) Health Plan revenues have consistently increased at a rate above the CMS final rates, and more so above the preliminary rate increases suggested in the 45 day notice. The discussion around the 45 day notice of rates centers around the simple payments to health plans directly from CMS. It ignores many other factors that play into health plan revenues including premiums and certain out of pocket member costs. As the chart below demonstrates, we estimate that plans showed revenues PMPM that were some 299 bps above CMS payments in 2008 and another 342 bps above in 2009. Based on the latest reports, we expect 2010 to come in some 165bps above CMS stated rates.

Figure 9: MA Plan Revenue PMPM vs. CMS Final Rates

	2005	2006	2007	2008	2009	2010E *
Aetna	\$827.25	\$965.00	\$1,019.27	\$1,043.76	\$1,068.63	\$981.63
PMPM Increase		16.7%	5.6%	2.4%	2.4%	(8.1)%
CIGNA	\$733.33	\$835.94	\$916.01	\$973.24	\$996.65	\$837.61
PMPM Increase		14.0%	9.6%	6.2%	2.4%	(16.0)%
Coventry	\$751.50	\$714.81	\$639.24	\$696.76	\$793.19	\$790.41
PMPM Increase		-4.9%	-10.6%	9.0%	13.8%	(0.4)%
Health Net	\$763.76	\$848.40	\$852.53	\$868.57	\$984.80	\$956.09
PMPM Increase		11.1%	0.5%	1.9%	13.4%	(2.9)%
HealthSpring	\$580.66	\$728.01	\$860.38	\$995.80	\$1,041.54	\$986.39
PMPM Increase		25.4%	18.2%	15.7%	4.6%	(5.3)%
Humana	\$770.81	\$766.58	\$822.52	\$847.78	\$913.14	\$914.47
PMPM Increase		-0.5%	7.3%	3.1%	7.7%	0.1%
Universal American	\$660.81	\$691.01	\$676.77	\$829.46	\$906.65	N/A
PMPM Increase		4.6%	-2.1%	22.6%	9.3%	
TOTALS	\$726.87	\$792.82	\$826.67	\$893.62	\$957.80	\$917.47
PMPM Increase		9.5%	4.1%	8.7%	7.7%	(2.1)%
CMS Final Rate		4.8%	7.1%	5.7%	4.2%	(3.8)%
Difference		4.6%	(3.1)%	3.0%	3.4%	1.6%

* - 2010 excludes certain outliers that saw meaningful membership mix changes

Source: CMS, Company Documents and Barclays Capital Estimates

The dependence on the Medicare program varies greatly among the publicly traded managed care companies, as well as versus historical levels. As the chart below shows, the contribution of Medicare Advantage to total revenue was just 13.3% in 2004 and increased to 24.4% in 2009. For 2010, we are estimating the first decrease in MA dependence since the MMA of 2003 to an average of 22.4%. In 2010, we estimate that four companies will have 25% of revenue coming from MA: HealthSpring, Humana, WellCare and UnitedHealth.

From a profit standpoint, there is a little more dispersion though similar overall percentages. Overall, we estimate that Medicare Advantage contributed approximately 13.4% of EPS in 2004 rising to 22.8% in 2008. We estimate that despite an increase in revenues in 2009, there was a modest decline in earnings exposure. In 2010, we estimate that the average dependence on MA earnings will be slightly better (due in part to certain one time gains) at 22.3%. Looking closer at 2010 estimates, HealthSpring is expected to generate the highest level of earnings from Medicare Advantage at 86%, with Humana next at 70%.

Figure 10: MA Revenue Exposure

	Medicare Advantage Revenues							
	2004	2005	2006	2007	2008	2009	2010E	2011E
HealthSpring	72.4%	82.4%	80.1%	86.6%	85.5%	85.9%	80.9%	82.0%
Humana	23.6%	31.8%	39.7%	44.2%	47.0%	53.0%	57.0%	55.0%
WellCare	24.0%	26.8%	22.9%	29.4%	37.4%	40.4%	24.8%	26.4%
UnitedHealth	5.8%	11.0%	18.1%	21.3%	21.9%	24.7%	25.7%	23.2%
Coventry	10.5%	10.1%	8.8%	21.7%	26.4%	35.1%	19.6%	20.1%
Health Net	12.7%	13.2%	15.4%	14.5%	19.5%	20.3%	19.0%	18.5%
Aetna	4.7%	4.5%	5.6%	8.3%	14.3%	15.6%	16.1%	15.5%
WellPoint	5.3%	2.8%	5.2%	5.2%	7.4%	6.7%	8.2%	8.8%
Molina	0.0%	0.0%	0.0%	2.0%	3.1%	3.9%	6.4%	8.3%
Amerigroup	0.0%	0.0%	0.0%	1.7%	2.5%	3.8%	4.0%	4.4%
CIGNA	1.6%	1.7%	1.9%	2.0%	2.1%	3.2%	7.0%	3.5%
Centene	0.0%	0.0%	0.0%	0.0%	0.1%	0.3%	0.7%	0.7%
Averages	13.4%	15.4%	16.5%	19.7%	22.3%	24.4%	22.4%	22.2%

Source: Company Documents and Barclays Capital Estimates

Figure 11: MA EPS Exposure

	Medicare Advantage EPS							
	2004	2005	2006	2007	2008	2009	2010E	2011E
HealthSpring	72.4%	81.7%	84.4%	88.1%	92.7%	82.0%	85.2%	85.6%
Humana	31.6%	42.3%	58.1%	55.0%	71.8%	74.3%	76.1%	69.5%
WellCare	23.9%	25.3%	22.9%	26.9%	35.5%	31.9%	22.2%	23.8%
UnitedHealth	3.8%	7.7%	14.0%	12.8%	14.0%	14.8%	19.7%	18.3%
Coventry	9.1%	7.1%	5.7%	15.1%	15.3%	14.1%	21.4%	15.4%
Health Net	14.9%	13.7%	10.2%	10.8%	23.1%	19.9%	17.9%	14.9%
Aetna	3.1%	2.8%	3.6%	5.2%	8.8%	10.8%	12.2%	10.8%
WellPoint	3.3%	2.5%	4.8%	4.8%	7.2%	5.8%	6.3%	6.8%
Molina	0.0%	0.0%	0.0%	1.6%	2.5%	3.5%	3.1%	4.8%
Amerigroup	0.0%	0.0%	0.0%	0.9%	2.1%	2.4%	1.8%	2.3%
CIGNA	0.9%	1.0%	1.2%	1.0%	1.1%	1.8%	1.6%	1.2%
Centene	0.0%	0.0%	0.0%	0.0%	0.1%	0.3%	0.4%	0.4%
Averages	13.6%	15.3%	17.1%	18.5%	22.8%	21.8%	22.3%	21.1%

Source: Company Documents and Barclays Capital Estimates

We estimate that a 5% reduction in Medicare Advantage margins would eliminate 1.1% of the EPS for our coverage universe, with a 10% cut leading to 2.2% lower EPS.

Figure 12: Potential Impact of MA Reimbursement Cuts

	Overall	MA	% of	Overall	MA Margin	5% Lower	Adjusted	% EPS	10% Lower	Adjusted	% EPS
	2010E EPS	2010E EPS	Total	Margin	Assumption	Margin	Impact	EPS	Margin	Impact	EPS
HealthSpring	\$3.25	\$2.77	85.2%	9.5%	10.0%	9.5%	(\$0.14)	\$3.11	(4.3)%	(\$0.28)	\$2.97
Humana	\$6.47	\$4.93	76.1%	5.2%	6.9%	6.6%	(\$0.25)	\$6.22	(3.8)%	(\$0.49)	\$5.98
WellCare	\$2.35	\$0.52	22.2%	3.0%	9.0%	8.6%	(\$0.03)	\$2.32	(1.1)%	(\$0.05)	\$2.30
UnitedHealth	\$4.10	\$0.81	19.7%	7.8%	6.0%	5.7%	(\$0.04)	\$4.06	(1.0)%	(\$0.08)	\$4.02
Health Net	\$2.61	\$0.47	17.9%	3.2%	3.0%	2.9%	(\$0.02)	\$2.59	(0.9)%	(\$0.05)	\$2.56
Coventry	\$4.15	\$0.89	21.4%	8.3%	9.0%	8.6%	(\$0.04)	\$4.11	(1.1)%	(\$0.09)	\$4.06
Aetna	\$3.66	\$0.45	12.2%	7.0%	5.3%	5.0%	(\$0.02)	\$3.64	(0.6)%	(\$0.04)	\$3.62
WellPoint	\$6.70	\$0.42	6.3%	7.3%	5.5%	5.2%	(\$0.02)	\$6.67	(0.3)%	(\$0.04)	\$6.65
Molina	\$1.90	\$0.06	3.1%	2.0%	1.0%	1.0%	(\$0.00)	\$1.90	(0.2)%	(\$0.01)	\$1.89
AMERIGROUP	\$4.80	\$0.09	1.8%	6.7%	3.0%	2.9%	(\$0.00)	\$4.80	(0.1)%	(\$0.01)	\$4.79
CIGNA	\$4.64	\$0.08	1.6%	9.5%	2.0%	1.9%	(\$0.00)	\$4.64	(0.1)%	(\$0.01)	\$4.64
Centene	\$1.82	\$0.01	0.4%	3.5%	2.0%	1.9%	(\$0.00)	\$1.82	(0.0)%	(\$0.00)	\$1.82
Average			22.3%	6.1%	5.2%	5.0%			(1.1)%		(2.2)%

Source: Company Documents, CMS and Barclays Capital Estimates

ANALYST(S) CERTIFICATION(S)

I, Joshua R. Raskin, CFA, hereby certify (1) that the views expressed in this research report accurately reflect my personal views about any or all of the subject securities or issuers referred to in this research report and (2) no part of my compensation was, is or will be directly or indirectly related to the specific recommendations or views expressed in this research report.

IMPORTANT DISCLOSURES

For current important disclosures, including, where relevant, price target charts, regarding companies that are the subject of this research report, please send a written request to: Barclays Capital Research Compliance, 745 Seventh Avenue, 17th Floor, New York, NY 10019 or refer to <http://publicresearch.barcap.com> or call 1-212-526-1072.

The analysts responsible for preparing this research report have received compensation based upon various factors including the firm's total revenues, a portion of which is generated by investment banking activities.

On September 20, 2008, Barclays Capital acquired Lehman Brothers' North American investment banking, capital markets, and private investment management businesses. All ratings and price targets prior to this date relate to coverage under Lehman Brothers Inc.

Barclays Capital produces a variety of research products including, but not limited to, fundamental analysis, equity-linked analysis, quantitative analysis, and trade ideas. Recommendations contained in one type of research product may differ from recommendations contained in other types of research products, whether as a result of differing time horizons, methodologies, or otherwise.

Materially Mentioned Stocks (Ticker, Date, Price)

Aetna Inc. (AET, 09-Feb-2011, USD 37.32), 1-Overweight/1-Positive
 AMERIGROUP Corp. (ACP, 09-Feb-2011, USD 54.16), 2-Equal Weight/1-Positive
 Centene Corp. (CNC, 09-Feb-2011, USD 29.56), 1-Overweight/1-Positive
 CIGNA Corp. (CI, 09-Feb-2011, USD 42.81), 2-Equal Weight/1-Positive
 Coventry Health Care (CVH, 09-Feb-2011, USD 29.85), 2-Equal Weight/1-Positive
 Health Net (HNT, 09-Feb-2011, USD 30.16), 3-Underweight/1-Positive
 HealthSpring Inc. (HS, 09-Feb-2011, USD 31.60), 1-Overweight/1-Positive
 Humana Inc. (HUM, 09-Feb-2011, USD 58.57), 2-Equal Weight/1-Positive
 Molina Healthcare (MOH, 09-Feb-2011, USD 33.53), 2-Equal Weight/1-Positive
 UnitedHealth Group (UNH, 09-Feb-2011, USD 42.07), 1-Overweight/1-Positive
 WellCare Health Plans (WCG, 09-Feb-2011, USD 31.77), 2-Equal Weight/1-Positive
 WellPoint, Inc. (WLP, 09-Feb-2011, USD 65.25), 1-Overweight/1-Positive

Other Material Conflicts

HUM: Barclays Capital is acting as financial advisor to Concentra Inc. in the company's potential acquisition by Humana Inc.

Guide to the Barclays Capital Fundamental Equity Research Rating System:

Our coverage analysts use a relative rating system in which they rate stocks as 1-Overweight, 2-Equal Weight or 3-Underweight (see definitions below) relative to other companies covered by the analyst or a team of analysts that are deemed to be in the same industry sector (the "sector coverage universe").

In addition to the stock rating, we provide sector views which rate the outlook for the sector coverage universe as 1-Positive, 2-Neutral or 3-Negative (see definitions below). A rating system using terms such as buy, hold and sell is not the equivalent of our rating system. Investors should carefully read the entire research report including the definitions of all ratings and not infer its contents from ratings alone.

Stock Rating

1-Overweight - The stock is expected to outperform the unweighted expected total return of the sector coverage universe over a 12-month investment horizon.

2-Equal Weight - The stock is expected to perform in line with the unweighted expected total return of the sector coverage universe over a 12-month investment horizon.

3-Underweight - The stock is expected to underperform the unweighted expected total return of the sector coverage universe over a 12-month investment horizon.

RS-Rating Suspended - The rating and target price have been suspended temporarily due to market events that made coverage impracticable or to comply with applicable regulations and/or firm policies in certain circumstances including when Barclays Capital is acting in an advisory capacity in a merger or strategic transaction involving the company.

Sector View

1-Positive - sector coverage universe fundamentals/valuations are improving.

2-Neutral - sector coverage universe fundamentals/valuations are steady, neither improving nor deteriorating.

IMPORTANT DISCLOSURES CONTINUED

3-Negative - sector coverage universe fundamentals/valuations are deteriorating.

Below is the list of companies that constitute the "sector coverage universe":

U.S. Health Care- Managed Care

Aetna Inc. (AET)	AMERIGROUP Corp. (AGP)	Centene Corp. (CNC)
CIGNA Corp. (CI)	Coventry Health Care (CVH)	Health Net (HNT)
HealthSpring Inc. (HS)	Healthways Inc. (HWAY)	Humana Inc. (HUM)
Magellan Health Services (MGLN)	Molina Healthcare (MOH)	UnitedHealth Group (UNH)
Universal American Corp. (UAM)	WellCare Health Plans (WCG)	WellPoint, Inc. (WLP)

Distribution of Ratings:

Barclays Capital Inc. Equity Research has 1721 companies under coverage.

42% have been assigned a 1-Overweight rating which, for purposes of mandatory regulatory disclosures, is classified as a Buy rating; 54% of companies with this rating are investment banking clients of the Firm.

43% have been assigned a 2-Equal Weight rating which, for purposes of mandatory regulatory disclosures, is classified as a Hold rating; 45% of companies with this rating are investment banking clients of the Firm.

12% have been assigned a 3-Underweight rating which, for purposes of mandatory regulatory disclosures, is classified as a Sell rating; 38% of companies with this rating are investment banking clients of the Firm.

Barclays Capital offices involved in the production of equity research:

London

Barclays Capital, the investment banking division of Barclays Bank PLC (Barclays Capital, London)

New York

Barclays Capital Inc. (BCI, New York)

Tokyo

Barclays Capital Japan Limited (BCJL, Tokyo)

São Paulo

Banco Barclays S.A. (BBSA, São Paulo)

Hong Kong

Barclays Bank PLC, Hong Kong branch (Barclays Bank, Hong Kong)

Toronto

Barclays Capital Canada Inc. (BCC, Toronto)

Johannesburg

Absa Capital, a division of Absa Bank Limited (Absa Capital, Johannesburg)

This publication has been prepared by Barclays Capital; the investment banking division of Barclays Bank PLC, and/or one or more of its affiliates as provided below. This publication is provided to you for information purposes only, and Barclays Capital makes no express or implied warranties, and expressly disclaims all warranties of merchantability or fitness for a particular purpose or use with respect to any data included in this publication. Prices shown in this publication are indicative and Barclays Capital is not offering to buy or sell or soliciting offers to buy or sell any financial instrument.

Without limiting any of the foregoing and to the extent permitted by law, in no event shall Barclays Capital, nor any affiliate, nor any of their respective officers, directors, partners, or employees have any liability for (a) any special, punitive, indirect, or consequential damages; or (b) any lost profits, lost revenue, loss of anticipated savings or loss of opportunity or other financial loss, even if notified of the possibility of such damages, arising from any use of this publication or its contents.

Other than disclosures relating to Barclays Capital, the information contained in this publication has been obtained from sources that Barclays Capital believes to be reliable, but Barclays Capital does not represent or warrant that it is accurate or complete. The views in this publication are those of Barclays Capital and are subject to change, and Barclays Capital has no obligation to update its opinions or the information in this publication.

The analyst recommendations in this report reflect solely and exclusively those of the author(s), and such opinions were prepared independently of any other interests, including those of Barclays Capital and/or its affiliates.

The securities discussed in this publication may not be suitable for all investors. Barclays Capital recommends that investors independently evaluate each issuer, security or instrument discussed in this publication and consult any independent advisors they believe necessary. The value of and income from any investment may fluctuate from day to day as a result of changes in relevant economic markets (including changes in market liquidity). The information in this publication is not intended to predict actual results, which may differ substantially from those reflected. Past performance is not necessarily indicative of future results.

This communication is being made available in the UK and Europe primarily to persons who are investment professionals as that term is defined in Article 19 of the Financial Services and Markets Act 2000 (Financial Promotion Order) 2005. It is directed at, and therefore should only be relied upon by, persons who have professional experience in matters relating to investments. The investments to which it relates are available only to such persons and will be entered into only with such persons. Barclays Capital is authorized and regulated by the Financial Services Authority ('FSA') and member of the London Stock Exchange.

Barclays Capital Inc., US registered broker/dealer and member of FINRA (www.finra.org), is distributing this material in the United States and, in connection therewith accepts responsibility for its contents. Any U.S. person wishing to effect a transaction in any security discussed herein should do so only by contacting a representative of Barclays Capital Inc. in the U.S. at 745 Seventh Avenue, New York, New York 10019.

Non-U.S. persons should contact and execute transactions through a Barclays Bank PLC branch or affiliate in their home jurisdiction unless local regulations permit otherwise.

This material is distributed in Canada by Barclays Capital Canada Inc., a registered investment dealer and member of IIROC (www.iiroc.ca).

Subject to the conditions of this publication as set out above, Absa Capital, the Investment Banking Division of Absa Bank Limited, an authorised financial services provider (Registration No.: 1986/004794/06), is distributing this material in South Africa. Absa Bank Limited is regulated by the South African Reserve Bank. This publication is not, nor is it intended to be, advice as defined and/or contemplated in the (South African) Financial Advisory and Intermediary Services Act, 37 of 2002, or any other financial, investment, trading, tax, legal, accounting, retirement, actuarial or other professional advice or service whatsoever. Any South African person or entity wishing to effect a transaction in any security discussed herein should do so only by contacting a representative of Absa Capital in South Africa, 15 Alice Lane, Sandton, Johannesburg, Gauteng 2196. Absa Capital is an affiliate of Barclays Capital.

In Japan, foreign exchange research reports are prepared and distributed by Barclays Bank PLC Tokyo Branch. Other research reports are distributed to institutional investors in Japan by Barclays Capital Japan Limited. Barclays Capital Japan Limited is a joint-stock company incorporated in Japan with registered office of 6-10-1 Roppongi, Minato-ku, Tokyo 106-6131, Japan. It is a subsidiary of Barclays Bank PLC and a registered financial instruments firm regulated by the Financial Services Agency of Japan. Registered Number: Kanto Zaimukyokuchō (kinsho) No. 143.

Barclays Bank PLC, Hong Kong Branch is distributing this material in Hong Kong as an authorised institution regulated by the Hong Kong Monetary Authority. Registered Office: 41/F, Cheung Kong Center, 2 Queen's Road Central, Hong Kong.

Barclays Bank PLC Frankfurt Branch is distributing this material in Germany under the supervision of Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin).

This material is distributed in Malaysia by Barclays Capital Markets Malaysia Sdn Bhd.

This material is distributed in Brazil by Banco Barclays S.A.

Barclays Bank PLC in the Dubai International Financial Centre (Registered No. 0060) is regulated by the Dubai Financial Services Authority (DFSA). Barclays Bank PLC-DIFC Branch, may only undertake the financial services activities that fall within the scope of its existing DFSA licence.

Barclays Bank PLC in the UAE is regulated by the Central Bank of the UAE and is licensed to conduct business activities as a branch of a commercial bank incorporated outside the UAE in Dubai (Licence No.: 13/1844/2008, Registered Office: Building No. 6, Burj Dubai Business Hub, Sheikh Zayed Road, Dubai City) and Abu Dhabi (Licence No.: 13/952/2008, Registered Office: Al Jazira Towers, Hamdan Street, PO Box 2734, Abu Dhabi).

Barclays Bank PLC in the Qatar Financial Centre (Registered No. 00018) is authorised by the Qatar Financial Centre Regulatory Authority (QFCRA). Barclays Bank PLC-QFC Branch may only undertake the regulated activities that fall within the scope of its existing QFCRA licence. Principal place of business in Qatar: Qatar Financial Centre, Office 1002, 10th Floor, QFC Tower, Diplomatic Area, West Bay, PO Box 15891, Doha, Qatar.

This material is distributed in Dubai, the UAE and Qatar by Barclays Bank PLC. Related financial products or services are only available to Professional Clients as defined by the DFSA, and Business Customers as defined by the QFCRA.

This material is distributed in Saudi Arabia by Barclays Saudi Arabia ('BSA'). It is not the intention of the Publication to be used or deemed as recommendation, option or advice for any action (s) that may take place in future. Barclays Saudi Arabia is a Closed Joint Stock Company, (CMA License No. 09141-37). Registered office Al Faisaliah Tower | Level 18 | Riyadh 11311 | Kingdom of Saudi Arabia. Authorised and regulated by the Capital Market Authority, Commercial Registration Number: 1010283024.

This material is distributed in Russia by Barclays Capital, affiliated company of Barclays Bank PLC, registered and regulated in Russia by the FSFM. Broker License #177-11850-100000; Dealer License #177-11855-010000. Registered address in Russia: 125047 Moscow, 1st Tverskaya-Yamskaya str. 21.

This material is distributed in India by Barclays Bank PLC, India Branch.

This material is distributed in Singapore by the Singapore branch of Barclays Bank PLC, a bank licensed in Singapore by the Monetary Authority of Singapore. For matters in connection with this report, recipients in Singapore may contact the Singapore branch of Barclays Bank PLC, whose registered address is One Raffles Quay Level 28, South Tower, Singapore 048583.

Barclays Bank PLC, Australia Branch (ARBN 062 449 585, AFSL 246617) is distributing this material in Australia. It is directed at 'wholesale clients' as defined by

Australian Corporations Act 2001.

IRS Circular 230 Prepared Materials Disclaimer: Barclays Capital and its affiliates do not provide tax advice and nothing contained herein should be construed to be tax advice. Please be advised that any discussion of U.S. tax matters contained herein (including any attachments) (i) is not intended or written to be used, and cannot be used, by you for the purpose of avoiding U.S. tax-related penalties; and (ii) was written to support the promotion or marketing of the transactions or other matters addressed herein. Accordingly, you should seek advice based on your particular circumstances from an independent tax advisor.

© Copyright Barclays Bank PLC (2011). All rights reserved. No part of this publication may be reproduced in any manner without the prior written permission of Barclays Capital or any of its affiliates. Barclays Bank PLC is registered in England No. 1026167. Registered office 1 Churchill Place, London, E14 5HP. Additional information regarding this publication will be furnished upon request.

U.S. Managed Care: A Medicare Advantage Risk Audit Tale

Ticker	Rating	CUR	12/10/2010 Closing Price	Target Price	TTM Rel. Perf.	Cash EPS			P/E			Yield
						2009A	2010E	2011E	2009A	2010E	2011E	
UNH	O	USD	36.67	46.00	8.5%	3.24	4.11	3.90	11.3	8.9	9.4	1.4%
HUM	O	USD	56.51	68.00	21.9%	6.15	6.97	6.81	9.2	8.1	8.3	NA
CVH	O	USD	26.62	32.00	1.5%	2.20	3.71	2.87	12.1	7.2	9.3	NA
AET	O	USD	30.61	39.00	-17.0%	2.75	3.60	3.51	11.1	8.5	8.7	0.1%
CI	O	USD	37.65	42.00	-6.7%	3.98	4.43	5.06	9.5	8.5	7.4	0.1%
HNT	M	USD	26.95	28.00	0.9%	2.25	2.64	2.89	12.0	10.2	9.3	NA
WLP	M	USD	57.68	63.00	-12.1%	6.09	6.56	6.36	9.5	8.8	9.1	NA
SPX			1240.40			61.70	64.62	65.65	20.1	14.7	13.0	1.9%

O – Outperform, M – Market-Perform, U – Underperform, N – Not Rated

Highlights

It is our understanding from information obtained through the MA marketplace and consultants that a risk audit by Center of Medicare and Medicaid Services (CMS) on UNH Medicare Advantage (MA) plans remains in dispute. The company UNH itself has not substantiated any of this in our discussions with them, though maintain that they are working with CMS on appropriate and reliable sampling methodologies for such determinations. Further, our own feedback as well as that from HUM, indicate that no specific risk audit judgments are currently in progress with HUM MA plans, though the industry leaders UNH and HUM continue to work with CMS on reliable sampling methodologies to determine required compliance.

- **Risk Audits or Risk Auditing Data Validation (RADV)** as they are popularly known in the Managed Care and investment community refer to the assessment by CMS on compliance by health plans w.r.t. reported health risk severity or diagnosis codes for MA members during encounters with doctors for reimbursement. The bearish investment thesis on MA has pointed to the ramp up of audit activity by CMS on health plans in 2010.
- **Based on our understanding, the issue for UNH MA plans in this case is one of incomplete administrative paperwork by the doctors or MA plan providers that service the UNH MA capitated contract arrangements, rather than the health plan itself.** Given that UNH has as much as 40% capitated arrangements with MA plan providers, it is our understanding that for such capitated contracts, the dispute centers on the level of completeness of administrative paperwork or patient health records and claims by the UNH Medicare Advantage doctors or plan providers. Since UNH has a significant percentage of risk capitated arrangements with plan providers, we understand the liability on completeness of paperwork is being attributed to UNH rather than the doctors themselves. While the onus of filling out the paperwork is on the providers or doctors, there appear to be little to no consequences for them on incompliance, with the capitated health plan such as UNH solely taking on the financial and administrative burden of audits.
- **We estimate the worst case impact on UNH 2011 EPS is a one-time charge of as much as 43c/share to 2011 earnings, the best case could be as low as 5 c to 2011 EPS on a one-time basis. It is also possible that the dispute may entirely go in UNH's favor with no impact to 2011 earnings post**

completion of administrative negotiations with CMS, as well as possible pursuit of legal or other remedies for abatement. We base our estimates on reported negotiations to date between UNH and CMS which we understand could have resulted in a judgment of an unknown *7 figure amount against the UNH Health Plans* (with more of the exposure in CA), though are also reported to have now been abated by as *much as half* over the course of discussions with CMS.

- **The worst case and highly unlikely impact of ~\$475 MM would still ensure no disturbance in planned share repurchase activity of \$2-\$2.4B, dividends of \$500 MM in 2011 given the company estimates >\$2.5B in cash available post capital expenditures exceeding \$1B in 2011**
- **We view the information that we have obtained to date as an opportunity to buy UNH on weakness.**
 - First, the assessment could be further or even completely abated. The judgment is being disputed by the company through negotiations with CMS, lobbying with a more insurer friendly House as also legal options that could be considered for complete abatement. Given that Congress is far more balanced in favor of the GOP post the mid-term, we view the likelihood of future occurrences as much lower with CMS being reported to be far more receptive to overtures from the GOP majority House representatives than prior to the election. The more MA plan friendly environment post the mid term election is evident in the significantly favorable determination to extend bonus rate payments to all MA plans that meet STAR quality rankings of 3 or higher, which qualifies over 80% of both UNH and HUM for a more favorable rate outlook 2012 and beyond.
 - Second, headline risk is minimal given the offense in dispute is largely administrative or paperwork related, and is on the part of the doctors from our understanding rather than UNH MA plans.
 - Third, even the worst case scenario poses a one-time hit to earnings of <45c/share in 2011, with cash flow remaining strong and no changes to planned share repurchase or dividend activity in 2011.
- **The overhang on HUM from Risk Audits by CMS should be mitigated given that no current specific risk audit judgments are reported to be in progress with HUM. Nonetheless, if there is any read-across for HUM, we view this as a buying opportunity for HUM as well. The other companies are much less impacted by this controversy given their lower exposure to Medicare Advantage.**

Please see our bull investment thesis on MA in the attached reports

US Managed Care: Medicare Advantage - Still a Profitable Franchise in 2010; But What About Long-Term Sustainability?

US Managed Care: Future of Retiree Health Benefits - Will the Managed Care Phoenix Rise from the Ashes?

Investment Conclusion

While risk audit judgments are obviously not good for UNH, it is better news than has been part of recent Street fears and expectations. We expect the company is likely to continue to pursue Administrative, Legal and Lobbying routes to further mitigate the impact, and post the mid-term election which has resulted in a GOP House majority and a more balanced Senate, view that the likelihood of success is much improved.

Even in the worst case of our estimated 2011 EPS impact of 5-45c/share on a one-time basis, we expect the company could continue to comfortably execute on planned share repurchase and dividend activity.

We believe headline risk associated with should be minimal given it appears to be related to administrative paperwork by doctors or MA plan providers rather than the UNH MA health plans. We continue to view

MA as sustainably profitable and growth franchises for the two industry leaders UNH and HUM and view any weakness in the names as a buying opportunity.

We rate UNH, HUM, CVH, AET and CI Outperform at Target Prices of \$46, \$68, \$32, \$39 and \$42 respectively. We rate WLP and HNT Market Perform at Target Prices of \$63 and \$28 respectively.

Details

U.S. Managed Care

Disclosure Appendix

Valuation Methodology

Our primary approach involved absolute and relative Price/Forward Earnings multiples as a function of the underlying fundamental drivers of the sector - underwriting margins based on spreads between premium yield and medical cost trends, the macroeconomic outlook and health care reform. The multiples and fundamentals driver analysis based on our forecasted underwriting expectations and a very modest effect of the macroeconomic outlook on health insurance suggests expansion of the managed care sector average relative NTM P/E multiple to 0.79x. We also conduct DCF valuations at 1.5% terminal growth rate and WACC of 9%.

Based on a combination of P/E multiples and DCF valuation, we rate:

- UNH Out-perform at a price target of \$46.
- HUM Out-perform at a price target of \$68.
- CVH Out-perform at a price target of \$32
- AET Out-perform at a price target of \$39
- CI Out-perform at a price target of \$42
- HNT Market-perform at a price target of \$28
- WLP Market Perform at a price target of \$63

Risks

Non-profit Blues or other insurers pricing irrationally in the Commercial market, rapidly accelerating medical cost trends

Medical cost trends coming in higher than anticipated from a potential double-dip recession with provider re-upping intensity of service delivery, COBRA accelerated uptake, and members utilizing more care in advance of lay-offs.

Employers exiting very rapidly from the sponsorship of health benefits to combat medical cost inflation catalyzed by a double dip recession.

Pricing and reserving risk from the adoption of high deductible plan designs without adequate databases of claims experience,

Risk from a further decline in investment yields and investment impairments.

Reform Risks

Health and Human Services coming in unfavorably with respect to the exclusion of Federal Taxes in the denominator lowering 2011 earnings and resulting in multiple compression.

Pricing to MLR floors in 2011 resulting in some under-pricing and underwriting margin compression.

State based actuarial rate reviews limiting sound pricing and underwriting and causing substantial underwriting margin compressions

Headline risk and reform dis-intermediating private health insurers from the health benefits marketplace, particularly in relation to public-private partnerships currently in place for the Medicare Advantage program and also from Employer sponsored health benefits.

Longer-term State based Health Insurance Exchanges with adverse selection reducing sustainable earnings power.

Employers 'dumping' employees into Health Insurance Exchanges with significant margin compression and also potential downside to membership and top line.

Company Specific Risks Include:

UNH-Outperform – Acquisition of assets in the Health Services arena that do not yield adequate return on capital.

HUM-Outperform – The largest downside risk to our rating and price target is poor actuarial underwriting of the WMT cobranded Medicare Part D product. Second, acquisitions that have less than adequate return on capital as compared to stock buybacks.

CVH-Outperform – Key upside risks includes acquisition by a larger player in the Managed Care industry at a significant premium.

AET-Outperform – Transition within the management team, which would have implications on strategic planning and near and medium term operational execution.

CI-Outperform – Declining investment yields and Other Than Temporary Impairments (OTTI) to investments including Commercial Real Estate Loans and further investment losses are also a risk to the stock's performance. Finally, performance of the equity markets which cannot be adequately hedged by the company could result in further expenses and reserve requirements on their Variable Annuity Death Benefits (VADBe) book of business with downward pressure on earnings and liquidity.

HNT –Market-Perform – Key company specific downside risks include significant deterioration in the penetration of private Managed Care CA Commercial market. Upside risks include the acquisition of HNT at a significant premium above current valuations.

WLP-Market-Perform – The largest downside risk to our rating and price target is operational issues around pricing and reserving re-emerging in its Commercial and Medicare Advantage books of business. Upside risks include accelerated conversion of non-profit Blues to for-profit status with acquisition by WLP in the medium term.

SRO REQUIRED DISCLOSURES

- References to "Bernstein" relate to Sanford C. Bernstein & Co., LLC, Sanford C. Bernstein Limited, and Sanford C. Bernstein, a unit of AllianceBernstein Hong Kong Limited, collectively.
- Bernstein analysts are compensated based on aggregate contributions to the research franchise as measured by account penetration, productivity and proactivity of investment ideas. No analysts are compensated based on performance in, or contributions to, generating investment banking revenues.
- Bernstein rates stocks based on forecasts of relative performance for the next 6-12 months versus the S&P 500 for stocks listed on the U.S. and Canadian exchanges, versus the MSCI Pan Europe Index for stocks listed on the European exchanges (except for Russian companies), versus the MSCI Emerging Markets Index for Russian companies and stocks listed on emerging markets exchanges outside of the Asia Pacific region, and versus the MSCI Asia Pacific ex-Japan Index for stocks listed on the Asian (ex-Japan) exchanges - unless otherwise specified. We have three categories of ratings:
 Outperform: Stock will outpace the market index by more than 15 pp in the year ahead.
 Market-Perform: Stock will perform in line with the market index to within +/-15 pp in the year ahead.
 Underperform: Stock will trail the performance of the market index by more than 15 pp in the year ahead.
 Not Rated: The stock Rating, Target Price and estimates (if any) have been suspended temporarily.
- As of 12/01/2010, Bernstein's ratings were distributed as follows: Outperform - 45.1% (1.6% banking clients) ; Market-Perform - 46.3% (1.0% banking clients); Underperform - 8.6% (0.0% banking clients); Not Rated - 0.0% (0.0% banking clients). The numbers in parentheses represent the percentage of companies in each category to whom Bernstein provided investment banking services within the last twelve (12) months.
- Ms. Gupte and a member of her household maintain long positions in Aetna Inc. (AET) and Cigna Corp. (CI) equities. As a former employee of Aetna, Ms. Gupte received, as part of Aetna's deferred compensation program, shares of restricted AET stock that continue to vest over time in accordance with the terms of the grant. A member of Ms. Gupte's household also is a former employee of Aetna and received awards of options to purchase AET equities at specified prices and shares of restricted AET stock that continue to vest over time in accordance with the terms of the grants.
- Accounts over which Bernstein and/or their affiliates exercise investment discretion own more than 1% of the outstanding common stock of the following companies UNH / UnitedHealth Group Inc, HUM / Humana Inc, CVH / Coventry Health Care Inc, HNT / Health Net Inc.
- The following companies are or during the past twelve (12) months were clients of Bernstein, which provided non-investment banking-securities related services and received compensation for such services UNH / UnitedHealth Group Inc, AET / Aetna Inc, CI / Cigna Corp, WLP / WellPoint Inc.
- An affiliate of Bernstein received compensation for non-investment banking-securities related services from the following companies AET / Aetna Inc.
- In the next three (3) months, Bernstein or an affiliate expects to receive or intends to seek compensation for investment banking services from UNH / UnitedHealth Group Inc, HUM / Humana Inc, CVH / Coventry Health Care Inc, AET / Aetna Inc, CI / Cigna Corp, HNT / Health Net Inc, WLP / WellPoint Inc.
- This research publication covers six or more companies. For price chart disclosures, please visit www.bernsteinresearch.com, you can also write to either: Sanford C. Bernstein & Co. LLC, Director of Compliance, 1345 Avenue of the Americas, New York, N.Y. 10105 or Sanford C. Bernstein Limited, Director of Compliance, Devonshire House, One Mayfair Place, London W1J 8SB, United Kingdom; or Sanford C. Bernstein, a unit of AllianceBernstein Hong Kong Limited, Director of Compliance, Suite 3401, 34th Floor, One IFC, One Harbour View Street, Central, Hong Kong.

12-Month Rating History as of 12/12/2010

Ticker Rating Changes

AET	O (IC) 10/03/08
CI	O (IC) 10/03/08
CVH	O (RC) 11/08/10 M (IC) 10/03/08
HNT	M (IC) 03/12/10
HUM	O (IC) 10/03/08
UNH	O (RC) 03/17/09
WLP	M (IC) 10/03/08

Rating Guide: O - Outperform, M - Market-Perform, U - Underperform, N - Not Rated

Rating Actions: IC - Initiated Coverage, DC - Dropped Coverage, RC - Rating Change

OTHER DISCLOSURES

A price movement of a security which may be temporary will not necessarily trigger a recommendation change. Bernstein will advise as and when coverage of securities commences and ceases. Bernstein has no policy or standard as to the frequency of any updates or changes to its

coverage policies. Although the definition and application of these methods are based on generally accepted industry practices and models, please note that there is a range of reasonable variations within these models. The application of models typically depends on forecasts of a range of economic variables, which may include, but not limited to, interest rates, exchange rates, earnings, cash flows and risk factors that are subject to uncertainty and also may change over time. Any valuation is dependent upon the subjective opinion of the analysts carrying out this valuation.

This document may not be passed on to any person in the United Kingdom (i) who is a retail client (ii) unless that person or entity qualifies as an authorised person or exempt person within the meaning of section 19 of the UK Financial Services and Markets Act 2000 (the "Act"), or qualifies as a person to whom the financial promotion restriction imposed by the Act does not apply by virtue of the Financial Services and Markets Act 2000 (Financial Promotion) Order 2005, or is a person classified as an "professional client" for the purposes of the Conduct of Business Rules of the Financial Services Authority.

To our readers in the United States: Sanford C. Bernstein & Co., LLC is distributing this publication in the United States and accepts responsibility for its contents. Any U.S. person receiving this publication and wishing to effect securities transactions in any security discussed herein should do so only through Sanford C. Bernstein & Co., LLC.

To our readers in the United Kingdom: This publication has been issued or approved for issue in the United Kingdom by Sanford C. Bernstein Limited, authorised and regulated by the Financial Services Authority and located at Devonshire House, 1 Mayfair Place, London W1J 8SB, +44 (0)20-7170-5000.

To our readers in member states of the EEA: This publication is being distributed in the EEA by Sanford C. Bernstein Limited, which is authorised and regulated in the United Kingdom by the Financial Services Authority and holds a passport under the Investment Services Directive.

To our readers in Hong Kong: This publication is being issued in Hong Kong by Sanford C. Bernstein, a unit of AllianceBernstein Hong Kong Limited. AllianceBernstein Hong Kong Limited is regulated by the Hong Kong Securities and Futures Commission.

To our readers in Australia: Sanford C. Bernstein & Co., LLC and Sanford C. Bernstein Limited are exempt from the requirement to hold an Australian financial services licence under the Corporations Act 2001 in respect of the provision of the following financial services to wholesale clients:

- providing financial product advice;
- dealing in a financial product;
- making a market for a financial product; and
- providing a custodial or depository service.

Sanford C. Bernstein & Co., LLC, Sanford C. Bernstein Limited and AllianceBernstein Hong Kong Limited are regulated by, respectively, the Securities and Exchange Commission under U.S. laws, by the Financial Services Authority under U.K. laws, and by the Hong Kong Securities and Futures Commission under Hong Kong laws, all of which differ from Australian laws.

One or more of the officers, directors, or employees of Sanford C. Bernstein & Co., LLC, Sanford C. Bernstein Limited, Sanford C. Bernstein, a unit of AllianceBernstein Hong Kong Limited, and/or their affiliates may at any time hold, increase or decrease positions in securities of any company mentioned herein.

Bernstein or its affiliates may provide investment management or other services to the pension or profit sharing plans, or employees of any company mentioned herein, and may give advice to others as to investments in such companies. These entities may effect transactions that are similar to or different from those recommended herein.

Bernstein Research Publications are disseminated to our customers through posting on the firm's password protected website, www.bernsteinresearch.com. Additionally, Bernstein Research Publications are available through email, postal mail and commercial research portals. If you wish to alter your current distribution method, please contact your salesperson for details.

Bernstein and/or its affiliates do and seek to do business with companies covered in its research publications. As a result, investors should be aware that Bernstein and/or its affiliates may have a conflict of interest that could affect the objectivity of this publication. Investors should consider this publication as only a single factor in making their investment decisions.

This publication has been published and distributed in accordance with Bernstein's policy for management of conflicts of interest in investment research, a copy of which is available from Sanford C. Bernstein & Co., LLC, Director of Compliance, 1345 Avenue of the Americas, New York, N.Y. 10105, Sanford C. Bernstein Limited, Director of Compliance, Devonshire House, One Mayfair Place, London W1J 8SB, United Kingdom, or Sanford C. Bernstein, a unit of AllianceBernstein Hong Kong Limited, Director of Compliance, Suite 3401, 34th Floor, One IFC, One Harbour View Street, Central, Hong Kong.

CERTIFICATIONS

- I/(we), Ana Gupte, Ph.D., Senior Analyst(s)/Analyst(s), certify that all of the views expressed in this publication accurately reflect my/(our) personal views about any and all of the subject securities or issuers and that no part of my/(our) compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views in this publication.

Approved By: NK

Copyright 2010, Sanford C. Bernstein & Co., LLC, Sanford C. Bernstein Limited, and AllianceBernstein Hong Kong Limited, subsidiaries of AllianceBernstein L.P. ~ 1345 Avenue of the Americas ~ NY, NY 10105 ~ 212/756-4400. All rights reserved.

This publication is not directed to, or intended for distribution to or use by, any person or entity who is a citizen or resident of, or located in any locality, state, country or other jurisdiction where such distribution, publication, availability or use would be contrary to law or regulation or which would subject Bernstein or any of their subsidiaries or affiliates to any registration or licensing requirement within such jurisdiction. This publication is based upon public sources we believe to be reliable, but no representation is made by us that the publication is accurate or complete. We do not undertake to advise you of any change in the reported information or in the opinions herein. This publication was prepared and issued by Bernstein for distribution to eligible counterparties or professional clients. This publication is not an offer to buy or sell any security, and it does not constitute investment, legal or tax advice. The investments referred to herein may not be suitable for you. Investors must make their own investment decisions in consultation with their professional advisors in light of their specific circumstances. The value of investments may fluctuate, and investments that are denominated in foreign currencies may fluctuate in value as a result of exposure to exchange rate movements. Information about past performance of an investment is not necessarily a guide to, indicator of, or assurance of, future performance.

CMS0001473

Equities

8 February 2011 | 15 pages

I Used To Think I Was Indecisive, But Now I'm Not So Sure

2012 Medicare Advantage Rate Preview

■ Industry Overview

Carl McDonald, CFA

+1-617-247-6312

carl.mcdonald@citi.com
James Naklicki, CFA
james.naklicki@citi.com

- **We expect initial 2012 Medicare rates on February 18th to be roughly flat, better than the consensus view that rates will fall 2%** —Reimbursement will be negatively impacted by the Medicare cuts in the reform bill, but those cuts are just one of many variables included in the rate. For instance, we think 2012 rates will benefit from an adjustment to prior estimates, as CMS assumed physician rates would fall 20%+ in both 2010 and 2011, which never happened. HealthSpring, Humana, and Universal American have the most Medicare exposure in the group.
- **CMS has an enormous amount of discretion over what 2012 rates look like** — Besides estimating what utilization will be in 2012, CMS also has to determine whether to include a risk coding intensity adjustment. In 2010, a similar adjustment negatively impacted Medicare rates by 3.4%, while CMS decided to make no adjustment last year. Our estimate of flat rates in 2012 assumes that the coding intensity adjustment negatively impacts reimbursement by an incremental 2.5%.
- **After the initial announcement next week, final rates will be announced on Monday, April 4th** — The actual rates received by plans in 2012 will be higher than what is announced by CMS, since CMS doesn't include any improvement of plan risk scores, and the rate may not include the impact of the new star quality bonus payments that begin in 2012. If CMS does announce roughly flat rates, we think most plans in the industry will see actual rates next year rise about 2%.
- **Whatever the actual rate outcome, it appears that Medicare enrollment can grow again in 2012** — While it's likely plans will have to cut some benefits in 2012, the changes are likely to be modest, and Medicare Advantage plans should still offer a far better product than what is available to seniors through the government, suggesting Medicare earnings can be stable to up next year.

See Appendix A-1 for Analyst Certification, Important Disclosures and non-US research analyst disclosures.

Citi Investment Research & Analysis is a division of Citigroup Global Markets Inc. (the "Firm"), which does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the Firm may have a conflict of interest that could affect the objectivity of this report. Investors should consider this report as only a single factor in making their investment decision.

Investment Thesis

We'll admit it. This is one of the least fun notes we write every year. Most of the time, when we get to the end of a research report, we feel like we've done enough work to have a pretty good understanding of the topic at hand and offer a definitive viewpoint on how it will impact the managed care plans. With Medicare Advantage reimbursement, on the other hand, the more work we do, the more apparent it becomes how little we really understand this topic. It's not for lack of trying, but there are just a lot of complicated moving pieces that don't always move in a consistent way from year to year.

Part of the issue is that while many pieces of the Medicare Advantage rate calculation are formulaic, CMS officials have a substantial amount of power over the interpretation and estimates that go into the rate calculation. And to be kind, the signals that we've gotten from CMS over the past few years have been mixed. For most of the middle part of the 2000's, CMS seemed to do whatever it could to aid the Medicare Advantage plans. Anytime there was an issue, there was a reasonable likelihood that CMS would side with the industry. Then the 2008 election happened, and all of a sudden, CMS was out with an announcement that private fee for service plans were being eliminated, and that every plan had to have contracted networks.

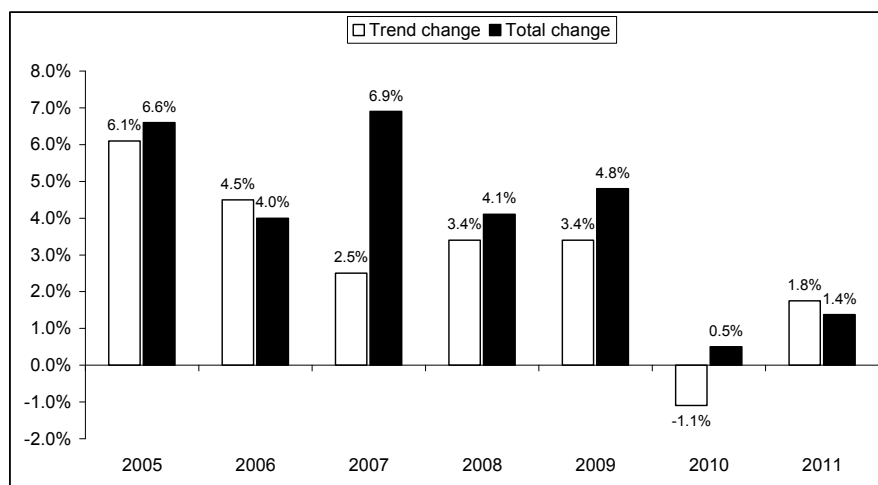
That was followed up by a couple of less than generous estimates included in the 2010 and 2011 Medicare rates, including a 4-5% rate cut in 2010, the first time in memory that Medicare Advantage rates dropped other than through an act of Congress. It seemed clear then that CMS was no longer going to be an ally, and CMS has seemingly been a lot quicker to suspend plans from marketing and enrolling new members lately. But CMS has done a few surprising things over the last year. First, it allowed plans to offer network fee for service plans in 2011, and seamlessly transition many PFFS members into the new product, which greatly increased the membership retention rates many plans are reporting this year. Second, CMS introduced a demonstration project around the star quality bonus payments that meant that a lot more plans were eligible for payments starting in 2012. Both the easing of the PFFS transition and the star payment demo were unexpected gifts for the industry. And just this past week, CMS issued a letter indicating that it was willing to work with the industry to lessen the impact of ongoing risk adjustment audits.

If it hasn't been made clear enough yet, the point here is that whether Medicare rates in 2012 are viewed as good or bad by the market will be dependent as much on the market's expectations (we think the consensus is for rates to fall around 2%) as it will be on how nice or mean CMS is to the industry, particularly in what CMS chooses to do around risk coding intensity. But more on that in a bit.

In terms of logistics, the initial Medicare rates will be announced on Friday, February 18th after the close. Adding to everyone's general enjoyment heading into the rate announcement is the seeming frequency with which rates get announced late on a Friday afternoon. It's always been a good week on the home front, since Valentine's Day is usually swallowed up by an earnings announcement after the close, and delivering the news that Friday is a no-go, too, because of a really important Medicare rate announcement always goes over well. In any event, this one really isn't the fault of CMS. By law, the initial rates have to come out 45 days in advance of the first Monday in April (Monday, April 4), and this year, it happens to be a Friday. Again.

The initial rate announcement itself (officially titled the *Advance Notice of Methodological Changes for Calendar Year (CY) 2011 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter*¹) last year was 98 pages long, but there are really only a few things that are important. The first is what is officially called the preliminary estimate of the national per capita growth percentage for calendar year 2011. Essentially, this is the estimate of how much CMS expects trends to increase / decrease in the upcoming year, with an adjustment for any updates to the estimates CMS used in prior years. In 2011, for example, the per capita growth percentage was 1.38%.² CMS assumed the 2011 trend change for the aged + disabled population would be 1.75%, while the revisions to the prior year estimates amounted to a negative of 0.35%, resulting in the net increase of 1.38%.³ The initial trends announced for 2010 and 2011 are considerably lower than the increases announced in prior years, mainly because of the assumption of a significant reduction in physician reimbursement, as illustrated in Figure 1.

Figure 1. Historical Initial Medicare Trend Change and Total Change



Source: Centers for Medicare & Medicaid Services (CMS) and Citi Investment Research and Analysis

For 2012, CMS will again assume a big reduction in doctor reimbursement, since that is what is written into current law, and Congress hasn't made any moves to develop a long-term fix. However, we think it's reasonable to assume that CMS will include an adjustment in 2012 for its assumption in both 2010 and 2011 that doctor rates would be cut, which didn't actually happen because of a series of short-term fixes passed by Congress. The negative impact on rates from the assumption that physician reimbursement would be cut has generally been about 4%, so we expect the revision to be a similar amount, assuming the industry gets back one year of the doc fix.

¹ For those that are interested, the document can be found at:

<http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2011.pdf>

² For those following along at home, this number can be found on page 5 of the pdf referenced in the prior footnote.

³ Because the total percentage change is multiplicative, not additive, it may not always match due to rounding.

Putting all the pieces together, we think the trend change assumed by CMS will be in the range of 0-1%, factoring in the big cut to doctor reimbursement, and the likelihood that CMS will assume that the current depressed level of utilization continues in 2011. We think the net impact of the revisions to prior year estimates will be around 3% (a little less than the 4% impact noted above, since the cut to doctor reimbursement in 2012 is a bit larger than the cuts assumed in prior years, while we're also leaving some room for offsetting revisions), resulting in an overall per capita growth rate of 3-4%. All of our specific assumptions can be found in Figure 5 on page 7.

It's also important to note whether CMS chooses to "rebase" fee for service county costs. Rebasing resets the fee for service costs based on actual experience, and it can only help managed care reimbursement. In 2011, CMS was planning on rebasing the FFS county rates, but because of the reform legislation holding managed care reimbursement flat, that didn't happen. As a result, we expect a rebasing to occur for 2012, which will help Medicare Advantage rates.

A second area of importance is the changes CMS chooses to make to what it calls the payment methodology. There are usually several adjustments. We walk through each of them below.

- In 2011, CMS proposed a recalibration of its risk adjustment model.⁴ Recalibrating the risk adjustment model is never a good thing for the industry. For example, if CMS adds new diagnosis codes to the risk adjustment model (the 2011 model had 87 HCC's (hierarchical condition categories), compared with 70 in 2010), plans probably won't have collected the necessary data, so it takes time to begin submitting the updates codes. Since the recalibration wasn't actually implemented in 2011 because of the reform bill, which mandated that Medicare Advantage rates be held flat, it seems likely that the recalibration will go into effect in 2012. So this will have a negative impact on 2012 reimbursement.
- Fee for service normalization⁵. This change adjusts beneficiary risk scores so that the average risk score remains at 1.0 in future years. In 2011, the preliminary 2011 normalization factor for the aged-disabled model was 1.031. To calculate the normalization factor, CMS used the risk adjustment model that was to be implemented in 2011 to calculate five years (2005-2009) of risk scores for the fee for service population. In 2012, our understanding is that CMS will use only two or three years to calculate the risk scores of the fee for service population, and this will be a good thing for 2012 reimbursement.
- The big one: adjustments for Medicare Advantage coding pattern differences.⁶ Historically, Medicare Advantage risk scores have increased more quickly than the fee for service program. Starting in 2010, CMS implemented a separate adjustment for Medicare Advantage plans to account for the coding differences between Medicare Advantage and fee for service. The adjustment in 2010 of 3.41% was based on the CMS estimate of how much lower Medicare plan's 2010 risk scores would have been if risk scores had grown at the same pace as fee for service beneficiaries between 2007-2010. In 2011, CMS chose to maintain the adjustment for coding

⁴ Page 7 of the CMS pdf.

⁵ Page 11 of the CMS pdf.

⁶ Page 14 of the CMS pdf.

pattern differences at 3.41%, meaning it had no impact on plan reimbursement. At the same time, CMS also asked for comments on whether it should revise the methodology. The key decision by CMS will be what time frame to use in calculating the adjustment. CMS could maintain the same number of years, or it could go up to five years depending on what kind of reduction to Medicare Advantage reimbursement they'd like to see. If CMS chooses to look at five years, we've seen some estimates that suggest the negative impact to rates could exceed 9%. So this adjustment, if implemented, would clearly have a negative impact on Medicare rates.

As part of the reform legislation, CMS has to calculate the value of the Medicare Advantage coding intensity adjustment each year, and the value of the adjustment has to be at least 5.7% by 2019.

- Budget neutrality.⁷ This is no longer a consideration in the payment calculation, as budget neutrality was completely phased out last year.
- Graduate medical education.⁸ As part of legislation from 2008, CMS is required to phase out indirect medical education (IME) amounts from the rates plans receive. The impact of this adjustment is heavily dependent on the number of teaching hospitals located in a particular county, but by statute, the maximum reduction that CMS would have applied to any one county in 2011 is 1.2% of the fee for service rate.

Of course, the third big area to focus on will be the impact on rates from the health reform legislation. It is unclear whether CMS will treat the reform related cuts as a separate adjustment, or blend them into the national per capita growth percentage discussed above. The rate cuts themselves are spelled out in the health care reform legislation. Each county in the country will be sorted based on the Medicare fee for service costs incurred, and the counties will be divided into quartiles. The highest cost counties are to be paid at 95% of the fee for service cost, while counties in the second quartile will receive 100% of fee for service cost. Counties in the third quartile will be paid 107.5% of fee for service cost, and counties in the fourth quartile (the lowest cost) will receive 115% of fee for service cost. How the cuts are phased in is dependent on how much of a cut will be incurred, with those counties receiving the largest reductions having the longest phase-ins. Counties with smaller cuts will see rate reductions phased in over two years, while those with larger cuts will have a six year phase-in.

Analysis of this breakdown suggests that around 65% of Medicare Advantage members are enrolled in counties that will receive Medicare payments at or below 100% of fee for service costs, while just 15% of existing Medicare Advantage members will receive reimbursement equivalent to 115% of fee for service costs.

⁷ Page 15 of the CMS pdf.

⁸ Page 17 of the CMS pdf, under Section I.

Figure 2. Breakdown of Medicare Advantage Enrollment By

FFS Benchmark	Medicare Advantage Members	% of MA Members	% Of Members In Rural Counties
115%	1,535,171	15.3%	40%
107.5%	1,782,865	17.8%	30%
100%	2,462,703	24.6%	18%
95%	4,233,541	42.3%	7%
National	10,014,280	100.0%	19%

Source: Medicare Advantage Payment Provisions, Brian Biles and Grace Arnold, George Washington University.

Universal American has done a good job of translating all this information. Based on their estimated membership at the end of 2010, the company anticipates that approximately 47% of its membership is in counties that will receive reimbursement equivalent to 100% or less of the fee for service benchmarks. However, a similar amount (50%) of their enrollment is located in a county that will see those rate cuts phased in over a six-year period, reducing the impact from the rate cuts in any single year.

Figure 3. Universal American's Medicare Membership by FFS Cost, And Phase-In Period

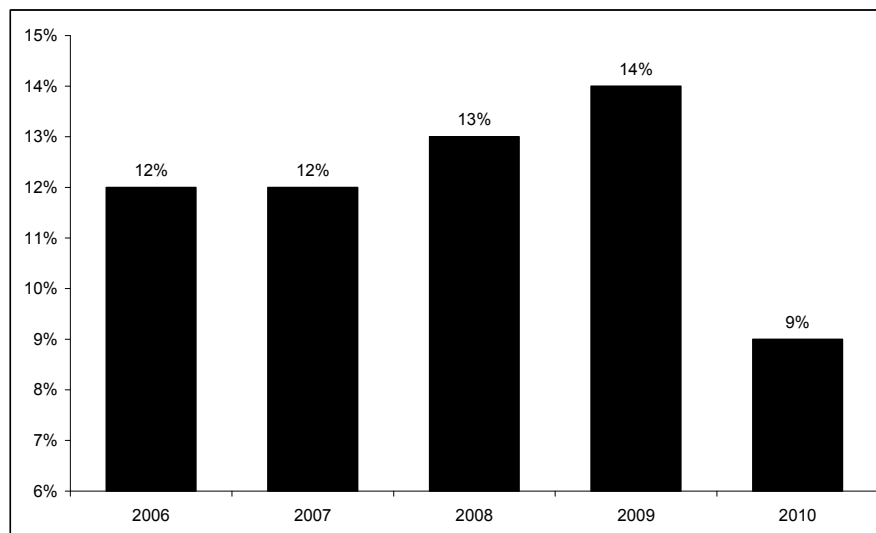
Transition Period	Target Benchmark / FFS Cost Ratio				Total
	95.0%	100.0%	107.5%	115.0%	
2 year	1%	2%	5%	10%	19%
4 year	3%	5%	6%	15%	30%
6 year	31%	3%	4%	12%	50%
Total	36%	11%	15%	38%	100%
HMO	94%	4%	2%	0%	100%
2010 PPOs	14%	21%	16%	50%	101%
PFFS - Non rural	9%	10%	19%	62%	100%
PFFS - Rural	17%	18%	27%	38%	100%
Total MA	36%	11%	15%	38%	100%

Note: Based on estimate of 2010 ending Medicare Advantage membership

Source: Company notes and Citi Investment Research and Analysis

It's been widely quoted that Medicare Advantage plans are paid an average of 114% more than fee for service costs nationally. Unfortunately, this is an old statistic. According to MedPac, which updates this calculation every year, the differential between Medicare Advantage rates and fee for service costs fell to 9% in 2010, mainly because of the assumption in plan payments that Medicare physician reimbursement would decline by 21%, which never happened. Because CMS again assumed a cut to physician rates that was included in 2011 reimbursement, we think it is likely that the differential between Medicare Advantage rates and fee for service costs could now be in the mid-single digits.

Figure 4. Average Medicare Advantage Payment Rates Relative To Medicare Fee For Service Benchmarks



Source: MedPac and Citi Investment Research and Analysis

This is important, because if the reform driven cuts were implemented to bring Medicare Advantage rates to parity with fee for service costs, and the average difference now between Medicare Advantage rates and fee for service costs is only 5-6%, it means that the cuts are going to be a lot smaller than what was expected when the reform bill was passed. For a large company like Humana, we anticipate that the rate cuts will be phased in over an average of something like three to four years. When the reform bill passed, and everyone viewed Medicare plans as being overpaid by 14%, it translated into a rate reduction of approximately 4% per year. Now that MedPac estimates the rate differential is only 9% for 2010, it means the rate reduction should be closer to 2.6% a year (on average), or using our estimate of a 5-6% differential, the rate cut may only be around 1.6% per year.

Putting all the pieces together, with the big caveat of what CMS chooses to do with the risk adjustment methodology, we're looking for overall Medicare rates to fall 0.3% in 2012 in the initial CMS announcement, better than the market's assumption that rates will be down around 2%. That said, it's almost absurd to try and put a specific estimate given all the moving pieces we've cited above.

Of course, the announcement on February 18th isn't the end of the story. February 18th is the initial announcement, while the final rates will come out on Monday, April 4th. What is never included in either the initial or final announcement is the amount by which plans are able to improve risk scores over the course of the year. We're assuming the amount of risk score improvement will be 1.5% in 2012, but in reality, the figure could be much higher. Like everyone in the industry, HealthSpring faced a 4-5% rate cut in 2010, and year to date, we think their PMPM Medicare reimbursement is actually up in 2010. At Humana, we're modeling a Medicare Advantage PMPM of \$914 in 2010, basically flat with the prior year. Clearly, mix issues and other factors can also impact reimbursement, but improving risk scores can also play a big role that we probably aren't fully capturing in our 1.5% estimate for 2012.

Figure 5. Citi's 2012 Medicare Advantage Rate Assumptions

Trend change for aged + disabled	0.5%
Revision for prior year estimates	3.0%
Growth percentage, net of adjustments	3.5%
Impact of county payment rebasing	0.5%
Recalibration of risk adjustment model	-0.5%
Net impact of budget neutrality	0.0%
Impact of fee for service normalization	1.2%
Impact of reform related Medicare cuts	-2.5%
Impact of risk score coding intensity adjustment	-2.5%
Net 2012 Medicare rate increase - February 18th	-0.3%
Impact of increased 2012 risk scores	1.5%
Star quality bonus payments	0.8%
Net 2012 Medicare rate increase - All in	2.0%

Source: Company notes and Citi Investment Research and Analysis

In addition to the improvement in risk scores, there is a new additional piece to reimbursement that probably won't be included in either the initial or final notice, which is the new demonstration project around quality star bonus payments. We estimate the overall impact on the industry from this demo project will be about 70 basis points. We estimate that the average star rating for the publicly traded plans is about 2.8 stars, so most of the industry is eligible for about a 3% boost to reimbursement. If we assume that the star ratings payments are phased in over an average of three and a half years, it works out to about an 0.8% boost to 2012 rates.

When the star bonus payments were first announced, only plans with 4 or more stars were eligible for the bonus payments, with 4 and 5 star plans receiving the same bonus amount. Because of the demonstration project, plans with 3 stars are also eligible for payments. As a result, 62% of all Medicare plans (covering 84% of beneficiaries) will be eligible for a bonus, compared with only 14% of plans under the prior interpretation. Clearly, improving star ratings has become a hugely important task, but it won't be easy, considering that many of the factors that go into the star ratings aren't really controlled by plans, like member satisfaction with their doctors.

Figure 6. Medicare Advantage Star Rating Summary

Summary	Bonus %	# of Plans	Total Enrollment	% of Total
5 Stars	5%	3	108,881	1.0%
4.5 Stars	4%	33	1,634,852	14.5%
4 Stars	4%	41	974,432	8.6%
3.5 Stars	3.5%	101	2,984,368	26.5%
3 Stars	3%	170	3,794,621	33.6%
2.5 Stars	0%	47	804,470	7.1%
2 Stars	0%	1	3,132	0.0%
Not applicable	3%	14	65,338	0.6%
Too new to be measured	3%	61	503,749	4.5%
Not enough data	3%	104	408,800	3.6%
Total plans ranked		575	11,282,643	100.0%

Source: Centers for Medicare and Medicaid Services (CMS) and Citi Investment Research and Analysis

Beyond the incremental revenue offered by the star ratings, the other key factor to consider is that plans with higher star ratings are allowed to keep a greater portion of the difference between the plan bid and the fee for service benchmark. Currently, plans keep 75% of the difference between their bid and the benchmark to use to improve benefits or lower cost sharing for members. Starting in 2012, the amount of the difference kept by the plans will be determined by the star rating, with plans deemed to be lower quality allowed to keep less of the rebate, meaning that they can keep fewer incremental benefits.

Figure 7. Going Forward, Rebate Percentages Will Be Determined By Star Ratings

Year	Star Ratings		
	< 3.5 ⚡	3.5 - 4.5 ⚡ & New Plan	≥ 4.5 ⚡ & Low Enroll
2011	75.0%	75.0%	75.0%
2012	66.7%	71.7%	73.3%
2013	58.3%	68.3%	71.7%
2014+	50.0%	65.0%	70.0%

Source: Milliman Inc. and Citi Investment Research and Analysis

Figure 8. Medicare Advantage Star Ratings Detail, By Publicly Traded Plan

Category	Aetna	AMERIGROUP	Centene	Coventry	Health Net	HealthSpring	Humana	Molina	Triple-S	Universal American	United	WellCare	WellPoint	Industry
5 Stars	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4.5 Stars	-	-	-	-	-	-	-	-	-	-	-	-	-	-
4 Stars	2,551	-	-	9,145	-	102,058	-	-	-	-	106,898	-	-	220,652
3.5 Stars	217,494	-	-	77,219	171,855	-	558,925	-	-	96,856	613,910	-	62,581	1,798,840
3 Stars	115,557	7,240	-	77,227	49,087	196,765	308,219	14,567	-	166,848	1,272,009	113,304	390,211	2,711,034
Below 3 Stars	838	7,764	-	1,949	-	-	433,938	4,440	54,622	-	72,011	1,947	15,766	593,275
Plan too new to be measured	522	-	-	-	-	2,861	438,280	520	-	-	-	-	-	442,183
Not enough data	6,042	3,725	2,961	3,114	746	97	18,945	3,684	-	26,959	18,893	717	6,958	92,841
Total	343,004	18,729	2,961	168,654	221,688	301,781	1,758,307	23,211	54,622	290,663	2,083,721	115,968	475,516	5,858,825
Total above 3 Stars	335,602	7,240	-	163,591	220,942	298,823	867,144	14,567	-	263,704	1,992,817	113,304	452,792	4,730,526
Average bonus percentage	3.3%	1.2%	0.0%	3.2%	3.4%	3.3%	2.4%	1.9%	0.0%	2.9%	3.1%	2.9%	2.9%	2.8%
Bonus payment (millions)	\$126.3	\$2.5	\$0.0	\$60.7	\$84.5	\$113.6	\$473.3	\$5.1	\$0.0	\$94.7	\$721.1	\$38.3	\$156.8	\$1,876.8

Category	Aetna	AMERIGROUP	Centene	Coventry	Health Net	HealthSpring	Humana	Molina	Triple-S	Universal American	United	WellCare	WellPoint	Industry
5 Stars	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
4.5 Stars	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
4 Stars	1%	0%	0%	5%	0%	34%	0%	0%	0%	0%	5%	0%	0%	4%
3.5 Stars	63%	0%	0%	46%	78%	0%	32%	0%	0%	33%	29%	0%	13%	31%
3 Stars	34%	39%	0%	46%	22%	65%	18%	63%	0%	57%	61%	98%	82%	46%
Below 3 Stars	0%	41%	0%	1%	0%	0%	25%	19%	100%	0%	3%	2%	3%	10%
Plan too new to be measured	0%	0%	0%	0%	0%	1%	25%	2%	0%	0%	0%	0%	0%	8%
Not enough data	2%	20%	100%	2%	0%	0%	1%	16%	0%	9%	1%	1%	1%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total above 3 Stars	98%	39%	0%	97%	100%	99%	49%	63%	0%	91%	96%	98%	95%	81%

Source: Centers For Medicare & Medicaid Services (CMS) and Citi Investment Research and Analysis

All in, we wouldn't be surprised to see the actual rates paid to Medicare Advantage plans rise something like 2% in 2012. This won't be enough to match underlying cost trend, but it will be enough of a rate increase to mean that plans will not have to make substantial benefit changes in 2012, which should enable most plans to keep Medicare earnings relatively stable next year.

Medicare by the Numbers

Among the publicly traded managed care plans, it's easy to argue that Medicare Advantage isn't overly important, because it represents a fairly small percentage of revenue, as we expect it to account for 16% of revenue at the average managed care plan in 2010 and even less in 2011, at about 15.6%. The decline is mainly due to the loss of private fee for service membership at plans such as CIGNA and Universal American. For all plans, including those that Medicare is a significant contributor to, like Humana, HealthSpring and Universal American, we calculate that Medicare will account for 27% of total revenue for 2011.

Figure 9. Medicare Advantage as a % of Total Revenue

	2005	2006	2007	2008	2009	2010E	2011E
AET	4.7%	5.7%	8.3%	14.2%	15.8%	15.7%	15.3%
CI	2.5%	2.6%	2.9%	3.0%	4.5%	9.6%	3.1%
CVH	10.2%	10.5%	22.0%	26.7%	35.1%	18.4%	20.5%
HNT	13.3%	15.5%	17.1%	19.6%	20.5%	19.0%	19.5%
HUM	32.2%	40.2%	44.7%	48.0%	53.5%	57.5%	56.4%
HS	27.7%	-42.0%	345.6%	-33.1%	18.0%	83.6%	77.1%
UAM	24.9%	31.1%	60.6%	55.0%	56.6%	59.4%	44.8%
UNH	7.1%	19.3%	20.4%	21.0%	24.1%	26.2%	26.6%
WCG	27.7%	20.0%	30.9%	37.5%	40.4%	24.5%	22.8%
WLP	2.8%	4.6%	5.7%	7.6%	7.4%	8.4%	8.7%
Average	15.3%	10.8%	55.8%	19.9%	27.6%	32.2%	29.5%
Average, excluding outliers (outliers include: HUM, HS, UAM and WCG)	6.8%	9.7%	12.7%	15.3%	17.9%	16.2%	15.6%

Source: Citi Investment Research and Analysis

Moreover, we calculate that Medicare Advantage will account for 17.2% of the industry's 2010 EBITDA, excluding Humana, Universal American, WellCare, and HealthSpring. At Humana, we expect Medicare Advantage to contribute 74.5% of EBITDA in 2010 and should contribute about 75.5% in 2011. At United, we calculate that EBITDA from Medicare Advantage will amount to 28% of total EBITDA in 2011. However, Medicare has driven much of the industry's earnings growth over the past few years, as commercial risk membership has fallen and margins were pressured by an uptick in cost trends last year and more aggressive pricing by non-profit Blues in prior years. In 2010, of course, with medical cost trend down, Medicare has been less important to earnings growth. But in several recent years, even though Medicare may not contribute a lot on an overall basis, it has been a major contributor to earnings growth in recent years.

Figure 10. Medicare Advantage EBITDA as a % of Total EBITDA

Company	Ticker	2009			2010E			2011E		
		Medicare Advantage EBITDA	Total EBITDA	% of Total	Medicare Advantage EBITDA	Total EBITDA	% of Total	Medicare Advantage EBITDA	Total EBITDA	% of Total
Humana Inc	HUM	\$1,276	\$1,664	76.7%	\$1,455	\$1,953	74.5%	\$845	\$1,119	75.5%
HealthSpring Inc	HS	\$170	\$252	67.7%	\$269	\$345	78.1%	\$306	\$416	73.5%
Universal American	UAM	\$138	\$258	53.6%	\$165	\$246	67.2%	\$68	\$123	55.8%
WellCare Health Plans	WCG	\$165	\$217	75.9%	\$115	\$188	61.4%	\$94	\$215	43.7%
Triple-S	GTS	\$17	\$75	23.3%	\$22	\$86	25.7%	\$25	\$80	31.0%
UnitedHealth Group	UNH	\$1,892	\$6,758	28.0%	\$2,282	\$8,149	28.0%	\$1,962	\$7,008	28.0%
Coventry Health Care	CVH	\$138	\$575	24.1%	\$171	\$898	19.0%	\$172	\$636	27.0%
Health Net Inc	HNT	\$152	\$373	40.7%	\$56	\$417	13.4%	\$53	\$457	11.7%
AMERIGROUP	AGP	\$31	\$223	13.9%	\$33	\$442	7.6%	\$29	\$329	8.8%
Aetna Inc	AET	\$178	\$2,447	7.3%	\$249	\$2,900	8.6%	\$156	\$2,304	6.8%
WellPoint Inc	WLP	\$540	\$4,639	11.6%	\$540	\$4,519	12.0%	\$206	\$4,206	4.9%
CIGNA Corp	CI	\$2	\$1,740	0.1%	-\$44	\$1,841	-2.4%	\$10	\$1,944	0.5%
Totals / Weighted Average		\$4,700	\$19,221	24.5%	\$5,314	\$21,984	24.2%	\$3,926	\$18,837	20.8%
Totals / Weighted Average, ex HS, HUM, WCG, UAM		\$2,951	\$16,830	17.5%	\$3,309	\$19,253	17.2%	\$2,614	\$16,965	15.4%

Source: Citi Investment Research and Analysis

Companies Mentioned:

(AET.N; US\$37.64; 2M); (AGP.N; US\$54.33; 1H); (CI.N; US\$42.66; 2M); (CVH.N; US\$29.78; 2H); (HNT.N; US\$29.78; 1H); (HS.N; US\$31.56; 2H); (HUM.N; US\$58.31; 1H); (UAM.N; US\$20.25; 1H); (UNH.N; US\$41.97; 2L); (WCG.N; US\$32.14; 1H); (WLP.N; US\$65.28; 2L); (GTS.N; US\$19.14; 1H)

Appendix A-1

Analyst Certification

The research analyst(s) primarily responsible for the preparation and content of this research report are named in bold text in the author block at the front of the product except for those sections where an analyst's name appears in bold alongside content which is attributable to that analyst. Each of these analyst(s) certify, with respect to the section(s) of the report for which they are responsible, that the views expressed therein accurately reflect their personal views about each issuer and security referenced and were prepared in an independent manner, including with respect to Citigroup Global Markets Inc and its affiliates. No part of the research analyst's compensation was, is, or will be, directly or indirectly, related to the specific recommendation(s) or view(s) expressed by that research analyst in this report.

IMPORTANT DISCLOSURES

Within the past 12 months, Citigroup Global Markets Inc. or its affiliates has acted as manager or co-manager of an offering of securities of Aetna, CIGNA, UnitedHealth, WellPoint.

Citigroup Global Markets Inc. or its affiliates has received compensation for investment banking services provided within the past 12 months from Aetna, CIGNA, Coventry Health, Humana, UnitedHealth, WellPoint.

Citigroup Global Markets Inc. or its affiliates expects to receive or intends to seek, within the next three months, compensation for investment banking services from UnitedHealth.

Citigroup Global Markets Inc. or an affiliate received compensation for products and services other than investment banking services from Aetna, CIGNA, Coventry Health, Triple-S Management Corp., Health Net, HealthSpring, Humana, Universal American, UnitedHealth, WellPoint in the past 12 months.

Citigroup Global Markets Inc. currently has, or had within the past 12 months, the following as investment banking client(s): Humana, Aetna, CIGNA, Coventry Health, UnitedHealth, WellPoint.

Citigroup Global Markets Inc. currently has, or had within the past 12 months, the following as clients, and the services provided were non-investment-banking, securities-related: Aetna, AMERIGROUP, CIGNA, Coventry Health, Triple-S Management Corp., Health Net, HealthSpring, Humana, Universal American, UnitedHealth, WellPoint.

Citigroup Global Markets Inc. currently has, or had within the past 12 months, the following as clients, and the services provided were non-investment-banking, non-securities-related: Aetna, CIGNA, Coventry Health, Triple-S Management Corp., Health Net, HealthSpring, Humana, Universal American, UnitedHealth, WellPoint.

Analysts' compensation is determined based upon activities and services intended to benefit the investor clients of Citigroup Global Markets Inc. and its affiliates ("the Firm"). Like all Firm employees, analysts receive compensation that is impacted by overall firm profitability which includes investment banking revenues.

The Firm is a market maker in the publicly traded equity securities of Universal American.

For important disclosures (including copies of historical disclosures) regarding the companies that are the subject of this Citi Investment Research & Analysis product ("the Product"), please contact Citi Investment Research & Analysis, 388 Greenwich Street, 28th Floor, New York, NY, 10013, Attention: Legal/Compliance. In addition, the same important disclosures, with the exception of the Valuation and Risk assessments and historical disclosures, are contained on the Firm's disclosure website at www.citigroupgeo.com. Valuation and Risk assessments can be found in the text of the most recent research note/report regarding the subject company. Historical disclosures (for up to the past three years) will be provided upon request.

Citi Investment Research & Analysis Ratings Distribution

Data current as of 31 Dec 2010

Citi Investment Research & Analysis Global Fundamental Coverage

% of companies in each rating category that are investment banking clients

12 Month Rating			Relative Rating		
Buy	Hold	Sell	Buy	Hold	Sell
52%	37%	11%	0%	100%	0%
45%	44%	40%	0%	44%	0%

Guide to Citi Investment Research & Analysis (CIRA) Fundamental Research Investment Ratings:

CIRA's stock recommendations include a risk rating and an investment rating.

Risk ratings, which take into account both price volatility and fundamental criteria, are: Low (L), Medium (M), High (H), and Speculative (S).

Investment ratings are a function of CIRA's expectation of total return (forecast price appreciation and dividend yield within the next 12 months) and risk rating.

Analysts may place covered stocks "Under Review" in response to exceptional circumstances (e.g. lack of information critical to the analyst's thesis) affecting the company and/or trading in the company's securities (e.g. trading suspension). Stocks placed "Under Review" will be monitored daily by management. As soon as practically possible, the analyst will publish a note re-establishing a rating and investment thesis.

To satisfy regulatory requirements, we correspond Under Review to Hold in our ratings distribution table for our 12-month fundamental rating system. However, we reiterate that we do not consider Under Review to be a recommendation.

Relative three-month ratings: CIRA may also assign a three-month relative call (or rating) to a stock to highlight expected out-performance (most preferred) or under-performance (least preferred) versus the analyst's coverage universe over a 3 month period. The relative call may highlight a specific near-term catalyst or event impacting the company or the market that is anticipated to have a short-term price impact on the equity securities of the company. Absent any specific catalyst the analyst(s) will indicate the most and least preferred stocks in his coverage universe, explaining the basis for this short-term view. This three-month view may be different from and does not affect a stock's fundamental equity rating, which reflects a longer-term total absolute return expectation. For purposes of NASD/NYSE ratings-distribution-disclosure rules, most preferred calls correspond to a buy recommendation and least preferred calls correspond to a sell recommendation. Any stock not assigned to a most preferred or least preferred call is considered non-relative-rated (NRR). For purposes of NASD/NYSE ratings-distribution-disclosure rules we correspond NRR to Hold in our ratings distribution table for our 3-month relative rating system. However, we reiterate that we do not consider NRR to be a recommendation.

For securities in developed markets (US, UK, Europe, Japan, and Australia/New Zealand), investment ratings are: Buy (1) (expected total return of 10% or more for Low-Risk stocks, 15% or more for Medium-Risk stocks, 20% or more for High-Risk stocks, and 35% or more for Speculative stocks); Hold (2) (0%-10% for Low-Risk stocks, 0%-15% for Medium-Risk stocks, 0%-20% for High-Risk stocks, and 0%-35% for Speculative stocks); and Sell (3) (negative total return).

For securities in emerging markets (Asia Pacific, Emerging Europe/Middle East/Africa, and Latin America), investment ratings are: Buy (1) (expected total return of 15% or more for Low-Risk stocks, 20% or more for Medium-Risk stocks, 30% or more for High-Risk stocks, and 40% or more for Speculative stocks); Hold (2) (5%-15% for Low-Risk stocks, 10%-20% for Medium-Risk stocks, 15%-30% for High-Risk stocks, and 20%-40% for Speculative stocks); and Sell (3) (5% or less for Low-Risk stocks, 10% or less for Medium-Risk stocks, 15% or less for High-Risk stocks, and 20% or less for Speculative stocks).

Investment ratings are determined by the ranges described above at the time of initiation of coverage, a change in investment and/or risk rating, or a change in target price (subject to limited management discretion). At other times, the expected total returns may fall outside of these ranges because of market price movements and/or other short-term volatility or trading patterns. Such interim deviations from specified ranges will be permitted but will become subject to review by Research Management. Your decision to buy or sell a security should be based upon your personal investment objectives and should be made only after evaluating the stock's expected performance and risk.

NON-US RESEARCH ANALYST DISCLOSURES

Non-US research analysts who have prepared this report (i.e., all research analysts listed below other than those identified as employed by Citigroup Global Markets Inc.) are not registered/qualified as research analysts with FINRA. Such research analysts may not be associated persons of the member organization and therefore may not be subject to the NYSE Rule 472 and NASD Rule 2711 restrictions on communications with a subject company, public appearances and trading securities held by a research analyst account. The legal entities employing the authors of this report are listed below:

Citigroup Global Markets Inc

Carl McDonald, CFA; James Naklicki, CFA

OTHER DISCLOSURES

Citigroup Global Markets Inc. and/or its affiliates has a significant financial interest in relation to Aetna, CIGNA, Coventry Health, Health Net, Humana, UnitedHealth, WellPoint. (For an explanation of the determination of significant financial interest, please refer to the policy for managing conflicts of interest which can be found at www.citigroupgeo.com.)

For securities recommended in the Product in which the Firm is not a market maker, the Firm is a liquidity provider in the issuers' financial instruments and may act as principal in connection with such transactions. The Firm is a regular issuer of traded financial instruments linked to securities that may have been recommended in the Product. The Firm regularly trades in the securities of the issuer(s) discussed in the Product. The Firm may engage in securities transactions in a manner inconsistent with the Product and, with respect to securities covered by the Product, will buy or sell from customers on a principal basis.

Securities recommended, offered, or sold by the Firm: (i) are not insured by the Federal Deposit Insurance Corporation; (ii) are not deposits or other obligations of any insured depository institution (including Citibank); and (iii) are subject to investment risks, including the possible loss of the principal amount invested. Although information has been obtained from and is based upon sources that the Firm believes to be reliable, we do not guarantee its accuracy and it may be incomplete and condensed. Note, however, that the Firm has taken all reasonable steps to determine the accuracy and completeness of the disclosures made in the Important Disclosures section of the Product. The Firm's research department has received assistance from the subject company(ies) referred to in this Product including, but not limited to, discussions with management of the subject company(ies). Firm policy prohibits research analysts from sending draft research to subject companies. However, it should be presumed that the author of the Product has had discussions with the subject company to ensure factual accuracy prior to publication. All opinions, projections and estimates constitute the judgment of the author as of the date of the Product and these, plus any other information contained in the Product, are subject to change without notice. Prices and availability of financial instruments also are subject to change without notice. Notwithstanding other departments within the Firm advising the companies discussed in this Product, information obtained in such role is not used in the preparation of the Product. Although Citi Investment Research & Analysis (CIRA) does not set a predetermined frequency for publication, if the Product is a fundamental research report, it is the intention of CIRA to provide research coverage of the/those issuer(s) mentioned therein, including in response to news affecting this issuer, subject to applicable quiet periods and capacity constraints. The Product is for informational purposes only and is not intended as an offer or solicitation for the purchase or sale of a security. Any decision to purchase securities mentioned in the Product must take into account existing public information on such security or any registered prospectus.

Investing in non-U.S. securities, including ADRs, may entail certain risks. The securities of non-U.S. issuers may not be registered with, nor be subject to the reporting requirements of the U.S. Securities and Exchange Commission. There may be limited information available on foreign securities. Foreign companies are generally not subject to uniform audit and reporting standards, practices and requirements comparable to those in the U.S. Securities of some foreign companies may be less liquid and their prices more volatile than securities of comparable U.S. companies. In addition, exchange rate movements may have an adverse effect on the value of an investment in a foreign stock and its corresponding dividend payment for U.S. investors. Net dividends to ADR investors are estimated, using withholding tax rates conventions, deemed accurate, but investors are urged to consult their tax advisor for exact dividend computations. Investors who have received the Product from the Firm may be prohibited in certain states or other jurisdictions from purchasing securities mentioned in the Product from the Firm. Please ask your Financial Consultant for additional details. Citigroup Global Markets Inc. takes responsibility for the Product in the United States. Any orders by US investors resulting from the information contained in the Product may be placed only through Citigroup Global Markets Inc.

Important Disclosures for Morgan Stanley Smith Barney LLC Customers: Morgan Stanley & Co. Incorporated (Morgan Stanley) research reports may be available about the companies that are the subject of this Citi Investment Research & Analysis (CIRA) research report. Ask your Financial Advisor or use smithbarney.com to view any available Morgan Stanley research reports in addition to CIRA research reports.

Important disclosure regarding the relationship between the companies that are the subject of this CIRA research report and Morgan Stanley Smith Barney LLC and its affiliates are available at the Morgan Stanley Smith Barney disclosure website at www.morganstanleysmithbarney.com/researchdisclosures.

The required disclosures provided by Morgan Stanley and Citigroup Global Markets, Inc. on Morgan Stanley and CIRA research relate in part to the separate businesses of Citigroup Global Markets, Inc. and Morgan Stanley that now form Morgan Stanley Smith Barney LLC, rather than to Morgan Stanley Smith Barney LLC in its entirety. For Morgan Stanley and Citigroup Global Markets, Inc. specific disclosures, you may refer to www.morganstanley.com/researchdisclosures and https://www.citigroupgeo.com/geopublic/Disclosures/index_a.html.

This CIRA research report has been reviewed and approved on behalf of Morgan Stanley Smith Barney LLC. This review and approval was conducted by the same person who reviewed this research report on behalf of CIRA. This could create a conflict of interest.

The Citigroup legal entity that takes responsibility for the production of the Product is the legal entity which the first named author is employed by. The Product is made available in Australia through Citigroup Global Markets Australia Pty Ltd. (ABN 64 003 114 832 and AFSL No. 240992), participant of the ASX Group and regulated by the Australian Securities & Investments Commission. Citigroup Centre, 2 Park Street, Sydney, NSW 2000. The Product is made available in Australia to Private Banking wholesale clients through Citigroup Pty Limited (ABN 88 004 325 080 and AFSL 238098). Citigroup Pty Limited provides all financial product advice to Australian Private Banking wholesale clients through bankers and relationship managers. If there is any doubt about the suitability of investments held in Citigroup Private Bank accounts, investors should contact the Citigroup Private Bank in Australia. Citigroup companies may compensate affiliates and their

representatives for providing products and services to clients. The Product is made available in Brazil by Citigroup Global Markets Brasil - CCTVM SA, which is regulated by CVM - Comissão de Valores Mobiliários, BACEN - Brazilian Central Bank, APIMEC - Associação dos Analistas e Profissionais de Investimento do Mercado de Capitais and ANBID - Associação Nacional dos Bancos de Investimento. Av. Paulista, 1111 - 11º andar - CEP. 01311920 - São Paulo - SP. If the Product is being made available in certain provinces of Canada by Citigroup Global Markets (Canada) Inc. ("CGM Canada"), CGM Canada has approved the Product. Citigroup Place, 123 Front Street West, Suite 1100, Toronto, Ontario M5J 2M3. This product is available in Chile through Banchile Corredores de Bolsa S.A., an indirect subsidiary of Citigroup Inc., which is regulated by the Superintendencia de Valores y Seguros. Agustinas 975, piso 2, Santiago, Chile. The Product is made available in France by Citigroup Global Markets Limited, which is authorised and regulated by Financial Services Authority. 1-5 Rue Paul Cézanne, 8ème, Paris, France. If the Product is made available in Hong Kong by, or on behalf of, Citigroup Global Markets Asia Ltd., it is attributable to Citigroup Global Markets Asia Ltd., Citibank Tower, Citibank Plaza, 3 Garden Road, Hong Kong. Citigroup Global Markets Asia Ltd. is regulated by Hong Kong Securities and Futures Commission. If the Product is made available in Hong Kong by The Citigroup Private Bank to its clients, it is attributable to Citibank N.A., Citibank Tower, Citibank Plaza, 3 Garden Road, Hong Kong. The Citigroup Private Bank and Citibank N.A. is regulated by the Hong Kong Monetary Authority. The Product is made available in India by Citigroup Global Markets India Private Limited, which is regulated by Securities and Exchange Board of India. Bakhtawar, Nariman Point, Mumbai 400-021. The Product is made available in Indonesia through PT Citigroup Securities Indonesia. 5/F, Citibank Tower, Bapindo Plaza, Jl. Jend. Sudirman Kav. 54-55, Jakarta 12190. Neither this Product nor any copy hereof may be distributed in Indonesia or to any Indonesian citizens wherever they are domiciled or to Indonesian residents except in compliance with applicable capital market laws and regulations. This Product is not an offer of securities in Indonesia. The securities referred to in this Product have not been registered with the Capital Market and Financial Institutions Supervisory Agency (BAPEPAM-LK) pursuant to relevant capital market laws and regulations, and may not be offered or sold within the territory of the Republic of Indonesia or to Indonesian citizens through a public offering or in circumstances which constitute an offer within the meaning of the Indonesian capital market laws and regulations. The Product is made available in Israel through Citibank NA, regulated by the Bank of Israel and the Israeli Securities Authority. Citibank, N.A. Platinum Building, 21 Ha'arba'ah St, Tel Aviv, Israel. The Product is made available in Italy by Citigroup Global Markets Limited, which is authorised and regulated by Financial Services Authority. Foro Buonaparte 16, Milan, 20121, Italy. The Product is made available in Japan by Citigroup Global Markets Japan Inc. ("CGMJ"), which is regulated by Financial Services Agency, Securities and Exchange Surveillance Commission, Japan Securities Dealers Association, Tokyo Stock Exchange and Osaka Securities Exchange. Shin-Marunouchi Building, 1-5-1 Marunouchi, Chiyoda-ku, Tokyo 100-6520 Japan. If the Product was distributed by Nikko Cordial Securities Inc. it is being so distributed under license. In the event that an error is found in an CGMJ research report, a revised version will be posted on the Firm's Global Equities Online (GEO) website. If you have questions regarding GEO, please call (81 3) 6270-3019 for help. The Product is made available in Korea by Citigroup Global Markets Korea Securities Ltd., which is regulated by the Financial Services Commission, the Financial Supervisory Service and the Korea Financial Investment Association (KOFIA). Citibank Building, 39 Da-dong, Jung-gu, Seoul 110-180, Korea. KOFIA makes available registration information of research analysts on its website. Please visit the following website if you wish to find KOFIA registration information on research analysts of Citigroup Global Markets Korea Securities Ltd. <http://dis.kofia.or.kr/fs/dis2/fundMgr/DISFundMgrAnalystPop.jsp?companyCd2=A03030&pageDiv=02>. The Product is made available in Malaysia by Citigroup Global Markets Malaysia Sdn Bhd, which is regulated by Malaysia Securities Commission. Menara Citibank, 165 Jalan Ampang, Kuala Lumpur, 50450. The Product is made available in Mexico by Acciones y Valores Banamex, S.A. De C. V., Casa de Bolsa, Integrante del Grupo Financiero Banamex ("Accival") which is a wholly owned subsidiary of Citigroup Inc. and is regulated by Comisión Nacional Bancaria y de Valores. Reforma 398, Col. Juárez, 06600 Mexico, D.F. In New Zealand the Product is made available through Citigroup Global Markets New Zealand Ltd. (Company Number 604457), a Participant of the New Zealand Exchange Limited and regulated by the New Zealand Securities Commission. Level 19, Mobile on the Park, 157 Lambton Quay, Wellington. The Product is made available in Pakistan by Citibank N.A. Pakistan branch, which is regulated by the State Bank of Pakistan and Securities Exchange Commission, Pakistan. AWT Plaza, 1.1. Chundrigar Road, P.O. Box 4889, Karachi-74200. The Product is made available in the Philippines through Citicorp Financial Services and Insurance Brokerage Philippines, Inc., which is regulated by the Philippines Securities and Exchange Commission. 20th Floor Citibank Square Bldg. The Product is made available in Poland by Dom Maklerski Banku Handlowego SA an indirect subsidiary of Citigroup Inc., which is regulated by Komisja Nadzoru Finansowego. Dom Maklerski Banku Handlowego S.A. ul. Senatorska 16, 00-923 Warszawa. The Product is made available in the Russian Federation through ZAO Citibank, which is licensed to carry out banking activities in the Russian Federation in accordance with the general banking license issued by the Central Bank of the Russian Federation and brokerage activities in accordance with the license issued by the Federal Service for Financial Markets. Neither the Product nor any information contained in the Product shall be considered as advertising the securities mentioned in this report within the territory of the Russian Federation or outside the Russian Federation. The Product does not constitute an appraisal within the meaning of the Federal Law of the Russian Federation of 29 July 1998 No. 135-FZ (as amended) On Appraisal Activities in the Russian Federation. 8-10 Gashka Street, 125047 Moscow. The Product is made available in Singapore through Citigroup Global Markets Singapore Pte. Ltd., a Capital Markets Services Licence holder, and regulated by Monetary Authority of Singapore. 1 Temasek Avenue, #39-02 Millenia Tower, Singapore 039192. The Product is made available by The Citigroup Private Bank in Singapore through Citibank, N.A., Singapore branch, a licensed bank in Singapore that is regulated by Monetary Authority of Singapore. Citigroup Global Markets (Pty) Ltd. is incorporated in the Republic of South Africa (company registration number 2000/025866/07) and its registered office is at 145 West Street, Sandton, 2196, Saxonwold. Citigroup Global Markets (Pty) Ltd. is regulated by JSE Securities Exchange South Africa, South African Reserve Bank and the Financial Services Board. The investments and services contained herein are not available to private customers in South Africa. The Product is made available in Spain by Citigroup Global Markets Limited, which is authorised and regulated by Financial Services Authority. 29 Jose Ortega Y Gassef, 4th Floor, Madrid, 28006, Spain. The Product is made available in Taiwan through Citigroup Global Markets Taiwan Securities Company Ltd., which is regulated by Securities & Futures Bureau. No portion of the report may be reproduced or quoted in Taiwan by the press or any other person. 14 and 15F, No. 1, Songzhi Road, Taipei 110, Taiwan. If the Product is related to non-Taiwan listed securities, neither the Product nor any information contained in the Product shall be considered as advertising the securities or making recommendation of the securities. The Product is made available in Thailand through Citicorp Securities (Thailand) Ltd., which is regulated by the Securities and Exchange Commission of Thailand. 18/F, 22/F and 29/F, 82 North Sathorn Road, Silom, Bangrak, Bangkok 10500, Thailand. The Product is made available in Turkey through Citibank AS which is regulated by Capital Markets Board. Tekfen Tower, Eski Büyükdere Caddesi # 209 Kat 2B, 23294 Levent, Istanbul, Turkey. In the U.A.E, these materials (the "Materials") are communicated by Citigroup Global Markets Limited, DIFC branch ("CGML"), an entity registered in the Dubai International Financial Center ("DIFC") and licensed and regulated by the Dubai Financial Services Authority ("DFSA") to Professional Clients and Market Counterparties only and should not be relied upon or distributed to Retail Clients. A distribution of the different CIRA ratings distribution, in percentage terms for Investments in each sector covered is made available on request. Financial products and/or services to which the Materials relate will only be made available to Professional Clients and Market Counterparties. The Product is made available in United Kingdom by Citigroup Global Markets Limited, which is authorised and regulated by Financial Services Authority. This material may relate to investments or services of a person outside of the UK or to other matters which are not regulated by the FSA and further details as to where this may be the case are available upon request in respect of this material. Citigroup Centre, Canada Square, Canary Wharf, London, E14 5LB. The Product is made available in United States by Citigroup Global Markets Inc, which is regulated by FINRA and the US Securities and Exchange Commission. 388 Greenwich Street, New York, NY 10013. Unless specified to the contrary, within EU Member States, the Product is made available by Citigroup Global Markets Limited, which is regulated by Financial Services Authority. Pursuant to Comissão de Valores Mobiliários Rule 483, Citi is required to disclose whether a Citi related company or business has a commercial relationship with the subject company. Considering that Citi operates multiple businesses in more than 100 countries around the world, it is likely that Citi has a commercial relationship

with the subject company.

Many European regulators require that a firm must establish, implement and make available a policy for managing conflicts of interest arising as a result of publication or distribution of investment research. The policy applicable to CIRA's Products can be found at www.citigroupgeo.com.

Compensation of equity research analysts is determined by equity research management and Citigroup's senior management and is not linked to specific transactions or recommendations.

The Product may have been distributed simultaneously, in multiple formats, to the Firm's worldwide institutional and retail customers. The Product is not to be construed as providing investment services in any jurisdiction where the provision of such services would not be permitted.

Subject to the nature and contents of the Product, the investments described therein are subject to fluctuations in price and/or value and investors may get back less than originally invested. Certain high-volatility investments can be subject to sudden and large falls in value that could equal or exceed the amount invested. Certain investments contained in the Product may have tax implications for private customers whereby levels and basis of taxation may be subject to change. If in doubt, investors should seek advice from a tax adviser. The Product does not purport to identify the nature of the specific market or other risks associated with a particular transaction. Advice in the Product is general and should not be construed as personal advice given it has been prepared without taking account of the objectives, financial situation or needs of any particular investor. Accordingly, investors should, before acting on the advice, consider the appropriateness of the advice, having regard to their objectives, financial situation and needs. Prior to acquiring any financial product, it is the client's responsibility to obtain the relevant offer document for the product and consider it before making a decision as to whether to purchase the product.

CIRA concurrently disseminates its research via proprietary and non-proprietary electronic distribution platforms. Periodically, individual analysts may also opt to circulate research to one or more clients by email. Such email distribution is discretionary and is done only after the research has been disseminated via the aforementioned distribution channels.

© 2011 Citigroup Global Markets Inc. Citi Investment Research & Analysis is a division of Citigroup Global Markets Inc. Citi and Citi with Arc Design are trademarks and service marks of Citigroup Inc. and its affiliates and are used and registered throughout the world. All rights reserved. Any unauthorized use, duplication, redistribution or disclosure of this report (the "Product"), including, but not limited to, redistribution of the Product by electronic mail, posting of the Product on a website or page, and/or providing to a third party a link to the Product, is prohibited by law and will result in prosecution. The information contained in the Product is intended solely for the recipient and may not be further distributed by the recipient to any third party. Where included in this report, MSCI sourced information is the exclusive property of Morgan Stanley Capital International Inc. (MSCI). Without prior written permission of MSCI, this information and any other MSCI intellectual property may not be reproduced, disseminated or used to create any financial products, including any indices. This information is provided on an "as is" basis. The user assumes the entire risk of any use made of this information. MSCI, its affiliates and any third party involved in, or related to, computing or compiling the information hereby expressly disclaim all warranties of originality, accuracy, completeness, merchantability or fitness for a particular purpose with respect to any of this information. Without limiting any of the foregoing, in no event shall MSCI, any of its affiliates or any third party involved in, or related to, computing or compiling the information have any liability for any damages of any kind. MSCI, Morgan Stanley Capital International and the MSCI indexes are services marks of MSCI and its affiliates. The Firm accepts no liability whatsoever for the actions of third parties. The Product may provide the addresses of, or contain hyperlinks to, websites. Except to the extent to which the Product refers to website material of the Firm, the Firm has not reviewed the linked site. Equally, except to the extent to which the Product refers to website material of the Firm, the Firm takes no responsibility for, and makes no representations or warranties whatsoever as to, the data and information contained therein. Such address or hyperlink (including addresses or hyperlinks to website material of the Firm) is provided solely for your convenience and information and the content of the linked site does not in anyway form part of this document. Accessing such website or following such link through the Product or the website of the Firm shall be at your own risk and the Firm shall have no liability arising out of, or in connection with, any such referenced website.

ADDITIONAL INFORMATION IS AVAILABLE UPON REQUEST

CMS May Be Looking to Calm the Waters On RADV Audits

3 February 2011

www.ubs.com/investmentresearch

■ CMS notice to plans “anticipates making changes to draft methodology”

CMS posted very brief notice to plans this morning in response to concerns around RADV audit methodology published on Dec 21. Agency indicates receiving comments from plans and most importantly indicates it is “thoroughly evaluating all comments and anticipates making changes to draft, based on input received”. We have been reading CMS notices for 10 years now and don’t EVER remember the agency indicating explicitly that there were changes coming in between publishing preliminary and final rules such as this. Very interesting indeed.

■ Not clear on what “changes” will be made but FFS adjuster in focus

While the brief, 1 paragraph notice (see Table 1 below) does not state what “changes” will be made, it is interesting to note that CMS mentions two industry comment areas specifically: (1) FFS adjuster and (2) RADV audit documentation standards. Plan public comments have made it clear that FFS adjuster is key to making RADV audits “fair” and likely make the potential liability “manageable”.

■ Should RADV be more smoke than fire there would be # of read-thrus

CMS decisions on RADV audits in “NT” along with CMS communication on Risk Score Intensity Adj w/2012 Advance Notice (Feb 18) will go a long way to understanding potential implications from risk scores to plans as well as provide insight into how CMS will oversee Med Adv in general during period of PPACA reimbursement pressure. A “kindler/gentler” CMS would be very bullish for Med Adv names (HUM/UNH/HS) and we expect all three to be up on this news

Justin Lake, CFA

Analyst

justin.lake@ubs.com

+1-212-713 2765

Ken LaVine, CFA

Associate Analyst

kenneth.lavine@ubs.com

+1-212-713 4237

Andrew Valen

Associate Analyst

andrew.valen@ubs.com

+1 212 713 2717

Dean Poniros, CPA

Associate Analyst

dean.poniros@ubs.com

+1-212-713 3229

Table 1: Text CMS Letter to Medicare Advantage Organizations

On Tuesday, December 21, 2010, CMS posted a description of the Agency’s proposed draft RADV sampling and payment error calculation methodology on our website at <https://www.cms.gov/HealthPlansGenInfo/> and invited public comment on this document. To date, we have received comments on a variety of topics, including a proposed FFS adjuster and RADV audit documentation standards. *We are thoroughly evaluating all comments and anticipate making changes to our draft*, based on input we received. We anticipate the final revised RADV sampling and payment error calculation methodology paper will be issued in the near future. CMS also plans to issue a question and answer document that summarizes the comments received on the RADV methodology and the Agency’s response to those comments.

Source: CMS

■ Statement of Risk

Risks to the Managed Care industry include but are not limited to potentially adverse impact under healthcare reform legislation, changes to Medicare and Medicaid reimbursement policies, potential for acceleration in medical cost trends, and competitive pricing pressures.

■ Analyst Certification

Each research analyst primarily responsible for the content of this research report, in whole or in part, certifies that with respect to each security or issuer that the analyst covered in this report: (1) all of the views expressed accurately reflect his or her personal views about those securities or issuers; and (2) no part of his or her compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views expressed by that research analyst in the research report.

Required Disclosures

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS.

For information on the ways in which UBS manages conflicts and maintains independence of its research product; historical performance information; and certain additional disclosures concerning UBS research recommendations, please visit www.ubs.com/disclosures. The figures contained in performance charts refer to the past; past performance is not a reliable indicator of future results. Additional information will be made available upon request. UBS Securities Co. Limited is licensed to conduct securities investment consultancy businesses by the China Securities Regulatory Commission.

UBS Investment Research: Global Equity Rating Allocations

UBS 12-Month Rating	Rating Category	Coverage ¹	IB Services ²
Buy	Buy	49%	40%
Neutral	Hold/Neutral	42%	35%
Sell	Sell	8%	21%
UBS Short-Term Rating	Rating Category	Coverage ³	IB Services ⁴
Buy	Buy	less than 1%	14%
Sell	Sell	less than 1%	0%

1:Percentage of companies under coverage globally within the 12-month rating category.

2:Percentage of companies within the 12-month rating category for which investment banking (IB) services were provided within the past 12 months.

3:Percentage of companies under coverage globally within the Short-Term rating category.

4:Percentage of companies within the Short-Term rating category for which investment banking (IB) services were provided within the past 12 months.

Source: UBS. Rating allocations are as of 31 December 2010.

UBS Investment Research: Global Equity Rating Definitions

UBS 12-Month Rating	Definition
Buy	FSR is > 6% above the MRA.
Neutral	FSR is between -6% and 6% of the MRA.
Sell	FSR is > 6% below the MRA.
UBS Short-Term Rating	Definition
Buy	Buy: Stock price expected to rise within three months from the time the rating was assigned because of a specific catalyst or event.
Sell	Sell: Stock price expected to fall within three months from the time the rating was assigned because of a specific catalyst or event.

KEY DEFINITIONS

Forecast Stock Return (FSR) is defined as expected percentage price appreciation plus gross dividend yield over the next 12 months.

Market Return Assumption (MRA) is defined as the one-year local market interest rate plus 5% (a proxy for, and not a forecast of, the equity risk premium).

Under Review (UR) Stocks may be flagged as UR by the analyst, indicating that the stock's price target and/or rating are subject to possible change in the near term, usually in response to an event that may affect the investment case or valuation.

Short-Term Ratings reflect the expected near-term (up to three months) performance of the stock and do not reflect any change in the fundamental view or investment case.

Equity Price Targets have an investment horizon of 12 months.

EXCEPTIONS AND SPECIAL CASES

UK and European Investment Fund ratings and definitions are: Buy: Positive on factors such as structure, management, performance record, discount; Neutral: Neutral on factors such as structure, management, performance record, discount; Sell: Negative on factors such as structure, management, performance record, discount.

Core Banding Exceptions (CBE): Exceptions to the standard +/-6% bands may be granted by the Investment Review Committee (IRC). Factors considered by the IRC include the stock's volatility and the credit spread of the respective company's debt. As a result, stocks deemed to be very high or low risk may be subject to higher or lower bands as they relate to the rating. When such exceptions apply, they will be identified in the Company Disclosures table in the relevant research piece.

Research analysts contributing to this report who are employed by any non-US affiliate of UBS Securities LLC are not registered/qualified as research analysts with the NASD and NYSE and therefore are not subject to the restrictions contained in the NASD and NYSE rules on communications with a subject company, public appearances, and trading securities held by a research analyst account. The name of each affiliate and analyst employed by that affiliate contributing to this report, if any, follows.

UBS Securities LLC: Justin Lake, CFA; Ken LaVine, CFA; Andrew Valen; Dean Poniro, CPA.

Company Disclosures

Company Name	Reuters	12-mo rating	Short-term rating	Price	Price date
HealthSpring Inc. ^{4, 5, 6a, 16}	HS.N	Neutral	N/A	US\$31.27	02 Feb 2011
Humana Inc. ^{6b, 7, 16}	HUM.N	Neutral	N/A	US\$58.95	02 Feb 2011
UnitedHealth Group ^{2, 4, 5, 6a, 6b, 6c, 7, 16}	UNH.N	Neutral	N/A	US\$41.95	02 Feb 2011

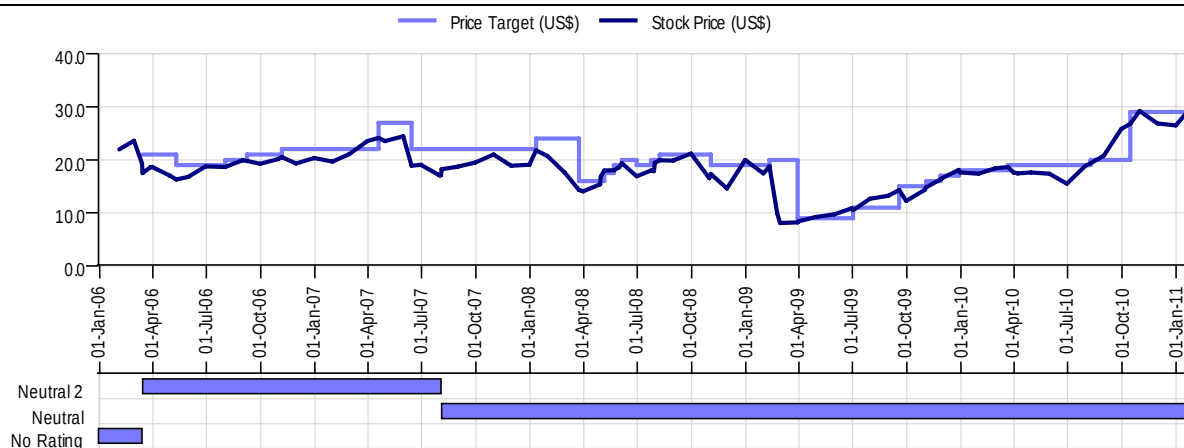
Source: UBS. All prices as of local market close.

Ratings in this table are the most current published ratings prior to this report. They may be more recent than the stock pricing date

2. UBS AG, its affiliates or subsidiaries has acted as manager/co-manager in the underwriting or placement of securities of this company/entity or one of its affiliates within the past 12 months.
4. Within the past 12 months, UBS AG, its affiliates or subsidiaries has received compensation for investment banking services from this company/entity.
5. UBS AG, its affiliates or subsidiaries expect to receive or intend to seek compensation for investment banking services from this company/entity within the next three months.
- 6a. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and investment banking services are being, or have been, provided.
- 6b. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-investment banking securities-related services are being, or have been, provided.
- 6c. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-securities services are being, or have been, provided.
7. Within the past 12 months, UBS Securities LLC has received compensation for products and services other than investment banking services from this company/entity.
16. UBS Securities LLC makes a market in the securities and/or ADRs of this company.

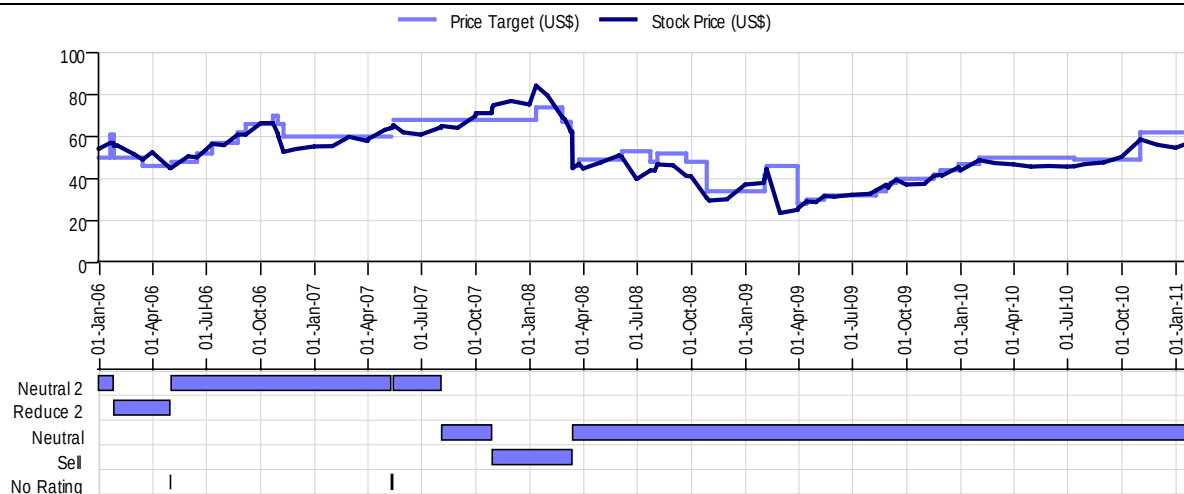
Unless otherwise indicated, please refer to the Valuation and Risk sections within the body of this report.

HealthSpring Inc. (US\$)



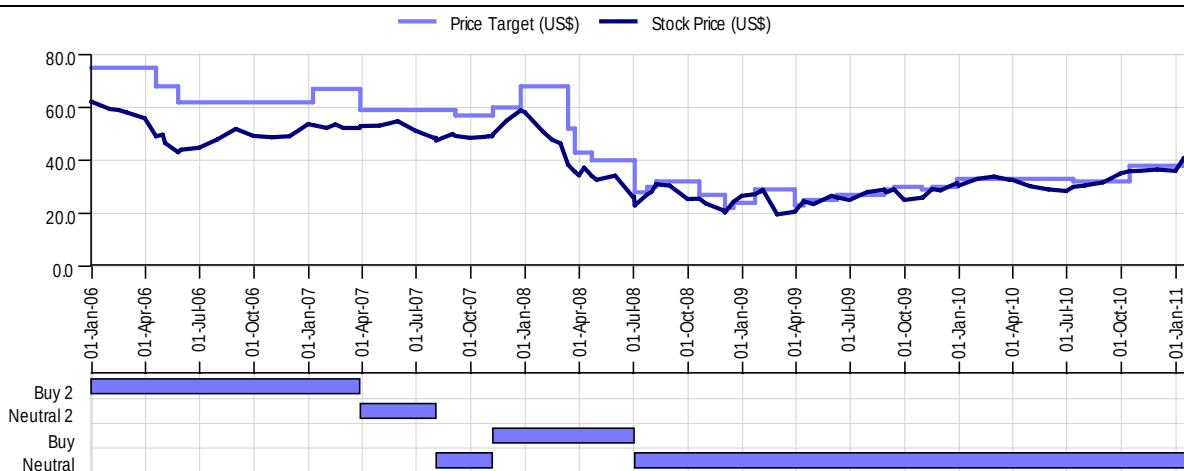
Source: UBS; as of 02 Feb 2011

Humana Inc. (US\$)



Source: UBS; as of 02 Feb 2011

UnitedHealth Group (US\$)



Source: UBS; as of 02 Feb 2011

Note: On August 4, 2007 UBS revised its rating system. (See 'UBS Investment Research: Global Equity Rating Definitions' table for details). From September 9, 2006 through August 3, 2007 the UBS ratings and their definitions were: Buy 1 = FSR is > 6% above the MRA, higher degree of predictability; Buy 2 = FSR is > 6% above the MRA, lower degree of predictability; Neutral 1 = FSR is between -6% and 6% of the MRA, higher degree of predictability; Neutral 2 = FSR is between -6% and 6% of the MRA, lower degree of predictability; Reduce 1 = FSR is > 6% below the MRA, higher degree of predictability; Reduce 2 = FSR is > 6% below the MRA, lower degree of predictability. The predictability level indicates an analyst's conviction in the FSR. A predictability level of '1' means that the analyst's estimate of FSR is in the middle of a narrower, or smaller, range of possibilities. A predictability level of '2' means that the analyst's estimate of FSR is in the middle of a broader, or larger, range of possibilities. From October 13, 2003 through September 8, 2006 the percentage band criteria used in the rating system was 10%.

Global Disclaimer

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS. In certain countries, UBS AG is referred to as UBS SA.

This report is for distribution only under such circumstances as may be permitted by applicable law. Nothing in this report constitutes a representation that any investment strategy or recommendation contained herein is suitable or appropriate to a recipient's individual circumstances or otherwise constitutes a personal recommendation. It is published solely for information purposes, it does not constitute an advertisement and is not to be construed as a solicitation or an offer to buy or sell any securities or related financial instruments in any jurisdiction. No representation or warranty, either express or implied, is provided in relation to the accuracy, completeness or reliability of the information contained herein, except with respect to information concerning UBS AG, its subsidiaries and affiliates, nor is it intended to be a complete statement or summary of the securities, markets or developments referred to in the report. UBS does not undertake that investors will obtain profits, nor will it share with investors any investment profits nor accept any liability for any investment losses. Investments involve risks and investors should exercise prudence in making their investment decisions. The report should not be regarded by recipients as a substitute for the exercise of their own judgement. Past performance is not necessarily a guide to future performance. The value of any investment or income may go down as well as up and you may not get back the full amount invested. Any opinions expressed in this report are subject to change without notice and may differ or be contrary to opinions expressed by other business areas or groups of UBS as a result of using different assumptions and criteria. Research will initiate, update and cease coverage solely at the discretion of UBS Investment Bank Research Management. The analysis contained herein is based on numerous assumptions. Different assumptions could result in materially different results. The analyst(s) responsible for the preparation of this report may interact with trading desk personnel, sales personnel and other constituencies for the purpose of gathering, synthesizing and interpreting market information. UBS is under no obligation to update or keep current the information contained herein. UBS relies on information barriers to control the flow of information contained in one or more areas within UBS, into other areas, units, groups or affiliates of UBS. The compensation of the analyst who prepared this report is determined exclusively by research management and senior management (not including investment banking). Analyst compensation is not based on investment banking revenues, however, compensation may relate to the revenues of UBS Investment Bank as a whole, of which investment banking, sales and trading are a part.

The securities described herein may not be eligible for sale in all jurisdictions or to certain categories of investors. Options, derivative products and futures are not suitable for all investors, and trading in these instruments is considered risky. Mortgage and asset-backed securities may involve a high degree of risk and may be highly volatile in response to fluctuations in interest rates and other market conditions. Past performance is not necessarily indicative of future results. Foreign currency rates of exchange may adversely affect the value, price or income of any security or related instrument mentioned in this report. For investment advice, trade execution or other enquiries, clients should contact their local sales representative. Neither UBS nor any of its affiliates, nor any of UBS' or any of its affiliates, directors, employees or agents accepts any liability for any loss or damage arising out of the use of all or any part of this report. For financial instruments admitted to trading on an EU regulated market: UBS AG, its affiliates or subsidiaries (excluding UBS Securities LLC and/or UBS Capital Markets LP) acts as a market maker or liquidity provider (in accordance with the interpretation of these terms in the UK) in the financial instruments of the issuer save that where the activity of liquidity provider is carried out in accordance with the definition given to it by the laws and regulations of any other EU jurisdictions, such information is separately disclosed in this research report. UBS and its affiliates and employees may have long or short positions, trade as principal and buy and sell in instruments or derivatives identified herein.

Any prices stated in this report are for information purposes only and do not represent valuations for individual securities or other instruments. There is no representation that any transaction can or could have been effected at those prices and any prices do not necessarily reflect UBS's internal books and records or theoretical model-based valuations and may be based on certain assumptions. Different assumptions, by UBS or any other source, may yield substantially different results.

United Kingdom and the rest of Europe: Except as otherwise specified herein, this material is communicated by UBS Limited, a subsidiary of UBS AG, to persons who are eligible counterparties or professional clients and is only available to such persons. The information contained herein does not apply to, and should not be relied upon by, retail clients. UBS Limited is authorised and regulated by the Financial Services Authority (FSA). UBS research complies with all the FSA requirements and laws concerning disclosures and these are indicated on the research where applicable. **France:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities France SA. UBS Securities France S.A. is regulated by the Autorité des Marchés Financiers (AMF). Where an analyst of UBS Securities France S.A. has contributed to this report, the report is also deemed to have been prepared by UBS Securities France S.A. **Germany:** Prepared by UBS Limited and distributed by UBS Limited and UBS Deutschland AG. UBS Deutschland AG is regulated by the Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin). **Spain:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities España SV, SA. UBS Securities España SV, SA is regulated by the Comisión Nacional del Mercado de Valores (CNMV). **Turkey:** Prepared by UBS Menkul Değerler AS on behalf of and distributed by UBS Limited. **Russia:** Prepared and distributed by UBS Securities CJSC. **Switzerland:** Distributed by UBS AG to persons who are institutional investors only. **Italy:** Prepared by UBS Limited and distributed by UBS Limited and UBS Italia Sim S.p.A.. UBS Italia Sim S.p.A. is regulated by the Bank of Italy and by the Commissione Nazionale per le Società e la Borsa (CONSOB). Where an analyst of UBS Italia Sim S.p.A. has contributed to this report, the report is also deemed to have been prepared by UBS Italia Sim S.p.A.. **South Africa:** UBS South Africa (Pty) Limited (Registration No. 1995/011140/07) is a member of the JSE Limited, the South African Futures Exchange and the Bond Exchange of South Africa. UBS South Africa (Pty) Limited is an authorised Financial Services Provider. Details of its postal and physical address and a list of its directors are available on request or may be accessed at <http://www.ubs.co.za>. **United States:** Distributed to US persons by either UBS Securities LLC or by UBS Financial Services Inc., subsidiaries of UBS AG; or by a group, subsidiary or affiliate of UBS AG that is not registered as a US broker-dealer (a "non-US affiliate"), to major US institutional investors only. UBS Securities LLC or UBS Financial Services Inc. accepts responsibility for the content of a report prepared by another non-US affiliate when distributed to US persons by UBS Securities LLC or UBS Financial Services Inc. All transactions by a US person in the securities mentioned in this report must be effected through UBS Securities LLC or UBS Financial Services Inc., and not through a non-US affiliate. **Canada:** Distributed by UBS Securities Canada Inc., a subsidiary of UBS AG and a member of the principal Canadian stock exchanges & CIPF. A statement of its financial condition and a list of its directors and senior officers will be provided upon request. **Hong Kong:** Distributed by UBS Securities Asia Limited. **Singapore:** Distributed by UBS Securities Pte. Ltd [mica (p) 039/11/2009 and Co. Reg. No.: 198500648C] or UBS AG, Singapore Branch. Please contact UBS Securities Pte Ltd, an exempt financial advisor under the Singapore Financial Advisers Act (Cap. 110); or UBS AG Singapore branch, an exempt financial adviser under the Singapore Financial Advisers Act (Cap. 110) and a wholesale bank licensed under the Singapore Banking Act (Cap. 19) regulated by the Monetary Authority of Singapore, in respect of any matters arising from, or in connection with, the analysis or report. The recipient of this report represent and warrant that they are accredited and institutional investors as defined in the Securities and Futures Act (Cap. 289). **Japan:** Distributed by UBS Securities Japan Ltd to institutional investors only. Where this report has been prepared by UBS Securities Japan Ltd, UBS Securities Japan Ltd is the author, publisher and distributor of the report. **Australia:** Distributed by UBS AG (Holder of Australian Financial Services License No. 231087) and UBS Securities Australia Ltd (Holder of Australian Financial Services License No. 231098) only to 'Wholesale' clients as defined by s761G of the Corporations Act 2001. **New Zealand:** Distributed by UBS New Zealand Ltd. An investment adviser and investment broker disclosure statement is available on request and free of charge by writing to PO Box 45, Auckland, NZ. **Dubai:** The research prepared and distributed by UBS AG Dubai Branch, is intended for Professional Clients only and is not for further distribution within the United Arab Emirates. **Korea:** Distributed in Korea by UBS Securities Pte. Ltd., Seoul Branch. This report may have been edited or contributed to from time to time by affiliates of UBS Securities Pte. Ltd., Seoul Branch. **Malaysia:** This material is authorized to be distributed in Malaysia by UBS Securities Malaysia Sdn. Bhd (253825-x). **India :** Prepared by UBS Securities India Private Ltd. 2/F, 2 North Avenue, Maker Maxity, Bandra Kurla Complex, Bandra (East), Mumbai (India) 400051. Phone: +912261556000 SEBI Registration Numbers: NSE (Capital Market Segment): INB230951431, NSE (F&O Segment) INF230951431, BSE (Capital Market Segment) INB010951437.

The disclosures contained in research reports produced by UBS Limited shall be governed by and construed in accordance with English law.

UBS specifically prohibits the redistribution of this material in whole or in part without the written permission of UBS and UBS accepts no liability whatsoever for the actions of third parties in this respect. Images may depict objects or elements which are protected by third party copyright, trademarks and other intellectual property rights. © UBS 2011. The key symbol and UBS are among the registered and unregistered trademarks of UBS. All rights reserved.



Source: Disease component from Exhibit 4 (August 26, 2008); base risk score from Exhibit 2								
Rate of Increase in Risk Scores and Disease Components of Risk Scores for								

Exhibit 1. Average Risk Scores for Beneficiaries in FFS and MA on July 1, 2004-2008

	Fee-for-Service			Medicare Advantage			Difference between MA and FFS in
	Number of Beneficiaries	Average Risk Score	Change from previous year	Number of Beneficiaries	Average Risk Score	Change from previous year	Amount of change
July, 2004	32,886,165	1.046		4,898,117	0.944		
July, 2005	32,993,880	1.064	0.018	5,332,034	0.986	0.042	0.024
July, 2006	31,911,561	1.085	0.021	7,046,689	1.022	0.036	0.015
July, 2007	31,346,146	1.102	0.017	8,298,334	1.060	0.038	0.021
July, 2008	30,919,077	1.116	0.014	9,625,446	1.104	0.044	0.030
Annual average			0.018			0.040	0.023

Notes:

Average risk scores calculated for July cohort from each year.

PACE and PFFS plans are included in the "MA" category.

Cost plans, ESRD beneficiaries, and hospice beneficiaries are excluded.

Diagnoses with a source of diagnostic radiology are included in the FFS risk score calculations.

Exhibit 2. Caseload Dynamics in MA and FFS, averages for four cohorts from 2004-05 to 2007-08

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	FFS	MA	Year 1	Year 2	Year 1	Year 2	FFS	MA	Difference
Stayers	91.7%	84.5%	1.03	1.12	0.96	1.07	0.080	0.095	0.015
Change in Risk Score for stayers				0.088		0.112			
Leavers									
Deceased	4.3%	3.7%	1.94		1.80		-0.037	-0.026	0.011
Hospice	0.5%	0.5%	1.85		1.73		-0.004	-0.003	0.001
ESRD	0.1%	0.1%	2.39		2.36		-0.002	-0.001	0.000
Other	0.4%	0.2%	0.75		0.86		0.001	0.000	-0.001
Subtotal	5.3%	4.5%	1.85		1.77		-0.041	-0.031	0.010
Joiners									
New eligible/other	6.9%	6.1%		0.69		0.66	-0.027	-0.024	0.003
Switchers									
Out to other sector	3.8%	3.9%	0.96		1.10		0.005	-0.002	-0.007
In from other sector	0.7%	15.8%		1.28		1.04	0.001	0.003	0.002
Subtotal							0.006	0.000	-0.006
Total			1.074	1.092	1.003	1.043	0.018	0.040	0.022

Note: Data in the table summarizes results from four cohorts: 2004-05, 2005-06, 2006-07, and 2007-08, and presents simple averages. Results for each cohort separately are shown in Exhibits A1-A4. Distribution percentages for stayers are calculated with the denominator enrollees in July from year 1 and year 2 of the cohort. Percentages for Leavers and Switchers-Out are calculated with year 1 enrollment as the denominator. Switchers-In with year 2 enrollment as the denominator. As a result, percentages do not add to 100%. Contribution to change in risk scores is shown in Appendix A.

Exhibit 3. Increase in disease scores for stayers, 2004-05 to 2007-08, MA and FFS

	2004-05		2005-06		2006-07		2007-08		Average Year-to-Year Increase in Disease Component of Risk Score
	<u>N</u>	<u>Year-to-Year Increase in Disease Component of Risk Score</u>	<u>N</u>	<u>Year-to-Year Increase in Disease Component of Risk Score</u>	<u>N</u>	<u>Year-to-Year Increase in Disease Component of Risk Score</u>	<u>N</u>	<u>Year-to-Year Increase in Disease Component of Risk Score</u>	
<u>2004-2005</u>									
MCOs	3,342,980	0.083	3,307,658	0.086	3,416,211	0.1	4,113,231	0.104	0.093
FFS	26,262,735	0.066	25,320,358	0.069	24,693,331	0.070	24,191,472	0.065	0.068
Difference		0.017		0.017		0.03		0.039	0.026
Difference controlling for age and survivor status		0.015		0.015		0.026		0.037	0.023

In each cohort, beneficiaries are restricted to stayers who were in the community in both July of year 1 and of year 2, who were in the same sector source for the risk score was either entirely FFS or entirely from a single MA contract. Adjustment for age and survivor status as described in Appendix

Exhibit 4. Distribution of Complicated and Uncomplicated Diabetes, MA and FFS, 2004-05 through 2007-08

		2004-05 cohort		2005-06 cohort		2006-07 cohort		2007-08 cohort	
		<u>2004</u>	<u>2005</u>	<u>2005</u>	<u>2006</u>	<u>2006</u>	<u>2007</u>	<u>2007</u>	<u>2008</u>
FFS	HCC19 Diabetes with Renal or Peripheral Circulatory Man	11.0%	12.7%	11.1%	12.8%	11.4%	13.1%	11.7%	13.4%
	HCC16 Diabetes with Ophthalmologic Manifestation	12.1%	13.1%	12.1%	13.3%	12.5%	13.7%	12.9%	13.8%
	HCC17 Diabetes with Acute Complications	0.9%	0.8%	0.8%	0.7%	0.7%	0.6%	0.6%	0.6%
	HCC18 Diabetes with Neurologic Manifestation	8.4%	8.4%	8.3%	8.2%	8.0%	7.9%	7.8%	7.8%
	HCC19 Diabetes without Complications	<u>67.6%</u>	<u>65.0%</u>	<u>67.8%</u>	<u>65.1%</u>	<u>67.4%</u>	<u>64.7%</u>	<u>66.9%</u>	<u>64.4%</u>
	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
MA	HCC19 Diabetes with Renal or Peripheral Circulatory Man	11.9%	17.1%	15.3%	20.6%	18.5%	24.3%	20.6%	25.0%
	HCC16 Diabetes with Ophthalmologic Manifestation	10.8%	12.4%	11.6%	13.4%	12.6%	13.8%	13.2%	14.2%
	HCC17 Diabetes with Acute Complications	0.8%	0.7%	0.7%	0.6%	0.6%	0.4%	0.5%	0.4%
	HCC18 Diabetes with Neurologic Manifestation	8.5%	8.4%	8.2%	7.9%	7.7%	7.4%	7.4%	7.2%
	HCC19 Diabetes without Complications	<u>67.9%</u>	<u>61.5%</u>	<u>64.3%</u>	<u>57.7%</u>	<u>60.6%</u>	<u>54.0%</u>	<u>58.3%</u>	<u>53.1%</u>
	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Cohorts are defined as in Exhibit 3 -- beneficiaries are restricted to community-based stayers with consistent data sources -- and are further restricted to beneficiaries with HCC 19 in both the first and second years of the cohort.

The CMS-HCC model contains a hierarchy of 5 diabetes HCCs: beneficiaries are assigned the most severe level of diabetes reported in the data collection year.

Exhibit 5. Persistence within disease groups, MA and FFS, 2004-05 to 2007-08

<u>Disease Group</u>	2004-05 Cohort			2005-06 Cohort			2006-07 Cohort			2007-08 Cohort		
	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
Coronary Artery Disease	42.1%	46.7%	4.5%	40.9%	49.3%	8.4%	40.5%	54.2%	13.6%	40.5%	56.3%	15.8%
Cancer	74.6%	72.4%	-2.2%	75.0%	73.2%	-1.8%	75.5%	73.0%	-2.4%	75.8%	73.9%	-1.9%
Cerebrovascular Disease	41.1%	41.5%	0.4%	40.8%	43.0%	2.2%	41.1%	44.6%	3.6%	41.2%	46.5%	5.2%
Diabetes	87.1%	88.6%	1.6%	87.0%	88.7%	1.7%	86.9%	88.8%	1.9%	86.9%	89.4%	2.5%
Liver	54.2%	58.0%	3.8%	54.4%	59.0%	4.6%	55.1%	61.5%	6.4%	55.9%	64.8%	8.9%
Paralysis	31.7%	28.9%	-2.7%	32.0%	32.6%	0.6%	31.9%	34.6%	2.7%	32.0%	36.8%	4.8%
Renal	50.4%	51.8%	1.3%	52.9%	57.1%	4.2%	57.8%	66.8%	9.0%	58.3%	71.2%	12.9%
Weighted average			1.1%			2.3%			3.7%			5.0%

Note: The denominator for each statistic is the number of beneficiaries in the cohort who were coded with an HCC in the disease group in year 1 of the cohort. The numerator is the number of beneficiaries coded in that disease group in year 2 of the cohort.

Analysis is limited to stayers with community risk scores and consistent data sources (as in Exhibit 3).

Weighted average is weighted by the number of FFS beneficiaries in the disease group in year 1 of the cohort.

Disease groups are sets of HCCs in the CMS-HCC model that are hierarchically related, that is, beneficiaries are assigned the most severe disease if more than one HCC is reported during the data collection period. The HCCs in each hierarchy are: CAD, HCCs 81-83; Cancer, HCCs 7-10; CVD, HCCs 95, 96, 100, 101; Diabetes, HCCs 15-19;

Exhibit 6. New Incidence of diagnoses within disease groups, MA and FFS, 2004-05 to 2007-08

<u>Disease Group</u>	2004-05 Cohort			2005-06 Cohort			2006-07 Cohort			2007-08 Cohort		
	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
Coronary Artery Disease	6.1%	5.7%	-0.4%	5.8%	5.6%	-0.2%	5.6%	5.8%	0.2%	5.4%	5.6%	0.1%
Cancer	3.8%	4.1%	0.3%	3.8%	4.2%	0.3%	3.9%	4.0%	0.2%	3.9%	4.1%	0.2%
Cerebrovascular Disease	3.0%	2.6%	-0.4%	2.9%	2.6%	-0.3%	2.9%	2.5%	-0.4%	2.9%	2.5%	-0.4%
Diabetes	5.1%	5.1%	0.0%	5.2%	5.0%	-0.2%	5.4%	5.2%	-0.1%	5.4%	5.8%	0.4%
Liver	0.4%	0.4%	-0.1%	0.4%	0.3%	-0.1%	0.4%	0.4%	-0.1%	0.4%	0.4%	0.0%
Paralysis	1.5%	1.2%	-0.3%	1.6%	1.3%	-0.2%	1.6%	1.3%	-0.3%	1.6%	1.3%	-0.3%
Renal	2.4%	2.6%	0.3%	2.7%	3.4%	0.6%	3.6%	5.7%	2.1%	3.7%	5.9%	2.2%
Other	13.4%	12.0%	-1.3%	13.6%	12.5%	-1.1%	13.6%	12.5%	-1.1%	13.6%	12.9%	-0.7%
Total	35.6%	33.8%	-1.8%	36.0%	34.9%	-1.2%	36.9%	37.3%	0.4%	36.8%	38.4%	1.5%

Note: The numerator for each statistic is the number of beneficiaries in the cohort who were coded with an HCC in the disease group in year 2 of the cohort who were not coded in the disease group in year 1 -- that is, the 'at risk' group. Analysis is limited to stayers with consistent data sources (as in Exhibit 3).

Disease groups are sets of HCCs in the CMS-HCC model that are hierarchically related, that is, beneficiaries are assigned the most severe disease if more than one HCC is reported during the data collection period. The HCCs in each hierarchy are: CAD, HCCs 81-83: Cancer, HCCs 7-10: CVD, HCCs 95, 96, 100, 101: Diabetes, HCCs 15-19: Other includes HCCs that are in partial hierarchies: HCCs 5, 51, 52, 54, 55, 77-79, 104, 105, 107, 108, 111, 112, 148, 149, 154, 155, 161, 177.

Exhibit 7. Disease score changes among continuously enrolled beneficiaries, 2004-2008

Year-to-year change in Disease Score

	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
2004-05	0.046	0.063	0.017
2005-06	0.053	0.072	0.019
2006-07	0.064	0.094	0.030
2007-08	0.069	0.115	0.046
Cumulative	0.232	0.344	0.112
Average Annual Change	0.058	0.086	0.028
N	18,850,283	2,250,622	

Note: Beneficiaries are included in the analysis if they were enrolled in a Medicare plan (or in FFS) in July of each year from 2004 through 2008, if they were U.S. residents in each year, and if all of the diagnostic data contributing to the disease score came from either FFS or from a single MA plan.

Exhibit 8. Annual average difference between increase in disease score in MA plans and increase in FFS, 2004-05 to 2007-08 cohorts, distribution across plans

<u>Percentile</u>	Annual average difference between increase in disease score for stayers and increase for comparable FFS beneficiaries
90th	0.062
75th	0.040
Median	0.019
25th	0.001
10th	-0.005
Mean	0.025
Average N	3,388,560

Note: 10% of MA-enrolled beneficiaries are in MA plans in which disease scores for stayers increased by at least 0.062 per year more quickly than for comparable beneficiaries in FFS. 25% of MA-enrolled beneficiaries are in plans in which disease scores for stayers increased, on average, by at least 0.04 more quickly than comparable beneficiaries in FFS. The weighted mean across all plans is 0.025, indicating that, on average, disease scores in MA plans increase by 0.025 per year more quickly than in FFS. The percentile distribution is weighted by the average number of stayers in the plans (averaged across the four cohorts from 2004-05 to 2007-08). MA plans are included in this analysis if they were continually under contract with Medicare from 2004 through 2008. In each cohort, stayers are included in the analysis if they were included in the analysis in Exhibit 3.

9. Annual average difference between increase in disease score in MA plans and increase 2004-05 to 2007-08 cohorts, 15 largest MA contracts

<u>Plan</u>	<u>Annual average difference in amount of increase in disease score between MA stayers and comparable FFS stayers</u>
A	0.087
B	0.086
C	0.046
D	0.040
E	0.036
F	0.030
G	0.015
H	0.010
I	0.008
J	0.001
K	0.000
L	0.000
M	0.000
N	-0.010
O	-0.020

Note: Statistic is calculated as in Exhibit 7. Data are sorted by size of difference. Each of an average of at least 42,000 stayers per cohort.

Exhibit A1. Caseload Dynamics in MA and FFS, 2004-05

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	<u>FFS</u>	<u>MA</u>	<u>2004</u>	<u>2005</u>	<u>2004</u>	<u>2005</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
Stayers	30,574,973	4,518,986	1.005	1.090	0.905	1.009	0.079	0.092	0.013
Change in Risk Score for stayers				0.085		0.104			
Leavers									
Deceased	1,451,111	189,984	1.880		1.683		-0.036	-0.027	0.010
Hospice	151,322	25,159	1.798		1.599		-0.003	-0.003	0.000
ESRD	41,283	5,760	2.297		2.203		-0.002	-0.001	0.000
Other	133,149	7,947	0.801		0.827		0.001	0.000	-0.001
Subtotal	1,776,865	228,850	1.802		1.657		-0.040	-0.031	0.009
Joiners									
New eligible/other	2,268,626	278,721		0.690		0.647	-0.025	-0.017	0.008
Switchers									
Out to other sector	534,327	150,281	0.885		1.022		0.003	-0.002	-0.004
In from other sector	150,281	534,327		1.220		0.968	0.001	0.000	0.000
Subtotal							0.004	-0.001	-0.005
Total			1.045	1.063	0.944	0.986	0.017	0.042	0.025

Average contribution to change in risk scores calculated as described in Appendix A.

Exhibit A2. Caseload Dynamics in MA and FFS, 2005-06

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	<u>FFS</u>	<u>MA</u>	<u>2005</u>	<u>2006</u>	<u>2005</u>	<u>2006</u>	<u>2005</u>	<u>2006</u>	<u>Difference</u>
Stayers	29,539,146	4,909,704	1.025	1.112	0.945	1.054	0.079	0.086	0.007
Change in Risk Score for stayers				0.087		0.109			
Leavers									
Deceased	1,404,142	201,209	1.915		1.760		-0.036	-0.025	0.012
Hospice	166,206	28,345	1.824		1.695		-0.004	-0.003	0.001
ESRD	42,331	6,240	2.351		2.320		-0.002	-0.001	0.000
Other	141,358	12,796	0.728		0.880		0.002	0.000	-0.001
Subtotal	1,754,037	248,590	1.821		1.721		-0.040	-0.029	0.012
Joiners									
New eligible/other	2,198,675	436,288		0.700		0.675	-0.025	-0.023	0.002
Switchers									
Out to other sector	1,700,697	173,740	0.945		1.099		0.007	-0.003	-0.009
In from other sector	173,740	1,700,697		1.273		1.020	0.001	0.004	0.003
Subtotal							0.008	0.002	-0.006
Total			1.061	1.084	0.986	1.022	0.021	0.036	0.015

Average contribution to change in risk scores calculated as described in Appendix A.

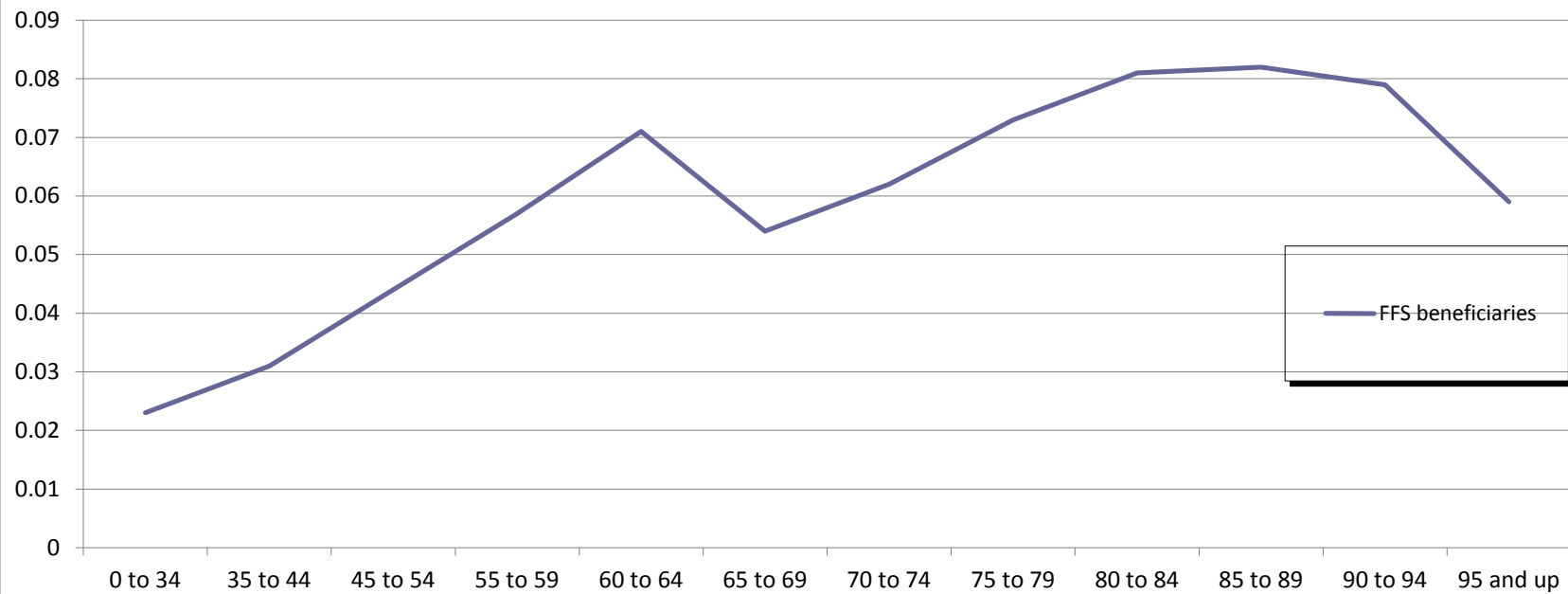
Exhibit A3. Caseload Dynamics in MA and FFS, 2006-07

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	<u>FFS</u>	<u>MA</u>	<u>2006</u>	<u>2007</u>	<u>2006</u>	<u>2007</u>	<u>2006</u>	<u>2007</u>	<u>Difference</u>
Stayers	28,928,146	6,489,357	1.043	1.132	0.981	1.092	0.081	0.094	0.012
Change in Risk Score for stayers				0.089		0.111			
Leavers									
Deceased	1,349,740	250,619	1.960		1.830		-0.037	-0.026	0.011
Hospice	170,986	37,705	1.859		1.772		-0.004	-0.004	0.001
ESRD	40,594	8,734	2.436		2.389		-0.002	-0.002	0.000
Other	122,044	11,304	0.728		0.867		0.001	0.000	-0.001
Subtotal	1,683,364	308,362	1.872		1.803		-0.041	-0.031	0.011
Joiners									
New eligible/other	2,168,614	512,459		0.686		0.646	-0.028	-0.026	0.002
Switchers									
Out to other sector	1,296,518	249,386	0.983		1.117		0.005	-0.002	-0.007
In from other sector	249,386	1,296,518		1.262		1.065	0.001	0.004	0.003
Subtotal							0.006	0.002	-0.004
Total			1.082	1.102	1.022	1.060	0.018	0.038	0.021

Average contribution to change in risk scores calculated as described in Appendix A.

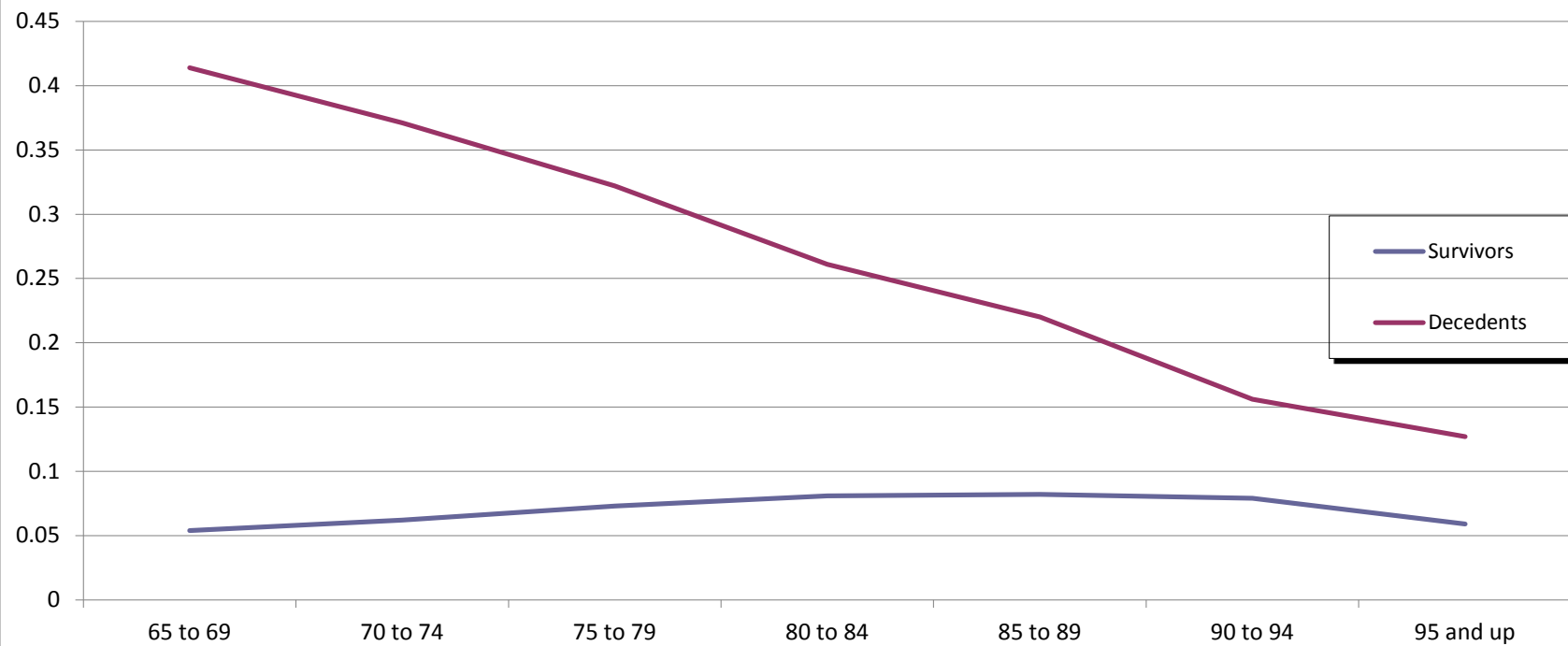
Exhibit A4. Caseload Dynamics in MA and FFS, 2007-08												
				Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
				FFS	MA	2007	2008	2007	2008	2007	2008	Difference
Stayers				28,380,166	7,675,815	1.059	1.148	1.017	1.142	0.081	0.107	0.026
Change in Risk Score for stayers							0.089		0.125			
Leavers												
Deceased				1,328,536	293,553	1.999		1.920		-0.038	-0.027	0.011
Hospice				171,239	44,793	1.900		1.842		-0.004	-0.004	0.001
ESRD				39,659	10,242	2.471		2.521		-0.002	-0.002	0.000
Other				122,097	12,760	0.732		0.858		0.001	0.000	-0.001
Subtotal				1,661,531	361,348	1.907		1.890		-0.043	-0.033	0.010
Joiners												
New eligible/other				2,277,740	645,182		0.686		0.665	-0.030	-0.030	0.000
Switchers												
Out to other sector				1,304,449	261,171	1.009		1.180		0.004	-0.003	-0.007
In from other sector				261,171	1,304,449		1.348		1.100	0.002	0.003	0.001
Subtotal										0.007	0.000	-0.008
Total						1.100	1.117	1.060	1.104	0.016	0.044	0.028
Average contribution to change in risk scores calculated as described in Appendix A.												

Ex. B1: Change in disease score, 2005-06, among FFS stayers who survived until at least 12/31/06, by age group

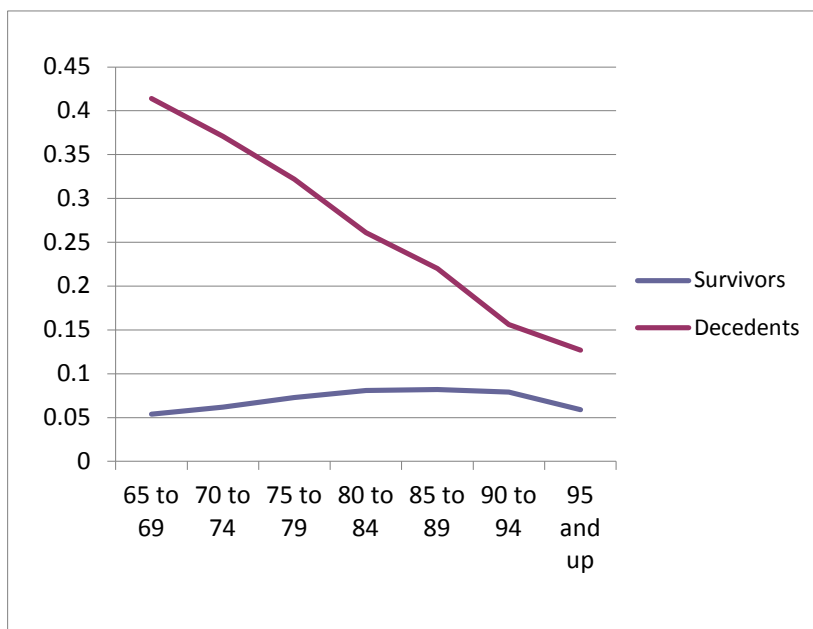


Note: Age group as assigned in the 2005 risk score.

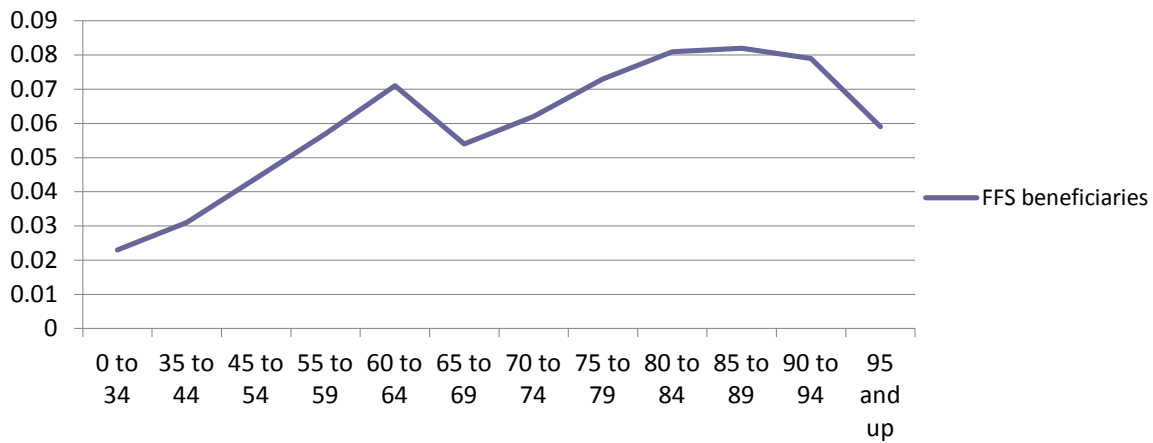
Ex. B2: Change in disease score, 2005-2006, among FFS stayers, by age group and survivor status



0 to 34	0.023	0.27
35 to 44	0.031	0.301
45 to 54	0.044	0.324
55 to 59	0.057	0.36
60 to 64	0.071	0.397
65 to 69	0.054	0.414
70 to 74	0.062	0.371
75 to 79	0.073	0.322
80 to 84	0.081	0.261
85 to 89	0.082	0.22
90 to 94	0.079	0.156
95 and up	0.059	0.127

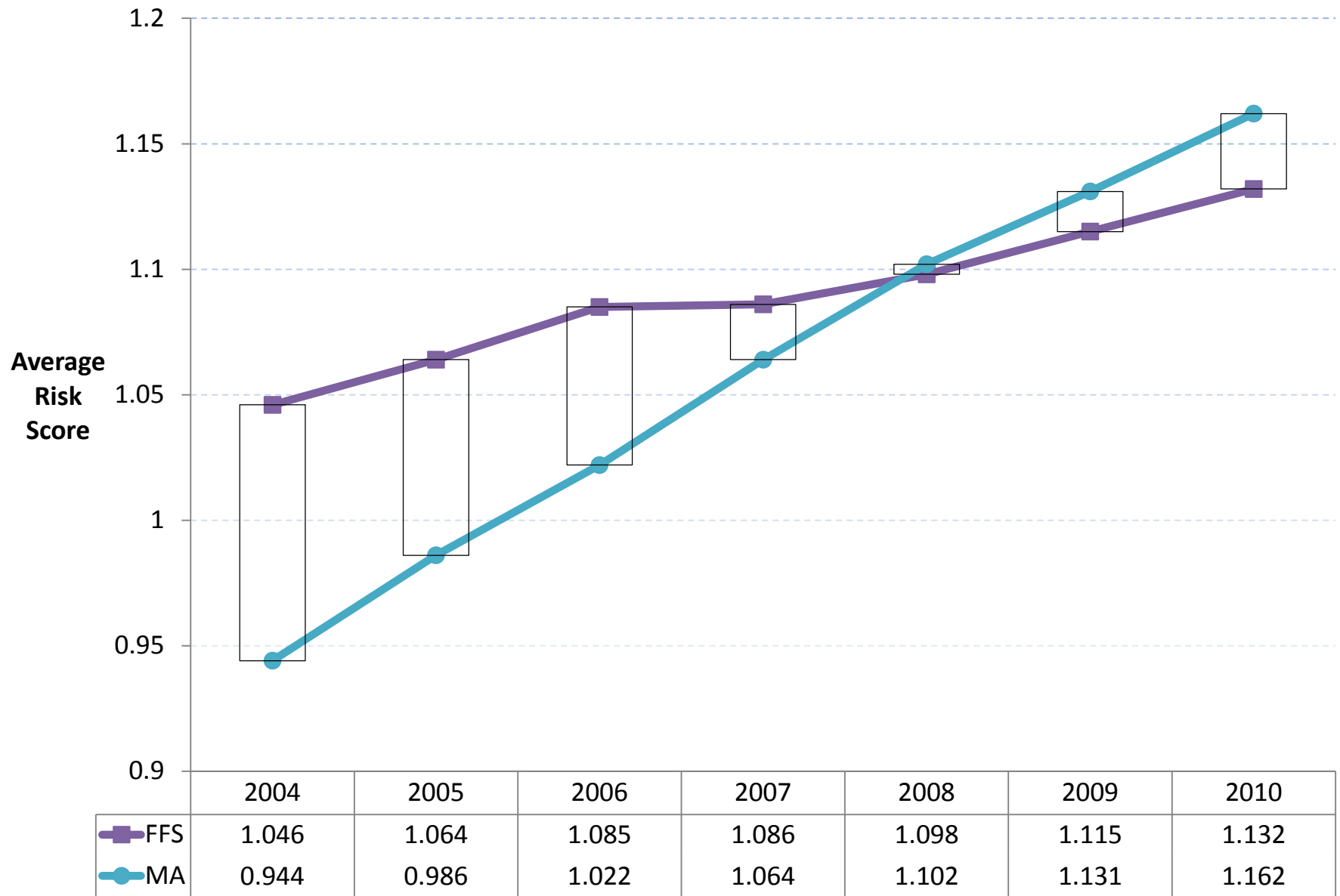


Change in disease score, 2005-06, among FFS stayers who survived until at least 12/31/06, by 2005 age group



Average Risk Scores for Beneficiaries in FFS vs. MA

(CMS-HCC Model V12 Calibrated Using 04-05 Data)



	FFS	MA	FFS	MA
2004	32.9	4.9	1.046	0.944
2005	33.0	5.3	1.064	0.986
2006	31.9	7.0	1.085	1.022
2007	31.3	8.3	1.086	1.064
2008	31.3	8.3	1.098	1.102
2009	30.9	9.6	1.115	1.131
2010	30.8	10.7	1.132	1.162

Note: 2006 and prior includes DR, 2007 and after excludes DR

Total Change in Risk Scores 2010 vs.	0.086	0.218
Difference of Total Change in Risk Scores (MA - FFS)		0.132

Exhibit 1 HCC Model 2004-2006
 Average Risk Scores for Beneficiaries
 in FFS and MCOs on July 1, 2004-
 2010
 2007a is with DR, 2007b is without
 DR

	Enrollment Status					
	Cost		FFS		MCO	
	Number of Beneficiaries	Average Risk Score	Number of Beneficiaries	Average Risk Score	Number of Beneficiaries	Average Risk Score
July, 2004	425,853	0.892	32,880,866	1.046	4,897,670	0.944
July, 2005	421,209	0.995	32,988,751	1.064	5,331,447	0.986
July, 2006	398,690	1.022	31,906,746	1.085	7,046,613	1.022
July, 2007a	380,700	1.044	31,341,475	1.106	8,302,930	1.067
July, 2007b	380,700	1.039	31,341,475	1.086	8,302,930	1.064
July, 2008	340,342	1.043	30,914,906	1.098	9,631,821	1.102
July, 2009	349,876	1.037	30,777,380	1.115	10,667,856	1.131
July, 2010	388,227	1.026	31,120,730	1.132	11,208,212	1.162

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group

Exhibit 1 HCC Model 2004-2006
Average Risk Scores for Beneficiaries in FFS and MCOs on July 1, 2004-2010
2007a is with DR, 2007b is without DR

	Enrollment Status					
	Cost		FFS		MCO	
	Number of Beneficiaries	Average Risk Score	Number of Beneficiaries	Average Risk Score	Number of Beneficiaries	Average Risk Score
July, 2004	425,853	0.892	32,880,866	1.046	4,897,670	0.944
July, 2005	421,209	0.995	32,988,751	1.064	5,331,447	0.986
July, 2006	398,690	1.022	31,906,746	1.085	7,046,613	1.022
July, 2007a	380,700	1.044	31,341,475	1.106	8,302,930	1.067
July, 2007b	380,700	1.039	31,341,475	1.086	8,302,930	1.064
July, 2008	340,342	1.043	30,914,906	1.098	9,631,821	1.102
July, 2009	349,876	1.037	30,777,380	1.115	10,667,856	1.131
July, 2010	388,227	1.026	31,120,730	1.132	11,208,212	1.162

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group

Exhibit 1 HCC Model 2004-2006
Average Risk Scores for Beneficiaries in FFS and MCOs on July 1,

	Enrollment Status			
	FFS		MCO	
	Number of Beneficiaries	Average Risk Score	Number of Beneficiaries	Average Risk Score
July, 2004	32,880,866	1.046	4,897,670	0.944
July, 2005	32,988,751	1.064	5,331,447	0.986
July, 2006	31,906,746	1.085	7,046,613	1.022
July, 2007a	31,341,475	1.106	8,302,930	1.067
July, 2007b	31,341,475	1.086	8,302,930	1.064
July, 2008	30,914,906	1.098	9,631,821	1.102
July, 2009	30,777,380	1.115	10,667,856	1.131
July, 2010	31,120,730	1.132	11,208,212	1.162

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group
2007a is with DR, 2007b is without DR

					Ex 1 Diff	Ex 2 Diff	Ex 4 Diff
2004-2005	107,885	0.018	433,777	0.042	0.024	0.019	
2005-2006	-1,082,005	0.021	1,715,166	0.036	0.015	0.021	
2006-2007	-565,271	0.021	1,256,317	0.045	0.024	0.046	
2007-2008	-426,569	0.012	1,328,891	0.038	0.026	0.037	
2008-2009	-137,526	0.017	1,036,035	0.029	0.012	0.032	
2009-2010	343,350	0.017	540,356	0.031	0.014	0.03	

Exhibit 2 HCC Model 2004-2006

Contribution of Stayers, Leavers (ineligibles and switchers separately), and Joiners (ineligibles and switchers separately) to the Difference in Growth between MCO and FFS Risk Scores

		FFS			MCO			FFS Diff	MA Diff	DIFF
		Number of Beneficiaries	Average Risk	Average Risk	Number of Beneficiaries	Average Risk	Average Risk			
			Score 04	Score 05		Score 04	Score 05			
Joiners from	A only/B only	402,346	.	0.82	45,681	.	0.74			
	Cost	10,606	0.88	1.062	15,752	0.799	0.96			
	ESRD	1,841	.	3.662	165	.	4.433			
	FFS	.	.	.	534,268	0.885	0.968			
	Hospice	16,008	.	2.202	2,125	.	2.111			
	MCO	150,275	1.022	1.22	.	.	.			
	Other	1,836,996	.	0.643	214,862	.	0.587			
Leavers to	A only/B only	85,796	0.704	.	3,863	0.765	.			
	Cost	27,009	1.191	1.292	3,430	0.917	1.023			
	Deceased	1,450,969	1.879	.	189,950	1.683	.			
	ESRD	41,442	2.298	.	5,812	2.202	.			
	FFS	.	.	.	150,275	1.022	1.22			
	Hospice	151,087	1.801	.	25,113	1.605	.			
	MCO	534,268	0.885	0.968	.	.	.			
	Other	19,616	0.693	.	633	0.714	.			
Stayers		30,570,679	1.005	1.091	4,518,594	0.905	1.01	0.086	0.105	0.019

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group

Note: 2006/2007 Data has diagnostic radiology; 2007/2008 does not

Exhibit 2 HCC Model 2004-2006

Contribution of Stayers, Leavers (ineligibles and switchers separately), and Joiners (ineligibles and switchers separately) to the Difference in Growth between MCO and FFS Risk Scores

		FFS			MCO			FFS Diff	MA Diff	DIFF
		Number of Beneficiaries	Average Risk	Average Risk	Number of Beneficiaries	Average Risk	Average Risk			
			Score 05	Score 06		Score 05	Score 06			
Joiners from	A only/B only	390,418	.	0.812	79,478	.	0.75			
	Cost	21,697	1.581	1.741	26,090	0.903	1.035			
	ESRD	1,947	.	3.769	223	.	4.566			
	FFS	.	.	.	1,700,857	0.945	1.02			
	Hospice	17,405	.	2.173	3,101	.	2.232			
	MCO	173,341	1.098	1.272	.	.	.			
	Other	1,766,850	.	0.644	327,417	.	0.611			
Leavers to	A only/B only	92,793	0.692	.	4,797	0.819	.			
	Cost	26,352	0.864	0.951	7,173	0.936	1.022			
	Deceased	1,404,308	1.915	.	201,281	1.76	.			
	ESRD	42,579	2.354	.	6,350	2.32	.			
	FFS	.	.	.	173,341	1.098	1.272			
	Hospice	166,075	1.827	.	28,315	1.7	.			
	MCO	1,700,857	0.945	1.02	.	.	.			
	Other	20,699	0.709	.	743	0.73	.			
Stayers		29,535,088	1.025	1.112	4,909,447	0.945	1.053	0.087	0.108	0.021

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS

Note: 2006/2007 Data has diagnostic radiology; 2007/2008 does not

Exhibit 2 HCC Model 2004-2006
Contribution of Stayers, Leavers (ineligibles and switchers separately), and Joiners (ineligibles and switchers separately) to the Difference in Growth between MCO and FFS Risk Scores

		FFS			MCO			FFS Diff	MA Diff	DIFF
		Number of Beneficiaries	Average Risk	Average Risk	Number of Beneficiaries	Average Risk	Average Risk			
			Score 06	Score 07		Score 06	Score 07			
Joiners from	A only/B only	402,209	.	0.813	88,118	.	0.746			
	Cost	11,895	0.991	1.113	15,003	0.932	1.063			
	ESRD	1,849	.	3.797	268	.	4.15			
	FFS	.	.	.	1,298,979	0.982	1.053			
	Hospice	21,128	.	2.131	4,406	.	2.268			
	MCO	247,645	1.117	1.264	.	.	.			
	Other	1,732,936	.	0.644	405,770	.	0.605			
Leavers to	A only/B only	93,929	0.706	.	7,248	0.823	.			
	Cost	12,743	0.838	0.909	2,824	0.981	1.086			
	Deceased	1,349,990	1.96	.	250,736	1.83	.			
	ESRD	40,719	2.436	.	8,788	2.391	.			
	FFS	.	.	.	247,645	1.117	1.264			
	Hospice	171,684	1.861	.	37,825	1.775	.			
	MCO	1,298,979	0.982	1.053	.	.	.			
	Other	14,889	0.777	.	1,161	0.85	.			
Stayers		28,923,813	1.043	1.114	6,490,386	0.981	1.098	0.071	0.117	0.046

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group
Note: 2006/2007 Data has diagnostic radiology; 2007/2008 does not

Exhibit 2 HCC Model 2004-2006

Contribution of Stayers, Leavers (ineligibles and switchers separately), and Joiners (ineligibles and switchers separately) to the Difference in Growth between MCO and FFS Risk Scores

		FFS			MCO			FFS Diff	MA Diff	DIFF
		Number of Beneficiaries	Average Risk	Average Risk	Number of Beneficiaries	Average Risk	Average Risk			
			Score 07	Score 08		Score 07	Score 08			
Joiners from	A only/B only	420,805	.	0.808	110,827	.	0.745			
	Cost	20,006	1.031	1.13	32,805	0.978	1.096			
	ESRD	2,049	.	3.836	330	.	4.498			
	FFS	.	.	.	1,305,459	0.998	1.083			
	Hospice	23,724	.	2.132	5,866	.	2.373			
	MCO	260,018	1.176	1.341	.	.	.			
	Other	1,816,551	.	0.641	496,421	.	0.602			
Leavers to	A only/B only	89,983	0.7	.	8,271	0.836	.			
	Cost	14,337	0.828	0.892	2,872	0.91	1.005			
	Deceased	1,329,186	1.962	.	293,973	1.921	.			
	ESRD	40,088	2.431	.	10,480	2.517	.			
	FFS	.	.	.	260,018	1.176	1.341			
	Hospice	174,679	1.862	.	45,773	1.846	.			
	MCO	1,305,459	0.998	1.083	.	.	.			
	Other	15,990	0.785	.	1,430	0.852	.			
Stayers		28,371,753	1.044	1.128	7,680,113	1.021	1.142	0.084	0.121	0.037

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group

Note: 2006/2007 Data has diagnostic radiology; 2007/2008 does not

Exhibit 2 HCC Model 2004-2006
Contribution of Stayers, Leavers (ineligibles and switchers separately), and Joiners (ineligibles and switchers separately) to the

		FFS			MCO			FFS Diff	MA Diff	DIFF
		Number of Beneficiaries	Average Risk Score 08	Average Risk Score 09	Number of Beneficiaries	Average Risk Score 08	Average Risk Score 09			
Joiners from	A only/B only	471,293		0.809	134,314		0.736			
	Cost	10,621	1.156	1.292	14,042	1.019	1.115			
	ESRD	1,884		3.887	437		4.396			
	FFS				1,082,991	0.952	1.034			
	Hospice	24,698		2.169	6,804		2.463			
	MCO	297,328	1.209	1.373						
	Other	1,738,717		0.655	510,132		0.607			
Leavers to	A only/B only	89,386	0.705		9,538	0.854				
	Cost	22,357	0.84	0.905	11,807	0.873	0.954			
	Deceased	1,258,330	1.999		326,606	2.016				
	ESRD	38,926	2.469		12,360	2.595				
	FFS				297,328	1.209	1.373			
	Hospice	176,684	1.896		53,599	1.921				
	MCO	1,082,991	0.952	1.034						
	Other	13,393	0.802		1,447	0.923				
Stayers		28,232,839	1.058	1.145	8,919,136	1.059	1.178	0.087	0.119	0.032

Note: Table assigns Chronic Care Improvement Plans (CCIPs) to the FFS group
Note: 2006/2007 Data has diagnostic radiology; 2007/2008 does not

Exhibit 2 HCC Model 2004-2006

Contribution of Stayers, Leavers (ineligibles and switchers separately), and Joiners (ineligibles and switchers separately) to the Difference in Growth between MCO and FFS Risk Scores

		FFS			MCO		
		Number of Beneficiaries	Average Risk	Average Risk	Number of Beneficiaries	Average Risk	Average Risk
			Score 09	Score 10		Score 09	Score 10
Joiners from	A only/B only	467,568	.	0.798	139,282	.	0.737
	Cost	4,671	1.153	1.295	9,519	1.09	1.215
	ESRD	1,576	.	4.057	413	.	4.843
	FFS	.	.	.	1,022,834	0.976	1.067
	Hospice	26,414	.	2.177	7,735	.	2.455
	MCO	700,790	1.134	1.249	.	.	.
	Other	1,756,506	.	0.666	511,704	.	0.622
Leavers to	A only/B only	86,369	0.719	.	10,853	0.879	.
	Cost	35,306	0.854	0.905	12,293	0.888	0.965
	Deceased	1,235,405	2.045	.	352,579	2.099	.
	ESRD	38,117	2.503	.	13,470	2.65	.
	FFS	.	.	.	700,790	1.134	1.249
	Hospice	180,404	1.941	.	59,366	2.005	.
	MCO	1,022,834	0.976	1.067	.	.	.
	Other	15,740	0.806	.	1,780	0.957	.
Stayers		28,163,205	1.074	1.163	9,516,725	1.088	1.207

Note: Table assigns Chronic Care Improvement Plans (CCIPs)

Note: 2006/2007 Data has diagnostic radiology; 2007/2008 does

FFS Diff MA Diff DIFF

0.089 0.119 0.03

File Type	Description	File Count	PII
1/75 Superset	Random sample of pre-reconciliation PDEs for the PEPV Sample	1	Yes
PDE	Contains prescription drug cost and payment data for Medicare Part D Beneficiaries.	78	No
PEMS Finder File	The PEMS Finder File provides, for each beneficiary in the LIS population, identification information, an indicator for LIS category, and the total Low Income Cost Share (LICS) paid on behalf of the beneficiary in 2009.	8	No
5% Sample		12	No
CME001	Contains an instance for each person that has applied for Medicare benefits. It includes those individuals approved for services (entitled) and those denied (non-entitled). The physical table name for this file type is CME_BENE.	7	No
CME015	Contains Medicare Beneficiary's delivery selections, MA, MA PDP or PDP, and coverage periods for the selection. Additionally other characteristics relevant to the selection are also captured. Both current and historical data are retained. The physical table name for this file type is CME_SRVC_DEL_ELCT.	6	No
CME069	Captures entries for Medicaid Dual Eligible beneficiaries that are submitted in the MMA state file and matched to the beneficiary in the CME. The physical table name for this file type is CME_DUAL_MDCR.	32	No
CME072	Identifies the Co Payment and effective and end dates for the Part D deemed beneficiary. Additionally, the source and reason, during the effective period, for this status is also identified. A beneficiary's Co Payment may change during the effective period. The physical table name for this file type is CME_DEEMD_COPMT.	5	No
CME073	Identifies a beneficiary that has been deemed through the CMS Deeming Process to receive 100% low income subsidy for Part D. The physical table name for this file type is CME_DEEMD.	4	No
CME082	Captures the enrollment periods for a beneficiary who is enrolled in either Part C (MA), Part C with Part D (MA PDP) or Part D (PDP). The physical table name for this file type is CME_PBP_ELCT.	11	No

CME085	Identifies a beneficiary that has applied and been approved for low income subsidy. Additionally the effective period for the subsidy is identified as well as additional information that relates to the subsidy determination for this period. The physical table name for this file type is CME_LIS.	1	No
First Data Bank	Contains data that is used to assign brand/generic status to a drug.	1	No
DRXDIS		1	
NCPDP		2	
Final_5per_sample (for PEPV simulation)		1	
Bene_link_key (for PEMS simulation)		1	
LICSBENES (for PELS)		1	
Sendtojon (for PEMS simulation)		1	
Cumbybene (for PELS)		1	
Cumbybene_lastweek (for PELS)		1	
Evidencing Documentation	Files that contain prescription hard copies and claim detail screenshots used by the auditors to extract payment details.	~9000	Yes
PBP Plan data (for DIR)	Data is from two primary sources - the Health Plan Management System (HPMS) Office of Financial Management (OFM) financial audits of sampled Part D sponsors from 2006 to 2009. HPMS contains administrative data and contract- and Plan Benefit Package (PBP)-level data for the population of Part D sponsors. Data fields include tax status, type of benefit package, enrollment counts, and total DIR reported by Part D sponsors for each PBP.	96	Plan level identifiable
PBP Plan data (for DIR)	Data is from two primary sources - the Health Plan Management System (HPMS) Office of Financial Management (OFM) financial audits of sampled Part D sponsors from 2006 to 2009. HPMS contains administrative data and contract- and Plan Benefit Package (PBP)-level data for the population of Part D sponsors. Data fields include tax status, type of benefit package, enrollment counts, and total DIR reported by Part D sponsors for each PBP.	190	Plan level identifiable
CMS Audits (June 2011)	Health claims data for CMS Audits	75	Individual level identifiable
CMS Audits (October 2011)	Health claims data for CMS Audits	18	Individual level identifiable

HPMS	Contains formulary_id, NDC, cost share tier level associated with the NDC, drug brand name, contract number, plan number.		No
Final 2009 PEAT Database	Contains all 2009 PEPV validations, extractions, and audit committee reviews.	2	Yes
First Data Bank Complete Set	Contain all information in the FDB set BAH purchased (2009 basic set?...not sure on info)	2418	No
Final 2009 PEPV Results Table	The table sent to CMS detailing our rationale for each PEPV error.	1	Yes
2009 PEPV Evidencing Documentation	The evidencing PDFs and supporting files downloaded from Acumen's site for validation.	10078	Yes
approvedformid_bidid_cross walk	I received these files from Tim and used them to construct the data set for the PEPV analysis. But I am not sure whether these are original data sets from the CMS or BAH has modified them.		No
approvedformularydata_a			No
pbp_b20			No
pbp_mrx			No
pbp_mrx_tier			No
pcntl50bydrug			No
drx_pharm			No
drx_pharm_plan			No
drx_pharm_plan_contract			No
pharmcost2			No
bridge_ndc			No
rndc14			No
rndc14_ndc_mstr			No
SamplingFrame	Sampling frame for selecting the PDE sample of 4526 -- SAS data set	1	

Measuring and Adjusting for Differences between Medicare Advantage and Fee-for-Service
in Diagnostic Coding Intensity

Richard Kronick¹, Rebecca Paul², David Freund³, Stephen Calfo², Sean Creighton²

September 29, 2009

1 University of California, San Diego; 2 Center for Medicare and Medicaid Services; 3 Fu
Associates

Measuring and Adjusting for Differences between Medicare Advantage and Fee-for-Service in Diagnostic Coding Intensity

Abstract: Diagnostic risk-adjustment provides strong incentives to Medicare Advantage (MA) plans to increase the number and severity of diagnoses that are reported for their members. This paper describes the research that CMS conducted to measure the extent to which MA plans increased the intensity of diagnostic reporting, and describes the decisions CMS made in implementing a coding pattern differences adjustment for the 2010 MA rates.

Measuring and Adjusting for Differences between Medicare Advantage and Fee-for-Service in Diagnostic Coding Intensity

INTRODUCTION

Payments to Medicare Advantage (MA) plans are risk adjusted to account for the relative health resources needed to provide care for each beneficiary (Pope, et. al., 2004). Payment for MA enrollees is based on the diagnoses that are reported for them by the plans in which they are enrolled. If an MA plan reports more or more serious diagnoses for a beneficiary, the plan is paid more than if fewer or less serious diagnoses are reported. The Medicare payment system provides strong incentives for MA plans to identify and report diagnostic information as completely as possible. As a result of these strong incentives, it seems likely that more diagnoses, and/or more serious diagnoses, will be reported for a beneficiary enrolled in an MA plan than would be reported for that same beneficiary if she were enrolled in fee-for-service (FFS). If diagnostic information is reported more intensely by MA plans than by FFS providers – that is, if the risk score for a beneficiary is greater if she is enrolled in MA than if she is receiving care in FFS – then MA plans will be overpaid.

In response to concerns about the effects of the incentives faced by MA plans to more intensely report diagnostic information, the Deficit Reduction Act (DRA) of 2005 required the Department of Health and Human Services to reflect in its risk adjustment for Part C payment “differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences. (add a reference to the DRA) This paper describes the analyses that CMS conducted to measure differences between MA and FFS in coding intensity, and the methods used to calculate the coding intensity differences adjustment that is being implemented in 2010 (CMS 2009a; CMS 2009b).

BACKGROUND

CMS uses diagnostic and cost data from Medicare fee-for-service (FFS) to estimate the coefficients of the CMS-HCC risk adjustment model (Pope, et. al., 2004). Using a ‘normalization’ factor, the model produces risk scores that average 1.0 in each payment year (CMS 2008c). That is, in 2010, the average FFS beneficiary is expected to have a normalized risk score of 1.0.

The critical question in determining whether MA risk scores are calculated appropriately – and in determining whether an adjustment for differences in coding intensity is warranted -- is whether the risk score for a beneficiary enrolled in an MA plan is the same, on average, as the risk score that beneficiary would have if she were enrolled in FFS, or whether that risk score will be systematically different. There are a number of reasons to expect that coding patterns in FFS and MA will differ. In FFS, claims payment has

historically not depended on the completeness of diagnostic coding and, thus, FFS providers have little incentive to include all relevant diagnoses on the claims. The surprisingly low rate of persistence of many chronic diagnoses in FFS claims data provides evidence of incomplete coding in FFS claims data (MedPAC, 1998).

In MA, health plans have strong incentives to increase the completeness of diagnostic reporting. If plans are able to increase risk scores through more complete diagnostic reporting, Medicare payments to plans increase. As evidence of the value of complete reporting of diagnoses to MA plans, a number of companies have successfully marketed services to help MA plans increase their risk scores.

There are three methods that MA plans might use to increase risk scores: they might increase the severity, the persistence, or the rate of new incidence of diagnoses. First, for diagnoses such as diabetes that are in a hierarchy in the CMS-HCC model, they might increase the severity of diagnoses from one year to the next, by encouraging physicians to be sure to code diagnoses in higher-weighted HCCs whenever possible. Second, they might increase the rate at which diagnoses persist from one year to the next by encouraging physicians to be sure to check for diagnoses which were recorded in previous years, and to code them again if they still contributed to the need for treatment. Third, they might increase the incidence of previously unreported diagnoses (new incidence) by encouraging physicians to be sure to record any diagnoses that contributed to the need for treatment or the complexity of the treatment.

The primary goal of the work we describe below was to estimate whether risk scores for beneficiaries enrolled in MA were systematically different from the scores these beneficiaries would have received if they had received care in the FFS sector.

DATA AND METHODS

We begin the analysis by measuring the difference between FFS and MA in the rate of increase in risk scores for beneficiaries enrolled in July of each year from 2004 through 2008.¹ We use the version of the CMS-HCC risk adjustment model used in payment for 2004-2006 to calculate a risk score for each beneficiary.² Diagnoses were obtained from the same sources used to calculate risk scores for payment: diagnoses reported by FFS providers were extracted from the National Medicare Utilization Database (NMUD) and diagnoses reported by MA plans were obtained from the Risk Adjustment Processing System (RAPS). The risk score for each year was based on diagnoses submitted for dates of service in the prior calendar year – that is, the risk score for 2004 was based on diagnoses for services rendered during calendar year 2003. We assigned each beneficiary the risk score that would have been used in payment – that is, new enrollees were assigned new enrollee risk scores, and full risk enrollees were assigned institutional or community risk scores depending on their institutional status.³ Beneficiaries enrolled in cost plans, and beneficiaries who had ESRD or

¹ Medicare Advantage plans include Coordinated Care Plans (CCPs), Regional PPOs (RPPOs), Local PPOs (LPPOs), and Private Fee-for-Service (PFFS). In our analysis, we include PACE organizations with MA plans.

² The CMS-HCC risk adjustment model used in payment 2004-2006 was calibrated using 1999 diagnoses to predict 2000 costs.

hospice status were excluded from the analysis: the ESRD beneficiaries have risk scores calculated on a separate model and the CMS-HCC model is not used to make payments for beneficiaries in hospice status. Diagnoses from diagnostic radiation claims were included in the analysis.⁴

As we show below in the result section, there are large differences between MA and FFS in the rate of increase in risk scores over the 2004 to 2008 period – risk scores for all beneficiaries enrolled in MA in July of each year increase much more quickly than risk scores for all July beneficiaries in FFS. Some of the difference between MA and FFS in the rate of increase in risk scores may be due to changes in the composition of the caseload – beneficiaries turning 65 join the caseload from one July to the next, beneficiaries who die leave the caseload, and beneficiaries switch from FFS to MA (and vice-versa). Each of these changes – which we call ‘caseload dynamics’ – has effects on the year-to-year change in MA and FFS risk scores.

To analyze the effects of caseload dynamics, we define four types of beneficiaries:

- Stayers – beneficiaries who are enrolled in one sector (FFS or MA) in July of a given year, and remain enrolled in the same sector in July of the subsequent year;
- Switchers – beneficiaries who were enrolled in one sector (either MA or FFS) in July of a given year, and switched to the other sector before July of the subsequent year;
- Leavers – beneficiaries who were enrolled in a sector in July of a given year, but who are not receiving regular Medicare benefits in July of the subsequent year. Most beneficiaries in this group are decedents, but the group also includes beneficiaries who elect hospice benefits, beneficiaries who move to ESRD status, and a few other small groups; and
- Joiners – beneficiaries who were not receiving full Medicare benefits in July of a given year, but were enrolled in a sector in July of the subsequent year. Most beneficiaries in this group are new eligibles who have turned 65, although this group also includes newly disabled beneficiaries and a few other small groups.

As described in Appendix A, we use a decomposition technique to measure the contributions of stayers, switchers, leavers, and joiners to the year-to-year change in MA and FFS risk scores for each pair of years from 2004 through 2008.

³ We used the 90-day assessment in the Minimum Data Set (MDS) as an indicator of Long-Term Institutionalized status. New enrollees do not have 12 months of Part B in the data collection period and are paid with demographic-only scores. These beneficiaries are typically new to Medicare. Full risk enrollees have 12 months of Part B in the data collection period.

⁴ MA plans have been instructed to exclude diagnoses from DR-sourced encounters. If MA plans followed this instruction and did exclude DR-sourced diagnoses, then we should also exclude DR-sourced diagnoses from FFS claims. However, we include DR-sourced diagnoses in FFS claims as a conservative approach, to assure that the trend in risk scores is based on consistent rules over the analytic period. If we had excluded DR-sourced diagnoses from FFS claims, the coding adjustment would have been slightly larger than the results presented below.

Our analysis of the differences in coding intensity between FFS and MA then focuses on the increase in risk scores among stayers. Risk scores are the sum of demographic factors (i.e., age, gender, Medicaid status, institutional status) and disease factors (i.e., components due to HCCs and interactions of HCCs with demographic variables). We focus the analysis on the disease portion of the risk score, because that is the portion potentially affected by MA coding intensity efforts.

Our analysis assumes that disease scores for stayers in MA should increase at the same rate as disease scores for ‘comparable’ stayers in FFS. To the extent that disease scores increase more quickly for MA stayers than for comparable FFS stayers, then we have evidence that coding intensity is changing at different rates in MA than in FFS.

In order to assure that MA and FFS stayers are as comparable as possible, we analyze a subset of the group of all stayers. We exclude stayers who had a new eligible risk score (that is, a beneficiary who was enrolled in FFS in July of 2004 and 2005 but who had a new eligible score in July of 2004 would be excluded), and we exclude stayers with an institutional risk score in either the first year or the second year of the cohort. Further, we limit the analysis to stayers whose diagnostic data came entirely from a consistent data source – that is, for FFS stayers, the analysis is limited to beneficiaries whose diagnostic data came entirely from FFS; for MA stayers, it is limited to stayers whose data came from a single MA contract. The restricted cohort of stayers accounts for approximately 60% of all MA stayers, and approximately 86% of FFS stayers (data not shown). The restricted group of stayers are a smaller proportion of MA stayers than of FFS stayers because a larger proportion of MA than of FFS stayers are beneficiaries who had relatively recently switched into the sector or switched MA contracts, and MA beneficiaries whose diagnostic data came in part from FFS or from a different MA plan are excluded from the analysis.

As shown in Appendix B, the rate of increase in disease score varies by age and survivor status. The increase in disease scores for under-65 disabled beneficiaries is smaller than for the elderly, and disease scores increase more quickly for beneficiaries who are close to death than for longer-term survivors. Using the standardization technique described in Appendix B, we control for age and survivor status in comparing the rate of increase in disease scores for MA and FFS stayers.

RESULTS

Average MA risk scores increased more than twice as quickly as average FFS risk scores between 2004 and 2008 (Exhibit 1). The average risk score for FFS beneficiaries increased by 0.018 per year from 2004 through 2008, while the average risk score for MA enrollees increased by 0.040 per year over the same time period.

In 2004, the average MA risk score was 0.102 below FFS; by 2008, the average MA score was virtually the same as FFS. As we show below, there are two main factors accounting for the fact that risk scores increased so much more quickly in MA than in FFS: first, differences between MA and FFS in the effects of leavers, joiners, and switchers on the year-to-year change in risk scores, which we call ‘caseload dynamics’; and second, differences between the sectors in the size of the increase in risk scores among beneficiaries who remain enrolled from one year to the next.

Understanding Caseload Dynamics

Caseload dynamics in FFS

On average over the four cohorts from 2004 to 2008, 92% of FFS beneficiaries are stayers, and risk scores for stayers increase substantially from one year to the next – by an average of 0.088 (Exhibit 2). This large increase in risk scores for stayers includes both increases in the number and severity of diagnoses as beneficiaries age and are one year closer to death, and the effects of aging on the demographic component of the risk score (the age factors increase as beneficiaries age from one five-year age group to the next).

Despite the fact that risk scores for 92% of the FFS beneficiaries increase by 0.088 from one year to the next, as was shown in Exhibit 1, average risk scores for all FFS beneficiaries increase by only 0.018. Risk scores increase relatively slowly because of the restraining effects of leavers and joiners, slightly counterbalanced by the effects of switchers.

An average of 5.3% of FFS beneficiaries in July of one year lose full Medicare eligibility by July of the subsequent year, and these leavers, primarily decedents, had average risk scores of 1.85 in July of the base year. The departure of these high-risk leavers from the caseload restrains the rate of growth of FFS risk scores from one year to the next. If the leavers had remained in FFS, and if their risk scores had stayed constant at 1.85, the average FFS risk score would have been 0.041 higher in the second year of the cohort than it actually was.

In addition, 6.9% of FFS beneficiaries in July of one year were not enrolled in Medicare A & B in July of the previous year, and these joiners, primarily persons turning 65, enter the caseload with a low average risk score of 0.69. The entrance of these low-risk score joiners also has the effect of restraining growth in risk scores. If the low-risk score joiners had not entered the caseload, the second year risk score would have been 0.027 higher.

Partially counterbalancing the effects of joiners and leavers, beneficiaries who switch out of FFS into MA slightly increase the second-year FFS risk score. An average of 3.8% of FFS beneficiaries switch to MA each year, and the risk score for these switchers is lower than the average FFS risk score. As a result of the departure of these relatively low-risk switchers, the second year FFS score is slightly higher than it would be if the switchers had remained in FFS.

Caseload dynamics in MA

Part of the reason that MA risk scores increase more quickly than FFS risk scores is as a result of differences between the sectors in the effects of caseload dynamics.

Leavers are a slightly smaller proportion of the MA caseload than of the FFS caseload (an average of 4.5% compared to 5.3%), primarily because decedents are a smaller proportion of MA enrollees than of FFS beneficiaries. Average risk scores for MA leavers are also somewhat lower than for FFS leavers (1.77 compared to 1.85). As a result, the restraining effect of leavers on the year-to-year increase in risk scores is larger for FFS than for MA. In FFS, leavers restrain the year-to-year increase in risk scores by 0.041, while in MA, the restraining effect is 0.031, or 0.01 less.

Similarly, the restraining effect of joiners on the year-to-year change in risk scores is slightly greater for FFS than for MA, primarily because low-risk joiners are a slightly larger share of FFS than of MA beneficiaries (6.7% compared to 5.7%). However, the difference

between MA and FFS in the effects of joiners on the year-to-year change in risk scores is much smaller than the effects of leavers – 0.01 for leavers, compared to 0.003 for joiners.

The effects of switchers partially counterbalance the effects of joiners and leavers. In FFS, those who switch to MA had lower risk scores than the average FFS beneficiary, and thus resulted in an increase in the year-to-year change in FFS risk scores. In contrast, MA beneficiaries who switch out of MA into FFS have higher risk scores than the average MA beneficiary; as a result, MA risk scores increase by slightly less than they would have if those who switched out had remained in MA.

However, although differences in caseload dynamics between MA and FFS account for part of the reason that MA risk scores increased more quickly than FFS risk scores, a large part of the difference between the sectors is due to differences in the rate of growth of risk scores for stayers. Among FFS stayers, risk scores increase by an average of 0.088 per year. Among MA stayers, risk scores increase by an average of 0.112 – 0.024 per year more quickly. The next section of the paper investigates the reasons that risk scores increased so much more rapidly among MA stayers than among FFS stayers.

Understanding increases in risk scores for stayers

In this section we analyze further the rate of increase in risk scores for stayers, focusing on understanding the extent to which differences in coding intensity account for differences between the 0.112 increase in risk scores for MA stayers and the 0.088 for FFS stayers. As described in the data and methods section, we exclude stayers with a new-eligible risk score, with an institutional risk score, or whose diagnostic data came from more than one data source (either a combination of FFS and MA, or more than one MA contract).

The disease component of the risk score increased by an average of 0.026 per year more quickly for the restricted cohort of MA stayers than for FFS stayers (Exhibit 3). The difference in disease score growth between the sectors increased towards the end of the period – a difference of 0.017 in the 2004-2005 cohort grew to 0.029 in the 2006-2007 cohort, and 0.039 in 2007-2008 cohort.

Controlling for age and survivor status, disease scores among MA enrollees increase by an average of 0.023 per year more than for FFS beneficiaries. The age and survivor adjusted results are slightly smaller than the unadjusted difference of 0.026, but still show that disease scores increased substantially more quickly for MA stayers than for similar FFS stayers.⁵ As in the unadjusted results, the age and survivor standardized results indicate that the difference between MA and FFS was larger in the later cohorts, growing from 0.015 in the 2004-05 and 2005-06 cohorts to 0.026 in the 2006-07 cohort, and 0.037 in the 2007-08 cohort.

There are three main hypotheses that could explain why disease scores increased more quickly for MA stayers than for FFS stayers. First, it is possible that MA plans increased the intensity with which they reported diagnoses from one year to the next more

⁵ The age and survivor-adjusted differences are slightly smaller than the unadjusted differences because MA enrollees are less likely than FFS beneficiaries to be under-65 disabled beneficiaries, and disease scores increase more slowly for the under-65 than for the elderly.

rapidly than did providers in FFS. A second possibility is that MA stayers are different than FFS stayers in ways that would cause disease scores to increase more quickly for MA stayers. The results above control for age and survivor status, but it is possible that there are other characteristics that are associated with the rate of increase in disease score and that are unbalanced between MA and FFS, and that it is these characteristics that account for the more rapid rate of growth in MA disease scores. A third possibility is that MA enrollees actually get sicker more quickly than otherwise similar FFS beneficiaries.

We can think of no plausible mechanism in support of the third hypothesis. It seems extremely unlikely that MA enrollees actually get sicker at faster rates than comparable FFS beneficiaries, and we reject this hypothesis. The second hypothesis – that there are omitted variables that are related both to MA enrollment and to the rate of increase in disease score – cannot be ruled out. It is possible that MA enrollees differ from FFS beneficiaries in ways that would cause disease scores to increase at differential rates; however, we did not identify any such differences when calculating the 2010 adjustment.

The most likely explanation for the greater rate of increase in disease scores for MA stayers than for FFS stayers is that MA plans successfully increased the intensity of diagnostic reporting – it seems likely that MA plans were successful at either increasing the persistence of diagnostic reporting, at identifying diagnoses that might not have been identified in FFS, or at increasing the severity of diagnoses. We explore these mechanisms further in the next section.

Evidence of change in the intensity of diagnostic reporting

The coding of diabetes provides clear evidence of MA efforts to increase the intensity of diagnostic reporting. Among FFS beneficiaries reported to have diabetes in both the 2004 risk score (that is, using diagnoses from 2003) and in the 2005 risk score, 68% were reported for the 2004 risk score to have uncomplicated diabetes (HCC 19), and 11% were coded as having Diabetes with Renal or Peripheral Circulatory Manifestations (HCC 15), which is the highest weighted diabetes HCC (Exhibit 4). In the 2004-2005 cohort, the fraction of FFS beneficiaries in HCC 19 declined slightly in the 2005 risk score to 65%, and the fraction coded with HCC 15 increased slightly to 13%. This pattern is repeated in each subsequent FFS cohort – there is very little difference across the cohorts in the distribution of diabetes in the baseline year, and in each cohort there is a small increase in complicated diabetes and a small decline in uncomplicated diabetes in the second year of the cohort.

The pattern in MA is quite different, and provides clear evidence of MA efforts at increasing the severity of diabetes coding. In the 2004-2005 cohort, the MA distribution of diabetes in the baseline year is virtually identical to FFS. However, in 2005, the proportion of diabetics coded in HCC 15 increases to 17%, substantially greater than the 13% in FFS. This pattern is repeated in each subsequent cohort. In the 2007-08 cohort, in the 2008 data fully 25% of diabetics are reported in HCC 15, almost twice the proportion in FFS. It seems extremely unlikely that the actual distribution of diabetics changed substantially in MA plans between 2004 and 2008, and the large increase in the fraction of diabetics reported as having complications almost surely reflects MA efforts to more fully document members' diagnoses.

Additional evidence of differences between MA and FFS in coding practices comes from analysis of the persistence of diagnoses. In FFS, among beneficiaries whose 2004 risk score included a coronary artery disease (CAD) HCC, 42% were diagnosed with CAD in

2005 as well (Exhibit 5). Persistence of CAD was higher in MA – 46.7%, or 4.5 percentage points higher than in FFS. And the difference in persistence between MA and FFS increased in later cohorts – in the 2007-2008 cohort, CAD persistence was 40.5% in FFS, and 56.3% in MA. In every disease group other than cancer, persistence is greater in MA than in FFS, and in every disease group persistence increases substantially in MA from 2004-05 to 2007-08. In the 2004-05 cohort, MA plans were more successful than FFS providers in assuring that diagnoses that had been identified in one year persisted into the next year, and MA plans were increasingly successful over time in assuring that diagnoses persisted.

Analysis of the ‘new incidence’ of disease produces some results that are consistent with the results of the severity and persistence analyses, but also presents a more nuanced understanding of the differences between MA and FFS. We define new incidence as the proportion of beneficiaries in the second year of a cohort who were coded in a disease group that was not recorded during the first year of the cohort. For example, among FFS beneficiaries in the 2004-05 cohort who did not have a coronary artery disease (CAD) diagnosis in their 2004 risk score, 6.1% did have a CAD diagnosis included in their 2005 risk score (Exhibit 6). The new incidence of CAD among FFS beneficiaries in 2004-05 was slightly greater than new incidence among MA beneficiaries. Summing across each of the disease groups in Exhibit 6, 35.6% of FFS beneficiaries had a diagnosis in their 2005 risk score that was not included in their 2004 risk score, slightly more than the 33.8% of MA enrollees. It is possible that the lower rate of new incidence in MA reflects the fact that MA enrollees were, on average, healthier than FFS beneficiaries, and that the rate of new incidence of disease really was lower for MA than FFS. It is also possible, however, that the lower rate of new incidence in MA reflects the fact that MA plans were less good at identifying and recording new diagnoses than were FFS providers.

The rate of new incidence increases sharply in MA over the four cohorts from 2004-05 to 2006-07, while changing little in FFS. As a result, by 2007-08, new incidence is higher in MA than in FFS, reversing the result from 2004-05. Although the increase in new incidence among MA members may in part reflect increases in the acuity level of enrollees, it seems likely that it largely results from increased intensity of MA coding. Thus, the analysis of new incidence is consistent with the severity and persistence analyses in demonstrating that MA coding intensity increased substantially over the four cohorts, but dissonant in suggesting that in the early cohorts MA plans may have coded somewhat less well than FFS, while the severity and persistence analyses each suggested that even in 2004-05 MA plans had surpassed FFS in coding intensity.

One-time or ongoing effects?

It is important to understand whether MA efforts at increasing coding intensity are cumulative over time. The analysis presented in Exhibit 3 showed that the disease score for MA stayers in 2006-07 increased by 0.03 faster, on average, than for FFS stayers, and by 0.039 faster, on average, for 2007-08 stayers. It is not clear, however, from the data in Exhibit 3 whether these results are cumulative for beneficiaries who are in both the 2006-07 and 2007-08 cohorts. It is possible that MA plans are able to increase coding intensity in a given year, but that longer periods of enrollment do not lead to larger increases in disease score. Answering the question of whether the effects are one-time or cumulative is important for designing an equitable adjustment for differences in coding intensity.

From analysis of data on a cohort of beneficiaries who were continuously enrolled in MA or FFS from July 2004 through July 2008, it is clear that the effects of MA efforts at

increasing coding intensity are cumulative. Among MA beneficiaries who were continuously enrolled, disease scores increased by 0.344 over the four years from 2004 to 2008 (Exhibit 7). In contrast, the average disease score for beneficiaries continuously enrolled in FFS during this same period increased by only 0.232, or 0.112 less than the MA amount. The annual difference between MA and FFS for the continuously enrolled cohort is very similar to the average difference across separate cohorts shown in Exhibit 3. It is clear that the effects of MA efforts at increasing coding intensity are cumulative – the longer a beneficiary is enrolled, the higher her disease score relative to what it would have been had she remained in FFS.

Plan specific results

There is substantial heterogeneity across MA plans in the rate at which disease scores for stayers increase from 2004 to 2008. Among the subset of MA plans that were continuously contracted with Medicare from 2004 to 2008, disease scores increased, on average, by 0.025 per year more than for comparable FFS stayers (Exhibit 8). However, 25% of MA beneficiaries were enrolled in plans in which disease scores among stayers increased by at least 0.042 per year more than for comparable FFS beneficiaries, and 10% of beneficiaries were in plans in which disease scores increased by at least 0.060 per year more quickly than for comparable FFS beneficiaries. Conversely, 25% of MA beneficiaries were enrolled in plans in which disease scores increased at the same rate as in FFS or more slowly than in FFS.

Substantial heterogeneity is apparent even among the very largest plans. Among the fifteen largest plans continuously under contract with Medicare from 2004 to 2008, there were two plans in which disease scores increased by more than 0.085 per year more quickly than in FFS, four plans in which the annual difference was between 0.03 and 0.046, and four plans that increased at virtually the same rate as FFS, and two plans that increased slightly more slowly than in FFS (Exhibit 9).⁶ Cumulating over a four year time period, disease scores (relative to comparable FFS beneficiaries) increased by 0.32 more quickly in the two plans with the largest increases in disease scores compared to the four plans that increased at the same

Calculation of the 2010 Coding Intensity Adjustment

The results presented in Exhibits 1-9 demonstrate clearly that MA plans increased the intensity of diagnostic coding during the 2004 to 2008 period. Disease scores for MA stayers increased more quickly than for FFS stayers of the same age, and the difference between MA and FFS was much larger in 2007-08 than in 2004-05. MA plans were much more likely than FFS to report complications for patients with diabetes, and also increased the proportion of diagnoses that persisted from one year to the next to substantially higher levels than in FFS.

Having determined that MA plans coded more intensely than FFS, we then had to assess the best approach to calculating a payment adjustment to address the impact on

⁶ Plans are categorized by the total number of stayers in the four cohorts from 2004-05 through 2007-08.

payment of the differences in coding. The goal in designing a payment adjustment for 2010 was to adjust for the impact on payment that was attributable to estimated differences between the disease score for the average beneficiary in an MA plan and the disease score that beneficiary would have had if she had received care in FFS. The major decisions needed to estimate this amount are described below. In particular, we consider the following methodological questions (#1-4), and the following policy question (#5):

- 1) Whether the adjustment should assume that in the earlier cohorts (e.g., 2004-05 and 2005-06) that MA plans were simply catching up to FFS levels of coding, or whether the adjustment should assume that even in the early years, MA plans were coding 'above and beyond' the level of coding intensity in FFS;
- 2) How the information from the multiple cohorts from 2004-05 to 2007-08 should be taken into account, what assumptions should be made about coding intensity in 2008-09 and 2009-10 (time periods for which data were not available at the time the coding adjustment was announced), and how this information should be used to project to the 2010 payment year;
- 3) Whether the adjustment should take into account the number of years beneficiaries have been enrolled in an MA plan;
- 4) How to take into account that not all MA enrollees in 2010 will be stayers, and the 2010 risk score for enrollees who are newly enrolled in MA will be based largely or completely on diagnoses submitted by FFS providers in 2009.
- 5) Whether the same adjustment should apply to all plans, whether the adjustment should differ for each plan, or whether plans should be grouped in some fashion and separate adjustments applied for each group.

Our approach to each of these questions is described below.

1) Whether the adjustment should assume that in the earlier cohorts (e.g., 2004-05 and 2005-06) that MA plans were simply catching up to FFS levels of coding, or whether the adjustment should assume that even in the early years, MA plans were coding 'above and beyond' the level of coding intensity in FFS.

CMS first began requiring MA plans to submit diagnostic information from ambulatory as well as inpatient claims for dates of service in 2003. Only 30% of MA payment in 2004 was based on 2003 diagnoses, with most of the weight given to the traditional AAPCC payment method (CMS, 2003). It is possible that MA plans were less complete than FFS providers in collecting and reporting diagnostic information in the early years of the system. Difficulties may especially have been encountered by plans that made capitated payments to provider groups, or paid their providers on a salary basis and may not have routinely collected encounter-level diagnostic information for payment purposes.

If MA plans coded less intensely than FFS providers in 2003, then the evidence presented in Exhibit 3 that disease scores increased more rapidly for MA than FFS stayers might indicate that MA coding was simply catching up to the level of FFS coding. If this

were the case, then even though disease scores increased more rapidly in MA than FFS among stayers, it is possible that the disease score for an MA enrollee might be no higher than it would have been if she were in FFS.

The findings in Exhibit 4 that diabetes coding was similar in MA and FFS in 2003, and in Exhibit 5 that persistence was, on average, higher in MA than FFS even in the 2004-05 cohort do not provide much support to the catching-up hypothesis. That is, the results in Exhibits 4 and 5 support the hypothesis that MA and FFS coding in 2003 were at approximately equal levels of intensity, and that the larger increases in disease scores among stayers in MA than FFS from 2004-05 through 2007-08 primarily represent MA plans surpassing FFS coding intensity, rather than simply catching up to FFS coding levels. However, in support of the catching-up hypothesis, the results in Exhibit 6 on the incidence of new disease show that the incidence of new disease was slightly lower in MA than in FFS in the 2004-05 and 2005-06 cohorts, providing some support for the hypothesis that MA plans may have been coding less completely than FFS in those years.

Although there was no obvious way to assess whether, and to what extent, there was catch-up in the early years of the MA program, CMS, in seeking to minimize the disruption in plan payments, made the determination to make an adjustment for three years (2007-2010). Implicitly, this assumes that FFS and MA coding were at equal levels of completeness in 2006. Since it seems more likely than not that the year of equality was before 2006, it seems very unlikely that any catch-up coding occurred within the period that was captured in the adjustment factor.

2) How the information from the multiple cohorts from 2004-05 to 2007-08 should be combined, and what assumptions should be made about coding intensity in 2008-09 and 2009-10 (time periods for which data were not available at the time the coding intensity adjustment was promulgated).

CMS needed to decide whether to assume that the difference between MA and FFS in the rate of increase in disease scores for stayers in the 2007-08, 2008-09 and 2009-10 cohorts would best be approximated by an average of the results from earlier cohorts, or whether it was more appropriate to estimate a trend. At the time the Advance Notice was published in February, 2009, the 2007-08 results were not available, and with only three data points available, taking an average of the three cohorts made more sense than assuming a trend. As a result, at the time of the Advance Notice, CMS made a preliminary decision to use the average of the 2004-05, 2005-06, and 2006-07 cohort results.

CMS computed the Average Annual Difference between MA and FFS stayers in the rate of increase in disease scores for in the 2004-05, 2005-06, and 2006-07 cohorts using the data in Exhibit 3, which showed that disease scores increased by 0.015, 0.015, and 0.025 more for MA than for age and survivor adjusted FFS stayers in the three cohorts respectively. CMS calculated a weighted average of these differences across the three cohorts, after rebasing the differences to allow comparisons across years. The Average Annual Difference for the 2004-05 to 2006-07 cohorts is calculated to be 1.75%, which is very close to the simple average of 0.015, 0.015, and 0.025.

Although CMS had originally planned to incorporate results from the 2007-08 cohort in formulating the coding pattern differences adjustment for 2010, CMS decided not to do so. The 2007-08 cohort results became available in the time period between publication of the Advance Notice and publication of the final Announcement. Incorporating the 2007-08 results would have increased the size of the final adjustment, both because, as shown in Exhibit 3, the difference between MA and FFS in the rate of increase in disease scores increased substantially to 0.037, and because the 2007-08 results suggest that assumption of a trend of a widening difference in 2008-09 and 2009-10 might be appropriate. However, CMS has frequently chosen to implement new payment methodologies, including new adjustments to existing payment methodologies, on a phased-in basis in order to minimize disruption to its programs. Given the limited time available to assess the 2007-08 results and the additional disruption incorporating these results would have had, CMS decided not to incorporate the 2007-08 results in the 2010 coding intensity adjustment.

3) Whether the adjustment should take into account the number of years beneficiaries have been enrolled in an MA plan.

The results in Exhibit 6 demonstrate clearly that for each additional year of enrollment in an MA plan, the difference between MA and FFS in the rate of increase in disease score increases. A beneficiary who first enrolled in an MA plan in January 2007, for example, would be expected to have a 2008 disease score that is closer to the score she would have in FFS than would a beneficiary who first enrolled in MA in January 2006. These results strongly support the position that a coding adjustment should take into account the length of time a beneficiary has been enrolled in MA.

In order to take into account the number of years that beneficiaries have been enrolled, CMS calculated an Enrollment Duration factor (EDF). We calculate the EDF for 2010 as follows. First, for beneficiaries enrolled in MA in January, 2010, we count the number of full-risk enrollees who were also enrolled in MA for all twelve months of calendar 2009. This group is similar to the stayers who were analyzed in Exhibit 3. We then count the number of full calendar years from 2007-2009 that these beneficiaries were enrolled in MA.⁷ Because data on enrollees in 2010 are not yet available, we used January 2009 enrollment, which was the most current data available at the time the EDF was calculated, to estimate the EDF for 2010.⁸ The EDF for January, 2009 enrollees was 2.45, indicating that among MA enrollees in January, 2009 who had been enrolled for all

⁷ By counting only full calendar years, the adjustment will be smaller than if it counted partial years of enrollment as well.

⁸ The EDF is calculated as follows. We sum the following: the number of full-risk beneficiaries enrolled in MA in January 2009 who were also in an MA plan for all twelve months of 2008; plus the number of full risk beneficiaries who were enrolled in MA in 2009, all twelve months in 2008, and all twelve months in 2007; plus, the number of full risk beneficiaries who were enrolled in MA in 2009, all twelve months in 2008, all twelve months in 2007, and all twelve months in 2006. We then divide this sum by the number of full risk enrollees in the January, 2009 who were in MA for all of 2008 to calculate the EDF.

twelve months of 2008, on average they were enrolled for 2.45 full calendar years in 2006, 2007, and 2008.

Combining the EDF calculation with the Average Annual Difference calculation, CMS is estimating that for MA enrollees in 2010 who were enrolled in MA for all twelve months of 2009, that, on average, they will have been exposed to increased MA coding intensity for 2.45 years, and that each year of exposure results in a 1.75% increase in risk scores. Multiplying the 1.75% by 2.45, for each MA enrollee in 2010 who was also enrolled for all of 2009 it is appropriate to reduce the 2010 risk score by 4.16%.

4) How to adjust for the fact that some MA enrollees in 2010 will be relatively newly enrolled in the plan, and the 2010 risk score for these enrollees will be based largely or completely on diagnoses submitted by FFS providers in 2009.

In January 2009, 81.8% of MA enrollees were enrolled in MA for all twelve months of 2008. The 4.16% adjustment calculated above applies to these enrollees. Because CMS applies adjustments to all payments, not just to the payments of stayers, CMS multiplied the 4.16% adjustment by 0.818 to calculate a final coding adjustment for 2010 of 3.41%.

5) Whether the same adjustment should apply to all plans, whether the adjustment should differ for each plan, or whether plans should be grouped in some fashion with separate adjustments applied to each group.

This final question is a policy question about whether the coding adjustment should apply to all plans, or whether the adjustment should be greater for some plans and smaller for other plans. The data in Exhibits 8 and 9 show that MA plans differ substantially in how much they increased the intensity of diagnostic reporting over the 2004 to 2008 period. Over the four cohorts studied, disease scores among stayers in some large plans increased by 0.30 more quickly than for comparable beneficiaries in FFS, while in other large plans disease scores increased at the same rate (or slightly more slowly) than in FFS.

The substantial differences across plans suggest that a plan-specific coding adjustment might be more equitable than an adjustment that treated all plans alike. However, a plan-specific adjustment raises technical and policy concerns. Plan-specific adjustments would create the scenario that the risk score used in payment for a beneficiary would depend on the plan in which she enrolled, which would strike some as odd. Work would be needed to determine the size of plan for which a plan-specific adjustment could be reliably computed, and lagged data would mean that CMS would not be able to calculate a plan-specific adjustment for a new plan even though the expertise available to the industry would certainly allow that new plan to code as intensely as already-existing plans.

An alternative to a plan-specific adjustment that also addresses variation in coding intensity across plans is an adjustment that groups plans into two or more buckets, and creates separate adjustment amounts for each bucket. However, a tiered adjustment

raises concerns that are similar to a plan-specific adjustment, as well as concern about the behavior of plans that fall just above or below tier cutoffs. CMS did propose a tiered adjustment in the Advance Notice for 2009, but then decided not to implement an adjustment at all in the final Announcement for 2009 rates (CMS 2008a; CMS 2008b).

CMS chose the approach that was implemented in 2010 – an industry-wide adjustment – because it addressed an industry-wide phenomenon. Given the incentives that all MA plans face -- and the expertise available to the industry -- to increase coding, CMS treated the difference between MA and FFS coding patterns as a trend that would likely affect all plans over time. Further, an industry-wide adjustment is parallel to the industry-wide adjustments for DRG-creep in inpatient hospital payments, as well as the normalization adjustments made to risk scores in the MA and Prescription Drug programs.

CONCLUSION

As was shown in Exhibit 1, risk scores for MA plans increased much more than did risk scores for FFS from 2004-2008: by an average of 0.018 per year in FFS compared to 0.040 per year in MA. We have shown that some of the difference between FFS and MA in the year-to-year rate of increase in risk scores is due to differences between the sectors in caseload dynamics. Decedents with high risk scores are a larger proportion of FFS beneficiaries than of MA enrollees; similarly, new eligibles entering the caseload with low risk scores are a larger fraction of FFS than of MA. The restraining effect of the departure of decedents and the entrance of new eligibles on the year-to-year change in risk scores is larger for FFS than MA.

Focusing on beneficiaries who stay in FFS or in an MA plan from one year to the next, we find large differences between the rate of increase in disease score for MA and FFS stayers – on average over the four cohorts from 2004-05 to 2007-08, disease scores increase for MA stayers by 0.023 per year more than for FFS stayers of the same age and survivor status. This difference in the rate of increase in disease scores for stayers provides strong evidence that MA plans have increased the intensity of diagnostic reporting relative to the reporting that is done by FFS providers. It is possible, although extremely unlikely, that MA stayers are actually getting sicker at faster rates than FFS stayers. Perhaps slightly more likely, MA stayers may be different from FFS stayers on characteristics other than age and survivor status in ways that are associated with the rate of increase in disease score. We continue to investigate this possibility.

We also describe the rationale for the decisions that CMS made in calculating the 3.41% coding adjustment for 2010. The findings presented in Exhibits 1-9 might have reasonably led to a variety of alternative decisions about how to calculate the adjustment. Some of those alternative decisions would have led to smaller adjustments; many would have led to larger adjustments.

One of the main rationales for implementation of diagnostic risk adjustment was to provide strong incentives for health plans to attract and retain beneficiaries most in need of care. In the absence of diagnostic risk adjustment, MA plans would have a strong disincentive to design systems of care that attract high need beneficiaries. Diagnostic risk adjustment may not be sufficient to foster the development of plans that are attractive to the sick, but it is almost certainly necessary.

In addition to creating incentives for plans to attract the sick, diagnostic risk adjustment clearly creates strong incentives for plans to increase the number and severity of diagnoses that are reported for their members. To the extent that increased and more accurate identification of disease results in better and more appropriate treatment, it is arguably beneficial for patients. However, to the extent that it results in higher risk scores for MA enrollees than would be the case if those same beneficiaries received care in FFS, then it also results in inappropriate payment levels. The coding adjustment described here is designed to assure that increased reporting of diagnoses by MA plans does not result in inappropriately large payments for the industry as a whole.

References

- CMS, 2003, Advance Notice, March 28, 2003. Available at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2004.pdf>
- CMS 2008a, Advance Notice of Methodological Changes for Calendar Year (CY) 2009 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, February 22, 2008, available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2009.pdf>
- CMS 2008b, Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, April 7, 2008, available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2009.pdf>
- CMS 2008c, 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide, page 1-10; available at <http://www.csscooperations.com/new/usergroup/traininginfo.html>
- CMS 2009a, Advance Notice of Methodological Changes for Calendar Year (CY) 2010 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, February 20, 2009, available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2010.pdf>
- CMS 2009b, Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, April 6, 2009, available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2010.pdf>
- Medicare Payment Advisory Commission. Report to the Congress: Medicare payment policy, volume II: analytic papers. Washington (DC), MedPAC. March 1998.
- Pope GC, Kautter J, Ellis RP, Ash AS, Ayanian JZ, Iezzoni LI, Ingber MJ, Levy JM, Robst J. Risk adjustment of Medicare capitation payments using the CMS-HCC model. Health Care Financing Review, June 22, 2004.

Appendix A

Estimating the Contribution of Stayers, Leavers, Joiners, and Switchers to the Year-to-Year change in Risk Scores

This appendix describes the methods we use in Exhibit 2 of the paper to calculate the contributions of stayers, leavers, joiners, and switchers to the year-to-year change in risk scores. We analyze four cohorts – 2004-05, 2005-06, 2006-07, and 2007-08.

We define Stayers (S), Leavers (L), Joiners (J), and Switchers (SO for switchers out , SI for switchers in) as follows:

FFS_N_S = the number of beneficiaries who have full Part A and Part B benefits, and are enrolled in FFS in July of the first year of a cohort and in July of the second year.

FFS_N_L_t1 = the number of beneficiaries who were in FFS in year 1, and who were not eligible for full Part A and Part B benefits in year 2 (Leavers). This group is further subdivided into beneficiaries who die before year 2 (FFS_N_L(D)_t1), those who elect hospice benefits (FFS_N_L(H)_t1), those who become ESRD (FFS_N_L(E)_t1), and those who lose full Part A and B benefits for other reasons (FFS_N_L(O)_t1). Note that $FFS\_N\_L\_t1 = FFS\_N\_L(D)\_t1 + FFS\_N\_L(H)\_t1 + FFS\_N\_L(E)\_t1 + FFS\_N\_L(O)\_t1$.

FFS_N_J_t2 = the number of beneficiaries who were not eligible for full Part A and B benefits in July of the first year, but were enrolled in FFS in July of the second year (Joiners).

FFS_N_SO_t1 = the number of beneficiaries who were enrolled in FFS in July of the first year of the cohort, but who switched to MA by July of the second year (Switchers Out).

FFS_N_SI_t2 = the number of beneficiaries who were enrolled in MA in July of the first year of the cohort, but who switched to FFS by July of the second year (Switchers In).

Similarly, we define the average risk scores for each of these groups by substituting RS for N – i.e., FFS_RS_L_t1 is the average risk score for leavers in year 1 of the cohort. We define equivalent statistics for MA by using the MA prefix. (Note that, by definition, $FFS\_N\_SO\_t1 = MA\_N\_SI\_t2$, and $MA\_N\_SO\_t1 = FFS\_N\_SI\_t2$ – that is, the number of beneficiaries switching out of FFS in year 1 is equal to the number of beneficiaries switching in to MA in year 2).

The simple average of the risk scores in year 1 and year 2 of the cohort is:

$$FFS\_RS\_t1t2 = .5*(FFS\_RS\_t1 + FFS\_RS\_t2)$$

And the simple average of the number of beneficiaries in year 1 and year 2 is:

$$FFS\_N\_t1t2 = .5*(FFS\_N\_t1 + FFS\_N\_t2)$$

We calculate the contribution of the change in risk scores for stayers as

$$\text{CONTRIBUTION(S)}_{\text{FFS}} = (\text{FFS\_RS\_S\_t2} - \text{FFS\_RS\_S\_t1}) * (\text{FFS\_N\_S} / \text{FFS\_N\_t1t2})$$

the contribution for leavers is

$$\text{CONTRIBUTION(L)}_{\text{FFS}} = - (\text{FFS\_RS\_L\_t1} - \text{FFS\_RS\_t1t2}) * (\text{FFS\_N\_L\_t1} / \text{FFS\_N\_t1t2})$$

the contribution for joiners is

$$\text{CONTRIBUTION(J)}_{\text{FFS}} = (\text{FFS\_RS\_J\_t2} - \text{FFS\_RS\_t1t2}) * (\text{FFS\_N\_J\_t2} / \text{FFS\_N\_t1t2})$$

the contribution for switchers out is:

$$\text{CONTRIBUTION(SO)}_{\text{FFS}} = - (\text{FFS\_RS\_SO\_t1} - \text{FFS\_RS\_t1t2}) * (\text{FFS\_N\_SO\_t1} / \text{FFS\_N\_t1t2})$$

and the contribution for switchers in is:

$$\text{CONTRIBUTION(SI)}_{\text{FFS}} = (\text{FFS\_RS\_SI\_t2} - \text{FFS\_RS\_t1t2}) * (\text{FFS\_N\_SI\_t2} / \text{FFS\_N\_t1t2})$$

The results for each of the four cohorts from 2004-05 to 2007-08 are shown in Exhibits A1-A4. The results in Exhibit 2 are the simple average of the results in A1-A4.

Appendix B

Standardization of year-to-year changes in disease scores for stayers for age and survivor status

The year-to-year change in disease score among stayers varies by age and survivor status, and this appendix describes the methods used to standardize the MA to FFS comparison for differences between the sectors in the distribution of beneficiaries by age and survivor status.

Among FFS stayers in the 2005-06 cohort who were still alive on December 31, 2006, the change in disease scores from 2005 to 2006 increased almost monotonically with age (Exhibit B1). For example, disease scores for stayers age 45-54 increased by just over 0.04 from 2005 to 2006, while disease scores for stayers age 80-84 increased by 0.08. The exceptions to this monotonic increase are that disease scores increase by less for 65-69 year olds than for the disabled age 60-64, and disease score increases decline somewhat for the very old. Similar patterns are observed for other cohorts (data not shown).

Among FFS stayers in the 2005-06 cohort who died before December 31, 2006, the change in disease scores from 2005 to 2006 was much greater, on average, than the change in disease scores for survivors (Exhibit B2). For example, among FFS stayers age 75-79 in 2005, disease scores increased by approximately 0.07 for stayers who survived past December 31, 2006, but by 0.32 for those who died before the end of 2006. Similar patterns are observed in other cohorts (data not shown).

We define: $FFS\_DELTA(a,s)$ = the increase in disease score for FFS stayers between year 1 and year 2 of a cohort for age group 'a' and survivor status 's'. Age groups are as defined in the risk adjustment model (0-34, 35-44, 45-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90-94, 95+), and survivor status has two values – either alive on December 31 of the second year of the cohort, or deceased by that time.

The expected change in disease score for an MA stayer in a given cohort is defined as the average change in disease score for a FFS stayer of the same age and survivor status, that is, as $FFS\_DELTA(a,s)$. We then calculate the expected change in disease scores for all MA stayers in a cohort by averaging the expected change for each MA stayer. Finally, we subtract the expected change in disease score from the actual change in disease score to calculate the difference between MA and FFS, adjusted for age and survivor status. The quantity $FFS\_DELTA(a,s)$ is calculated separately for each two-year cohort (that is, for 2005-06, 2006-07, 2007-08, and 2008-09).

As shown in Exhibit 3, the difference between MA and FFS adjusting for age and survivor status is slightly smaller, in each cohort, than the unadjusted difference. This is because under-65 disabled beneficiaries are underrepresented among MA enrollees, and, as shown in Exhibit B1, disease score increases for these beneficiaries are smaller than for the elderly.

Exhibit 1. Average Risk Scores for Beneficiaries in FFS and MA on July 1, 2004-2008

	Fee-for-Service			Medicare Advantage			Difference between MA and FFS in
	Number of Beneficiaries	Average Risk Score	Change from previous year	Number of Beneficiaries	Average Risk Score	Change from previous year	Amount of change
July, 2004	32,886,165	1.046		4,898,117	0.944		
July, 2005	32,993,880	1.064	0.018	5,332,034	0.986	0.042	0.024
July, 2006	31,911,561	1.085	0.021	7,046,689	1.022	0.036	0.015
July, 2007	31,346,146	1.102	0.017	8,298,334	1.060	0.038	0.021
July, 2008	30,919,077	1.116	0.014	9,625,446	1.104	0.044	0.030
Annual average			0.018			0.040	0.023

Notes:

Average risk scores calculated for July cohort from each year.

PACE and PFFS plans are included in the "MA" category.

Cost plans, ESRD beneficiaries, and hospice beneficiaries are excluded.

Diagnoses with a source of diagnostic radiology are included in the FFS risk score calculations.

Exhibit 2. Caseload Dynamics in MA and FFS, averages for four cohorts from 2004-05 to 2007-08

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	FFS	MA	Year 1	Year 2	Year 1	Year 2	FFS	MA	Difference
Stayers	91.7%	84.5%	1.03	1.12	0.96	1.07	0.080	0.095	0.015
Change in Risk Score for stayers				0.088		0.112			
Leavers									
Deceased	4.3%	3.7%	1.94		1.80		-0.037	-0.026	0.011
Hospice	0.5%	0.5%	1.85		1.73		-0.004	-0.003	0.001
ESRD	0.1%	0.1%	2.39		2.36		-0.002	-0.001	0.000
Other	0.4%	0.2%	0.75		0.86		0.001	0.000	-0.001
Subtotal	5.3%	4.5%	1.85		1.77		-0.041	-0.031	0.010
Joiners									
New eligible/other	6.9%	6.1%		0.69		0.66	-0.027	-0.024	0.003
Switchers									
Out to other sector	3.8%	3.9%	0.96		1.10		0.005	-0.002	-0.007
In from other sector	0.7%	15.8%		1.28		1.04	0.001	0.003	0.002
Subtotal							0.006	0.000	-0.006
Total			1.074	1.092	1.003	1.043	0.018	0.040	0.022

Note: Data in the table summarizes results from four cohorts: 2004-05, 2005-06, 2006-07, and 2007-08, and presents simple averages of the results across the four cohorts. Results for each cohort separately are shown in Exhibits A1-A4. Distribution percentages for stayers are calculated with the denominator equal to the average number of enrollees in July from year 1 and year 2 of the cohort. Percentages for Leavers and Switchers-Out are calculated with year 1 enrollment as the denominator; for Joiners and Switchers-In with year 2 enrollment as the denominator. As a result, percentages do not add to 100%. Contribution to change in risk scores calculated as described in Appendix A.

Exhibit 3. Increase in disease scores for stayers, 2004-05 to 2007-08, MA and FFS

	2004-05		2005-06		2006-07		2007-08		Average Year-to-Year Increase in Disease Component of Risk Score
	N	Year-to-Year Increase in Disease Component of Risk Score	N	Year-to-Year Increase in Disease Component of Risk Score	N	Year-to-Year Increase in Disease Component of Risk Score	N	Year-to-Year Increase in Disease Component of Risk Score	
<u>2004-2005</u>									
MCOs	3,342,980	0.083	3,307,658	0.086	3,416,211	0.1	4,113,231	0.104	0.093
FFS	26,262,735	0.066	25,320,358	0.069	24,693,331	0.070	24,191,472	0.065	0.068
Difference		0.017		0.017		0.03		0.039	0.026
Difference controlling for age and survivor status		0.015		0.015		0.026		0.037	0.023

In each cohort, beneficiaries are restricted to stayers who were in the community in both July of year 1 and of year 2, who were in the same sector for both Julys, and for whom the data source for the risk score was either entirely FFS or entirely from a single MA contract. Adjustment for age and survivor status as described in Appendix B.

Exhibit 4. Distribution of Complicated and Uncomplicated Diabetes, MA and FFS, 2004-05 through 2007-08

		2004-05 cohort		2005-06 cohort		2006-07 cohort		2007-08 cohort	
		<u>2004</u>	<u>2005</u>	<u>2005</u>	<u>2006</u>	<u>2006</u>	<u>2007</u>	<u>2007</u>	<u>2008</u>
FFS	HCC15 Diabetes with Renal or Peripheral Circulatory Manifestation	11.0%	12.7%	11.1%	12.8%	11.4%	13.1%	11.7%	13.4%
	HCC16 Diabetes with Ophthalmologic Manifestation	12.1%	13.1%	12.1%	13.3%	12.5%	13.7%	12.9%	13.8%
	HCC17 Diabetes with Acute Complications	0.9%	0.8%	0.8%	0.7%	0.7%	0.6%	0.6%	0.6%
	HCC18 Diabetes with Neurologic Manifestation	8.4%	8.4%	8.3%	8.2%	8.0%	7.9%	7.8%	7.8%
	HCC19 Diabetes without Complications	<u>67.6%</u>	<u>65.0%</u>	<u>67.8%</u>	<u>65.1%</u>	<u>67.4%</u>	<u>64.7%</u>	<u>66.9%</u>	<u>64.4%</u>
	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
MA	HCC15 Diabetes with Renal or Peripheral Circulatory Manifestation	11.9%	17.1%	15.3%	20.6%	18.5%	24.3%	20.6%	25.0%
	HCC16 Diabetes with Ophthalmologic Manifestation	10.8%	12.4%	11.6%	13.4%	12.6%	13.8%	13.2%	14.2%
	HCC17 Diabetes with Acute Complications	0.8%	0.7%	0.7%	0.6%	0.6%	0.4%	0.5%	0.4%
	HCC18 Diabetes with Neurologic Manifestation	8.5%	8.4%	8.2%	7.9%	7.7%	7.4%	7.4%	7.2%
	HCC19 Diabetes without Complications	<u>67.9%</u>	<u>61.5%</u>	<u>64.3%</u>	<u>57.7%</u>	<u>60.6%</u>	<u>54.0%</u>	<u>58.3%</u>	<u>53.1%</u>
	Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Cohorts are defined as in Exhibit 3 -- beneficiaries are restricted to community-based stayers with consistent data sources -- and are further restricted to beneficiaries with a diagnosis in HCC 15 through HCC 19 in both the first and second years of the cohort.

The CMS-HCC model contains a hierarchy of 5 diabetes HCCs: beneficiaries are assigned the most severe level of diabetes reported in the data collection year.

Exhibit 5. Persistence within disease groups, MA and FFS, 2004-05 to 2007-08

<u>Disease Group</u>	2004-05 Cohort			2005-06 Cohort			2006-07 Cohort			2007-08 Cohort		
	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
Coronary Artery Disease	42.1%	46.7%	4.5%	40.9%	49.3%	8.4%	40.5%	54.2%	13.6%	40.5%	56.3%	15.8%
Cancer	74.6%	72.4%	-2.2%	75.0%	73.2%	-1.8%	75.5%	73.0%	-2.4%	75.8%	73.9%	-1.9%
Cerebrovascular Disease	41.1%	41.5%	0.4%	40.8%	43.0%	2.2%	41.1%	44.6%	3.6%	41.2%	46.5%	5.2%
Diabetes	87.1%	88.6%	1.6%	87.0%	88.7%	1.7%	86.9%	88.8%	1.9%	86.9%	89.4%	2.5%
Liver	54.2%	58.0%	3.8%	54.4%	59.0%	4.6%	55.1%	61.5%	6.4%	55.9%	64.8%	8.9%
Paralysis	31.7%	28.9%	-2.7%	32.0%	32.6%	0.6%	31.9%	34.6%	2.7%	32.0%	36.8%	4.8%
Renal	50.4%	51.8%	1.3%	52.9%	57.1%	4.2%	57.8%	66.8%	9.0%	58.3%	71.2%	12.9%
Weighted average			1.1%			2.3%			3.7%			5.0%

Note: The denominator for each statistic is the number of beneficiaries in the cohort who were coded with an HCC in the disease group in year 1 of the cohort. The numerator is the subset of that group who were also coded in that disease group in year 2 of the cohort.

Analysis is limited to stayers with community risk scores and consistent data sources (as in Exhibit 3).

Weighted average is weighted by the number of FFS beneficiaries in the disease group in year 1 of the cohort.

Disease groups are sets of HCCs in the CMS-HCC model that are hierarchically related, that is, beneficiaries are assigned the most severe disease if more than one HCC is reported during the data collection period.

The HCCs in each hierarchy are: CAD, HCCs 81-83; Cancer, HCCs 7-10; CVD, HCCs 95, 96, 100, 101; Diabetes, HCCs 15-19; Liver, HCCs 25-27; Paralysis, HCCs 67-69, 157; Renal, HCCs 130-132.

Exhibit 6. New Incidence of diagnoses within disease groups, MA and FFS, 2004-05 to 2007-08

<u>Disease Group</u>	2004-05 Cohort			2005-06 Cohort			2006-07 Cohort			2007-08 Cohort		
	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
Coronary Artery Disease	6.1%	5.7%	-0.4%	5.8%	5.6%	-0.2%	5.6%	5.8%	0.2%	5.4%	5.6%	0.1%
Cancer	3.8%	4.1%	0.3%	3.8%	4.2%	0.3%	3.9%	4.0%	0.2%	3.9%	4.1%	0.2%
Cerebrovascular Disease	3.0%	2.6%	-0.4%	2.9%	2.6%	-0.3%	2.9%	2.5%	-0.4%	2.9%	2.5%	-0.4%
Diabetes	5.1%	5.1%	0.0%	5.2%	5.0%	-0.2%	5.4%	5.2%	-0.1%	5.4%	5.8%	0.4%
Liver	0.4%	0.4%	-0.1%	0.4%	0.3%	-0.1%	0.4%	0.4%	-0.1%	0.4%	0.4%	0.0%
Paralysis	1.5%	1.2%	-0.3%	1.6%	1.3%	-0.2%	1.6%	1.3%	-0.3%	1.6%	1.3%	-0.3%
Renal	2.4%	2.6%	0.3%	2.7%	3.4%	0.6%	3.6%	5.7%	2.1%	3.7%	5.9%	2.2%
Other	13.4%	12.0%	-1.3%	13.6%	12.5%	-1.1%	13.6%	12.5%	-1.1%	13.6%	12.9%	-0.7%
Total	35.6%	33.8%	-1.8%	36.0%	34.9%	-1.2%	36.9%	37.3%	0.4%	36.8%	38.4%	1.5%

Note: The numerator for each statistic is the number of beneficiaries in the cohort who were coded with an HCC in the disease group in year 2 of the cohort who were not coded in that disease group in year 1 -- that is, new incidence. The denominator is the number of beneficiaries who were not coded in the disease group in year 1 -- that is, the 'at risk' group. Analysis is limited to stayers with community risk scores and consistent data sources (as in Exhibit 3).

Disease groups are sets of HCCs in the CMS-HCC model that are hierarchically related, that is, beneficiaries are assigned the most severe disease if more than one HCC is reported during the data collection period.

The HCCs in each hierarchy are: CAD, HCCs 81-83; Cancer, HCCs 7-10; CVD, HCCs 95, 96, 100, 101; Diabetes, HCCs 15-19; Liver, HCCs 25-27; Paralysis, HCCs 67-69, 157; Renal, HCCs 130-132.

Other includes HCCs that are in partial hierarchies: HCCs 5, 51, 52, 54, 55, 77-79, 104, 105, 107, 108, 111, 112, 148, 149, 154, 155, 161, 177.

Exhibit 7. Disease score changes among continuously enrolled beneficiaries, 2004-2008

Year-to-year change in Disease Score

	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
2004-05	0.046	0.063	0.017
2005-06	0.053	0.072	0.019
2006-07	0.064	0.094	0.030
2007-08	0.069	0.115	0.046
Cumulative	0.232	0.344	0.112
Average Annual Change	0.058	0.086	0.028
N	18,850,283	2,250,622	

Note: Beneficiaries are included in the analysis if they were enrolled in the same MA plan (or in FFS) in July of each year from 2004 through 2008, if they were community residents in each year, and if all of the diagnostic data contributing to the disease score came from either FFS or from a single MA plan.

Exhibit 8. Annual average difference between increase in disease score in MA plans and increase in FFS, 2004-05 to 2007-08 cohorts, distribution across plans

<u>Percentile</u>	Annual average difference between increase in disease score for stayers and increase for comparable FFS beneficiaries
90th	0.062
75th	0.040
Median	0.019
25th	0.001
10th	-0.005
Mean	0.025
Average N	3,388,560

Note: 10% of MA-enrolled beneficiaries are in MA plans in which disease scores for stayers increased by at least 0.062 per year more quickly than for comparable beneficiaries in FFS. 25% of MA-enrolled beneficiaries are in plans in which disease scores for stayers increased, on average, by at least 0.04 more quickly than comparable beneficiaries in FFS. The weighted mean across all plans is 0.025, indicating that, on average, disease scores in MA plans increase by 0.025 per year more quickly than in FFS. The percentile distribution is weighted by the average number of stayers in the plan (averaged across the four cohorts from 2004-05 to 2007-08). MA plans are included in this analysis if they were continually under contract with Medicare from 2004 through 2008. In each cohort, stayers are included in the analysis if they were included in the analysis in Exhibit 3.

Exhibit 9. Annual average difference between increase in disease score in MA plans and increase in FFS,
2004-05 to 2007-08 cohorts, 15 largest MA contracts

<u>Plan</u>	<u>Annual average difference in amount of increase in disease score between MA stayers and comparable FFS stayers</u>
A	0.087
B	0.086
C	0.046
D	0.040
E	0.036
F	0.030
G	0.015
H	0.010
I	0.008
J	0.001
K	0.000
L	0.000
M	0.000
N	-0.010
O	-0.020

Note: Statistic is calculated as in Exhibit 7. Data are sorted by size of difference. Each of the 15 contracts has an average of at least 42,000 stayers per cohort.

Exhibit A1. Caseload Dynamics in MA and FFS, 2004-05

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	<u>FFS</u>	<u>MA</u>	<u>2004</u>	<u>2005</u>	<u>2004</u>	<u>2005</u>	<u>FFS</u>	<u>MA</u>	<u>Difference</u>
Stayers	30,574,973	4,518,986	1.005	1.090	0.905	1.009	0.079	0.092	0.013
Change in Risk Score for stayers				0.085		0.104			
Leavers									
Deceased	1,451,111	189,984	1.880		1.683		-0.036	-0.027	0.010
Hospice	151,322	25,159	1.798		1.599		-0.003	-0.003	0.000
ESRD	41,283	5,760	2.297		2.203		-0.002	-0.001	0.000
Other	133,149	7,947	0.801		0.827		0.001	0.000	-0.001
Subtotal	1,776,865	228,850	1.802		1.657		-0.040	-0.031	0.009
Joiners									
New eligible/other	2,268,626	278,721		0.690		0.647	-0.025	-0.017	0.008
Switchers									
Out to other sector	534,327	150,281	0.885		1.022		0.003	-0.002	-0.004
In from other sector	150,281	534,327		1.220		0.968	0.001	0.000	0.000
Subtotal							0.004	-0.001	-0.005
Total			1.045	1.063	0.944	0.986	0.017	0.042	0.025

Average contribution to change in risk scores calculated as described in Appendix A.

Exhibit A2. Caseload Dynamics in MA and FFS, 2005-06

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	<u>FFS</u>	<u>MA</u>	<u>2005</u>	<u>2006</u>	<u>2005</u>	<u>2006</u>	<u>2005</u>	<u>2006</u>	<u>Difference</u>
Stayers	29,539,146	4,909,704	1.025	1.112	0.945	1.054	0.079	0.086	0.007
Change in Risk Score for stayers				0.087		0.109			
Leavers									
Deceased	1,404,142	201,209	1.915		1.760		-0.036	-0.025	0.012
Hospice	166,206	28,345	1.824		1.695		-0.004	-0.003	0.001
ESRD	42,331	6,240	2.351		2.320		-0.002	-0.001	0.000
Other	141,358	12,796	0.728		0.880		0.002	0.000	-0.001
Subtotal	1,754,037	248,590	1.821		1.721		-0.040	-0.029	0.012
Joiners									
New eligible/other	2,198,675	436,288		0.700		0.675	-0.025	-0.023	0.002
Switchers									
Out to other sector	1,700,697	173,740	0.945		1.099		0.007	-0.003	-0.009
In from other sector	173,740	1,700,697		1.273		1.020	0.001	0.004	0.003
Subtotal							0.008	0.002	-0.006
Total			1.061	1.084	0.986	1.022	0.021	0.036	0.015

Average contribution to change in risk scores calculated as described in Appendix A.

Exhibit A3. Caseload Dynamics in MA and FFS, 2006-07

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	FFS	MA	2006	2007	2006	2007	2006	2007	Difference
Stayers	28,928,146	6,489,357	1.043	1.132	0.981	1.092	0.081	0.094	0.012
Change in Risk Score for stayers				0.089		0.111			
Leavers									
Deceased	1,349,740	250,619	1.960		1.830		-0.037	-0.026	0.011
Hospice	170,986	37,705	1.859		1.772		-0.004	-0.004	0.001
ESRD	40,594	8,734	2.436		2.389		-0.002	-0.002	0.000
Other	122,044	11,304	0.728		0.867		0.001	0.000	-0.001
Subtotal	1,683,364	308,362	1.872		1.803		-0.041	-0.031	0.011
Joiners									
New eligible/other	2,168,614	512,459		0.686		0.646	-0.028	-0.026	0.002
Switchers									
Out to other sector	1,296,518	249,386	0.983		1.117		0.005	-0.002	-0.007
In from other sector	249,386	1,296,518		1.262		1.065	0.001	0.004	0.003
Subtotal							0.006	0.002	-0.004
Total			1.082	1.102	1.022	1.060	0.018	0.038	0.021

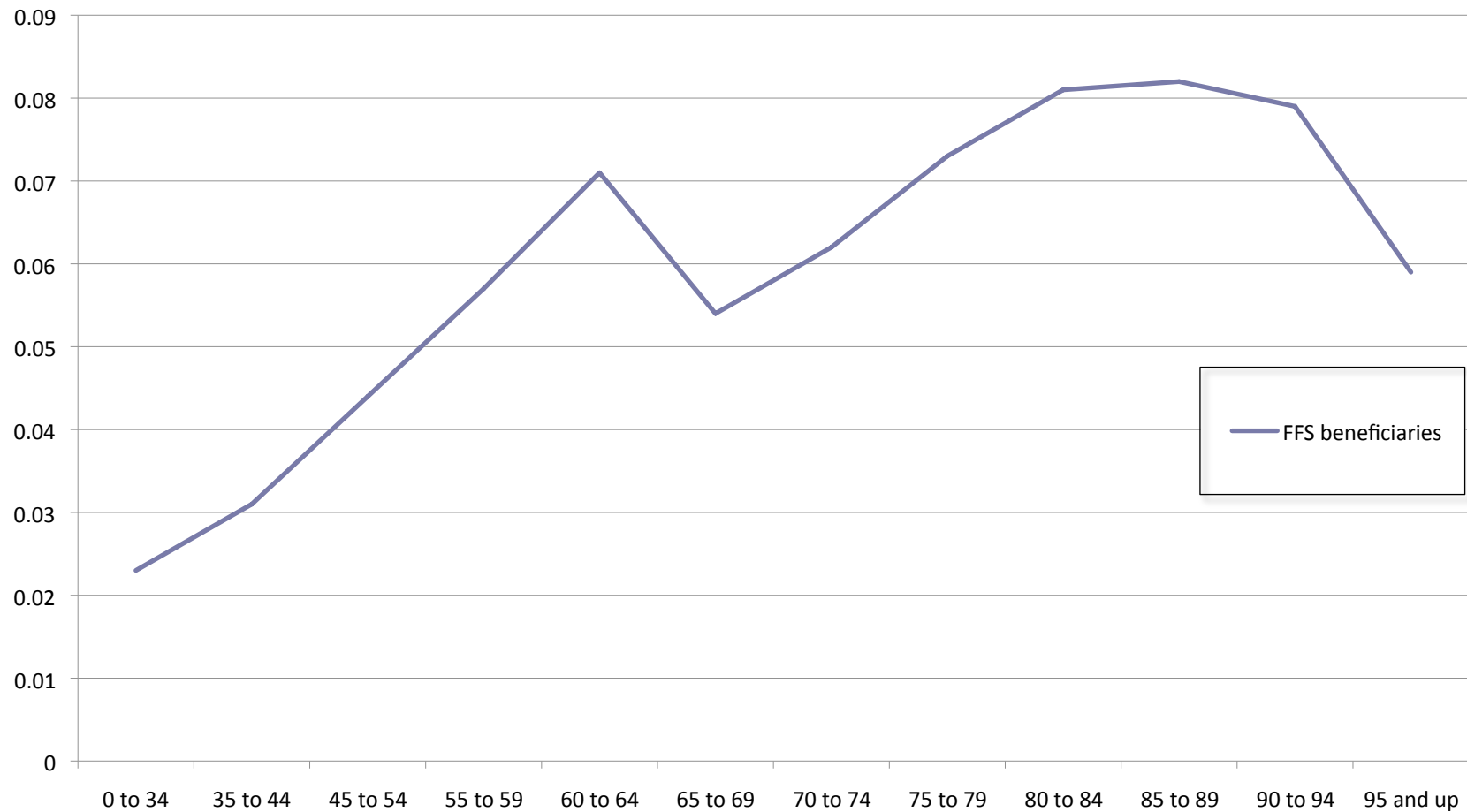
Average contribution to change in risk scores calculated as described in Appendix A.

Exhibit A4. Caseload Dynamics in MA and FFS, 2007-08

	Distribution Of Beneficiaries		FFS Risk Scores		MA Risk Scores		Contribution to change in risk scores		
	<u>FFS</u>	<u>MA</u>	<u>2007</u>	<u>2008</u>	<u>2007</u>	<u>2008</u>	<u>2007</u>	<u>2008</u>	<u>Difference</u>
Stayers	28,380,166	7,675,815	1.059	1.148	1.017	1.142	0.081	0.107	0.026
Change in Risk Score for stayers				0.089		0.125			
Leavers									
Deceased	1,328,536	293,553	1.999		1.920		-0.038	-0.027	0.011
Hospice	171,239	44,793	1.900		1.842		-0.004	-0.004	0.001
ESRD	39,659	10,242	2.471		2.521		-0.002	-0.002	0.000
Other	122,097	12,760	0.732		0.858		0.001	0.000	-0.001
Subtotal	1,661,531	361,348	1.907		1.890		-0.043	-0.033	0.010
Joiners									
New eligible/other	2,277,740	645,182		0.686		0.665	-0.030	-0.030	0.000
Switchers									
Out to other sector	1,304,449	261,171	1.009		1.180		0.004	-0.003	-0.007
In from other sector	261,171	1,304,449		1.348		1.100	0.002	0.003	0.001
Subtotal							0.007	0.000	-0.008
Total			1.100	1.117	1.060	1.104	0.016	0.044	0.028

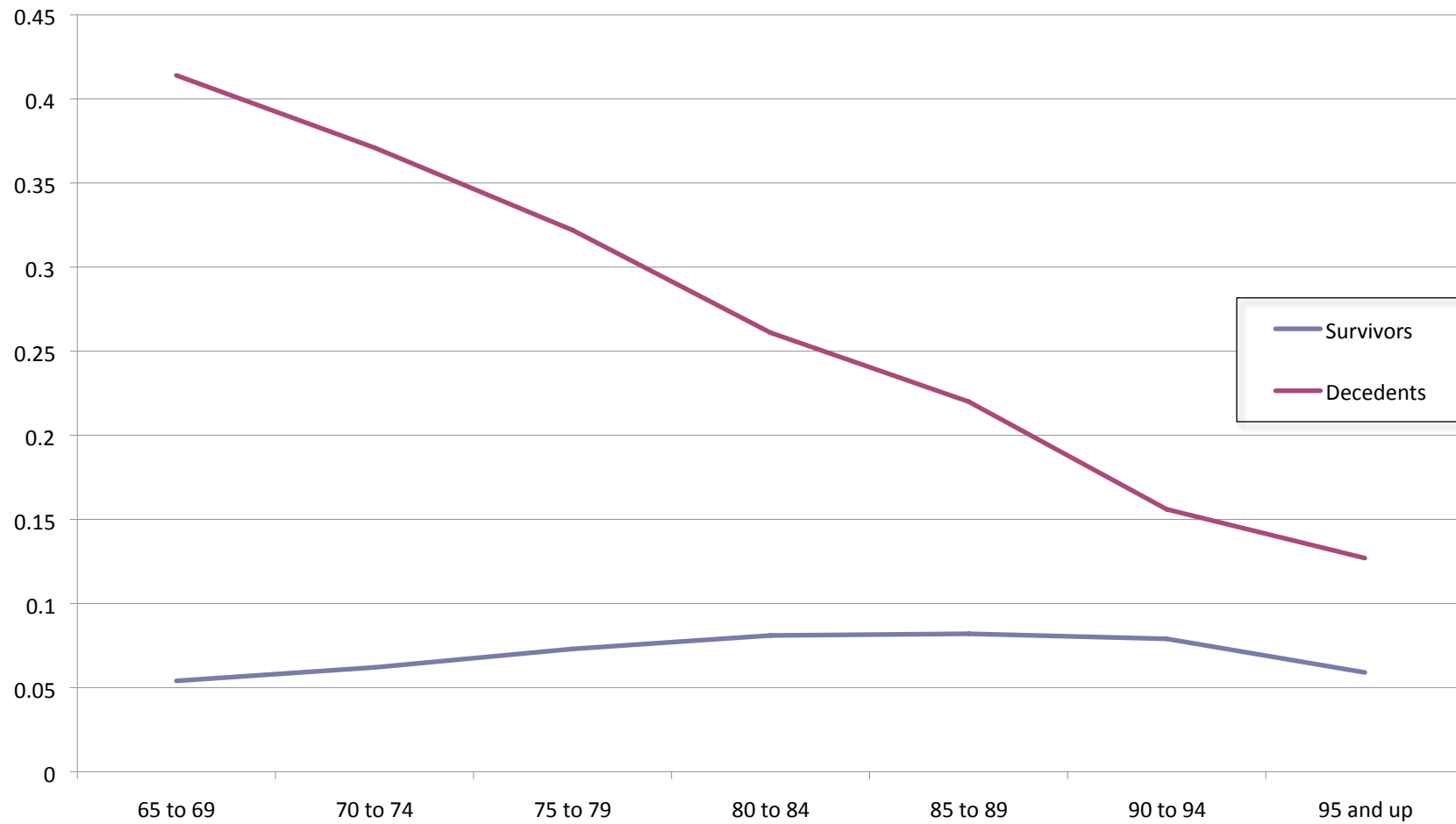
Average contribution to change in risk scores calculated as described in Appendix A.

Ex. B1: Change in disease score, 2005-06, among FFS stayers who survived until at least 12/31/06, by age group



Note: Age group as assigned in the 2005 risk score.

Ex. B2: Change in disease score, 2005-2006, among FFS stayers, by age group and survivor status



Note: Survivors are beneficiaries who were alive 12/31/06. Age group is assigned based on age in 2005.

1. Health Insurers

1.1 Medicare Advantage (MA): Risk Adjustment Data Validation Methodology Discussion and CMS Note

- **Summary:** Risk Adjustment Data Validation (RADV) refers to the methodology used to reimburse MA health plans when they report patients' health risk severity or diagnosis codes. In late December, CMS issued a Request for Comment on its methodology (external link, click [here](#)). In early February, CMS issued a very brief (six sentence) note to health plans as an update on the process.
- **CMS Note in February:** The note stated: "To date, we have received comments on a variety of topics, including a proposed FFS adjuster and RADV audit documentation standards. We are thoroughly evaluating all comments and anticipate making changes to our draft, based on input we received. We anticipate the final revised RADV sampling and payment error calculation methodology paper will be issued in the near future."
- **Industry View That Audit Methodology Was Flawed:** According to the industry, the RADV methodology did not properly account for coding problems that generally occur within the Medicare program – whether the beneficiary was enrolled in a managed care plan or not. As the argument goes, the MA plans would be unfairly penalized for a phenomena that occurs across Medicare beneficiaries, as physicians and other providers may code incorrectly. Further, the industry argues that extrapolating the results from a sample may unfairly penalize plans – in other words, the experience from the sample population may not adequately reflect the experience for all beneficiaries.

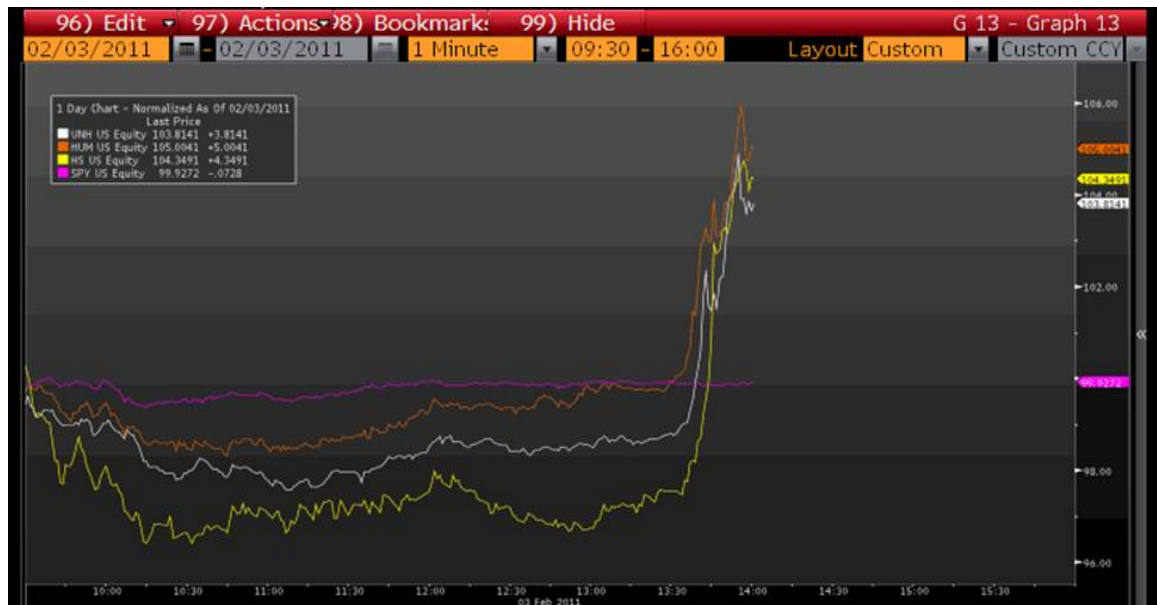
Humana's CEO Michael McCallister, on the company's February 7 quarterly call, stated that the proposed methodology was not "actuarially sound", and without changes, could "jeopardize the program itself."

- The Wells Fargo analyst articulates the argument: "it may be more appropriate to extrapolate the data from all audits to all of Medicare rather than just a specific audit to a Medicare contract since the same problems that probably exist at the contract level may also exist in traditional Medicare. Since this would lower the level of risk scores in traditional Medicare at

the same rate that it would lower the risk score of all the plans, it would mean that the payments to plans would stay similar on average, since the value of the overall risk score in traditional Medicare would rise to reflect the same traditional Medicare claim costs and the lower risk score average. We believe this is a continuing problem with the audit data being extrapolated to the contract level and not including some fix for the same issues existing in traditional Medicare.”

- **Wall Street Response:** Wall Street felt that the February note was an extremely positive development for the managed care companies with large MA exposure, such as HealthSpring, Humana, and UnitedHealth Group.

After analyst notes came out at roughly 1:30 pm on February 3, the stock prices for these companies jumped, as the chart below shows. While the benchmark S&P 500 was roughly flat (the purple line), Humana increased by 5%, HealthSpring 4%, and UnitedHealth 4%. To put this into perspective, a 4% jump for UnitedHealth Group - with an equity market capitalization of roughly \$45 billion – is nearly \$2 billion in “implied newly created equity value” for the company.



1.2 2012 Medicare Advantage: Speculation Surrounding Rates

- **Summary:** The preliminary MA rate announcement is expected in mid-February, while the final rate announcement is expected in early April. While the announcement has a major impact on many managed care companies, analysts have a very difficult time understanding the rates. From Citigroup Global Markets: “With Medicare Advantage reimbursement...the more work we do, the more apparent it becomes how little we really understand this topic. It’s not for lack of trying, but there are just a lot of complicated moving pieces that don’t always move in a consistent way from year to year.”
- **Rates Expected to Be Flat to Higher in 2012:** Analysts have speculated that the rates will not be as bad as once feared after the passage of ACA. In fact, the market now believes that rates may be higher in 2012 than 2011. (It should be noted that the market and policymakers sometimes view rate changes differently. The market typically looks at rate increases relative to the benchmark dollar amount from the previous year. Some policymakers discuss rate changes relative to existing law – and how the changes are projected to impact the federal budget. This report discusses changes in the terms used by the market.)

According to Credit Suisse, “our survey suggests consensus [the market] is looking for a 0% to +2%” increase. On its quarterly investor call, Humana’s CFO put the range at “minus 2% to plus 2%.”

The new benchmark – which was included in ACA - goes into effect in 2012, and was projected to cut MA rates below those plans receive in 2011. However, factors such as an expected increase to rates due to revisions for prior year estimates (the benchmarks used for the prior two years included cuts to physician payment rates that were later restored) may offset the ACA cuts.

- **Impact of the Quality Bonus:** Analysts have also taken note to the quality bonus demonstration, and quantified its potential impact. In November, CMS announced a demonstration project that will pay larger quality bonus payments to MA plans than those enacted in the ACA. Under the ACA, MA plans that have a quality rating of 4 stars or more stood to receive bonus payments starting in 2012. The size of the bonus payments will gradually increase between 2012 and 2014; by 2014, the maximum bonus payment will be 5 percent of the plan’s benchmark.

According to an analyst from Barclays Capital: “Based on these rankings we estimate that the new payment system will result in an average incremental increase of roughly 1.26% for 2012.” Barclays Capital estimates due to the demonstration is presented in the table below by company and year.

2011 Summary Star Ranking (By Membership)	New Demonstration			Old Method			Incremental Positive Change		
	2012 Bonus	2013 Bonus	2014 Bonus	2012 Bonus	2013 Bonus	2014 Bonus	2012 Bonus	2013 Bonus	2014 Bonus
Aetna Inc.	1.9%	3.7%	4.4%	0.5%	1.9%	3.2%	1.4%	1.8%	1.1%
AMERIGROUP Corporation	0.4%	0.8%	1.0%	0.1%	0.6%	1.0%	0.2%	0.2%	0.0%
CIGNA	2.0%	4.0%	5.0%	0.7%	3.0%	5.0%	1.3%	1.0%	0.0%
Centene Corporation	2.0%	4.0%	5.0%	0.7%	3.0%	5.0%	1.3%	1.0%	0.0%
Coventry Health Care Inc.	1.7%	3.5%	3.9%	0.3%	1.3%	2.1%	1.4%	2.2%	1.8%
Health Net, Inc.	1.7%	3.4%	3.4%	0.0%	0.0%	0.0%	1.7%	3.4%	3.4%
HealthSpring, Inc.	1.6%	3.3%	3.8%	0.4%	1.6%	2.6%	1.3%	1.7%	1.2%
HealthSpring Inc. Bravo Health	1.5%	3.0%	3.4%	0.3%	1.0%	1.7%	1.3%	2.0%	1.6%
Humana Inc.	1.3%	2.6%	2.9%	0.2%	0.8%	1.4%	1.1%	1.8%	1.6%
Molina Healthcare, Inc.,	1.3%	2.6%	2.8%	0.1%	0.5%	0.9%	1.2%	2.1%	1.9%
UnitedHealth Group, Inc.	1.6%	3.2%	3.2%	0.0%	0.1%	0.1%	1.6%	3.1%	3.1%
Universal Health Care Inc.	1.5%	2.9%	2.9%	0.0%	0.0%	0.1%	1.5%	2.9%	2.9%
Wellpoint, Inc.	1.5%	3.1%	3.1%	0.0%	0.0%	0.1%	1.5%	3.0%	3.0%
WellCare Health Plans, Inc.	1.1%	2.2%	2.2%	0.0%	0.0%	0.0%	1.1%	2.2%	2.2%
Average	1.5%	3.0%	3.4%	0.2%	1.0%	1.7%	1.3%	2.0%	1.7%





M A R W O O D G R O U P[®]

Policy Preview

February 3, 2010

Medicare Advantage: Preliminary 2011 Rates Likely To Include Several Negative Adjustments

Marwood expects that CMS will release a preliminary notice on Medicare Advantage (MA) payment rates for 2011 on Friday, February 19th. In the release—known as the “45-day notice” because it is announced 45 days in advance of the final ratebook publication—CMS will publish a preliminary per capita growth increase and a preliminary estimate of the fee-for-service normalization factor, two major components of the annual update to MA payment benchmarks. The budget neutrality factor, previously a third component, is no longer an aspect of the MA update, having phased out completely for 2011 and beyond. The final MA ratebook will be released Monday, April 5th.

Highlights:

This year, Marwood expects two significant downward pressures against 2011 rates: (1) a mostly artificial negative stemming from a lower-than-likely projection of Medicare physician payments for both 2010 and 2011, and (2) a renewed aggressive adjustment for “coding intensity.” Combined together, we believe that MA providers should brace for another unpleasant rate update.

- **Overall Growth Trend—*Marwood believes the proposed growth update will be lower than current expectations.*** The MA benchmark rates are partially based on current projected Medicare Part A and B spending—which for 2011 will include an almost five percent reduction in Medicare’s projected physician payments. If not addressed by Congress, CMS has no option other than to abide by projections under current law, and therefore will base its national increase in Medicare growth on an assumption that the cuts will take effect. The upcoming reduction in physician payments in the benchmark formula is typically partially offset by correcting for past congressional action that increased physician spending in the previous year. However, in the absence of a doc fix, current law continues to

include a roughly 21 percent cut from March 2010 until the end of the year and an additional five percent for 2011.

- We continue to expect Congress to enact at least a two-year doc fix. However, if Congress has not resolved this by February 19th for the 45-day notice release, the lack of a physician fix will affect the proposed MA rates negatively. ***That would cause the MA per capita growth update (basically the “market basket” for MA) to be artificially low in the forward-looking 2011 projections to adjust for the five percent cut. Furthermore, the update would not be positively adjusted retroactively to account for any increase in 2010 physician rates, which have only been patched by Congress until February 28, 2010.*** That retroactive increase is widely assumed to materialize for plans for 2011 and to fall within the range of approximately 3-4 percent (*Marwood also notes that the Senate-passed legislation would reduce the MA update for 2011 by three percent, a deliberate effort to reclaim this retroactive adjustment, which plans already adjusted for in last year’s rate update cycle.*)
- **Risk Score Adjustment—***Marwood expects that CMS will propose changes for “coding intensity” in Medicare Advantage as part of this release.* Last year, CMS applied a negative 3.41 percentage reduction to all plans’ risk scores for 2010 based on data from 2004 to 2007. This is a negative adjustment across all plan’s risk scores that CMS implemented to adjust for what the agency has determined to be risk score growth in MA plans that outpaces traditional fee-for-service Medicare. ***Marwood expects that once again the 45-day notice will contain a negative coding intensity adjustment.*** We note that both the House and Senate passed healthcare bills grant authority for CMS to continue to do coding intensity adjustments. CMS actuaries estimated that for 2011 this provision would save around \$3.5 billion out of a baseline of approximately \$123 billion in MA spending.
- The president’s budget, released on Monday, requested that Congress clarify CMS’ statutory authority to extrapolate Medicare Advantage plan sample error rates to entire plan payments when the agency performs risk adjustment audits. The budget estimated the policy would save only \$11 million in 2011, but \$2.3 billion over five years and \$7.6 billion over 10. This policy is different from coding intensity adjustments, where the coding is input correctly but the agency deems it overly aggressive, meaning that risk scores are increasing but the underlying relative illness of the patient mix is not. Currently, the agency conducts risk score audits to identify overpayments from improper coding, but can only recoup overpayments for errors identified in the sample. Marwood understands that the administration asked that this change be included in healthcare reform legislation, if talks proceed on using reconciliation to modify Senate-passed legislation.
- **Fee-for-Service Normalization Factor**—This is a uniform downward adjustment across all MA plan risk scores, updated each year for the expected

increase in risk scores for traditional Medicare beneficiaries. CMS uses this adjustment to bring MA risk scores in line with risk score increases in traditional Medicare. Risk scores are used to adjust payments to plans on a per-member basis. This has remained generally flat over last several years. As a reminder, CMS applied a normalization adjustment to the risk scores of 1.041 percent, or negative 4.1 percent, for 2010. That compares to a 1.03, or negative three percent, adjustment for 2009.

- **IME Phase-Out**—As directed by 2008 MIPPA legislation, 2011 marks the second year that CMS will phase out the additional amount in county benchmarks for areas that had qualified for indirect medical education (IME) payments. The reduction for 2010 was a maximum of 0.6 percent for applicable counties, followed by an additional 0.6 percent in 2011 and subsequent years, for a 1.2 percent max net reduction in 2011, a 1.8 percent max net reduction in 2012 and so on. CMS will identify the amount of IME for each county in the final ratebook.
- **What It Won't Include**—Marwood notes that the 45-day notice does not include several adjustments to the eventual rates, including the budget neutrality adjustment component, which was traditionally held until the final ratebook but now has been completely phased out. We also believe a rebase of county rates is unlikely. While CMS under the Bush Administration rebased rates every other year, we do not believe that the Obama Administration will perform this non-required exercise when the net result of a rebase would be an increase to MA payment benchmarks.

Also pending from CMS is the annual draft 2011 Call Letter asking health plans to participate in Medicare Advantage and the Part D program (normally released in late January), and a final regulation from an October 2009 proposal to regulate Medicare Advantage which we believe that CMS is trying to release by the end of March. As signaled in last year's call letter and proposed October regulation, CMS is moving to further constrain the MA program. These releases are likely to include such policies as restricting the flexibility of a plan's cost-sharing structure and disallowing plans from offering overly similar plan structures in one particular service area.

Background:

Medicare Advantage payment increases to local capitation rates (benchmarks) is primarily driven the per-capita Medicare Advantage growth percentage (the budget neutrality factor was the second factor in previous years, but is now permanently set at zero). Plans bid against the county benchmark rates each June for the areas in which they operate, and those plans who bid under the county benchmarks receive 75 percent of the difference as a rebate to enhance benefits (lower premiums or offer additional services) for their enrollees. The federal government retains the other 25 percent.

Final plan and member-specific rates will vary considerably based on how plans bid against the benchmarks to determine standard payment, which is then adjusted per member by a risk score which reflects demographic and health status characteristics.

Plans with higher risk scores (i.e., plans with less healthy enrollees than the payment area's fee-for-service population) experience significantly higher updates. Thus, there is an incentive for MA plans to ensure that all diagnosis codes reflecting the severity of their members' conditions are captured. The degree to which certain plans have increased the diagnoses codes reported to CMS is what has led the agency for 2010 to implement a coding intensity adjustment for all contracts.

CMS also applies a FFS normalization factor across-the-board to risk scores to bring them in line with those found under traditional Medicare; that's because risks scores tend to grow faster in MA than in fee-for-service.

Marwood Group Research, LLC

Brian Fortune
(212) 532-3651
research@marwoodgroup.com

Analyst Certification

Each research analyst responsible for the content of this research report certifies that:

1. All views expressed in this report accurately reflect his or her personal views about any of the subject securities or issuers, and
2. No part of his or her compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views expressed in this report.

Required Disclosures

None.

Marwood Group Research, LLC, Member FINRA, SIPC

The information herein is provided for informational purposes only. The information herein is not intended to be, nor should it be relied upon in any way, as investment advice to any individual person, corporation, or other entity. This information should not be considered a recommendation or advice with respect to any particular stocks, bonds, or securities or any particular industry sectors and makes no recommendation whatsoever as to the purchase, sale, or exchange of securities and investments. Reference herein to any specific commercial products, process, or service by trade name, trademark, manufacturer, or otherwise, does not necessarily constitute or imply its endorsement, recommendation, or favoring by Marwood Group Research, LLC ("Marwood").

All information contained herein is provided "as is" without warranty of any kind. While an attempt is made to present appropriate factual data from a variety of sources, no representation or assurances as to the accuracy of information or data published or provided by third parties used or relied upon contained herein is made. Marwood makes no representations and disclaims all express, implied and statutory warranties of any kind, including any warranties of accuracy, timeliness, completeness, merchantability and fitness for a particular purpose.

Neither Marwood nor its affiliates shall be liable to any other entity or individual for any loss of profits, revenues, trades, data or for any direct, indirect, special, punitive, consequential or incidental loss or damage of any nature arising from any cause whatsoever, even if Marwood has been advised of the possibility of such damage. Marwood and its affiliates shall have no liability in tort, contract

or otherwise to any third party. The copyright for any material created by the author is reserved. The information herein is proprietary to Marwood. Any duplication or use of such material is not permitted without the author's written agreement.

© 2010 Marwood Group Research, LLC

North America United States

Health Care Managed Care

09 Dec 2010 - 01:52:48 PM EDT

INDUSTRY ALERT

Breaking News

Managed Care

Update on Medicare Advantage RADV Coding Audits

Focus stocks

Aetna (AET.N),USD29.98 Buy, Price Target USD36.00

AmeriGroup (AGP.N),USD44.28 Buy, Price Target USD50.00

CIGNA (CI.N),USD36.93 Hold, Price Target USD40.00

Centene (CNC.N),USD24.69 Hold, Price Target USD25.00

Coventry Health Care (CVH.N),USD26.25 Hold, Price Target USD26.00

eHealth (EHTH.OQ),USD15.61 Hold, Price Target USD13.00

Triple-S (GTS.N),USD18.98 No Recommendation, -

Health Net (HNT.N),USD26.57 Hold, Price Target USD28.00

HealthSpring (HS.N),USD28.76 Hold, Price Target USD29.00

Humana (HUM.N),USD56.43 Hold, Price Target USD56.00

Healthways Inc (HWAY.OQ),USD10.33 Hold, Price Target USD11.00

Magellan Health (MGLN.OQ),USD48.94 Buy, Price Target USD53.00

Molina (MOH.N),USD24.88 Hold, Price Target USD28.00

Universal American (UAM.N),USD15.61 Hold, Price Target USD16.00

UnitedHealth Group (UNH.N),USD36.84 Hold, Price Target USD39.00

WellCare Health Plans (WCG.N),USD28.88 Hold, Price Target USD29.00

WellPoint (WLP.N),USD56.53 Buy, Price Target USD68.00

One of the most binary risks facing the stocks of MCOs with significant Medicare Advantage (MA) exposure relates to the ongoing risk adjustment data validation (RADV) audits that the HHS Office of Inspector General is conducting of MA plans. Indeed, the RADV audit process is one of the reasons we have remained relatively cautious on the MA sub-sector. On 11/24, the Department of Justice announced the first RADV audit settlement with America's Health Choice Medical Plans (AHC). AHC agreed to pay \$22.6 million to resolve allegations that they caused Medicare to overpay based on submission of false diagnoses codes. The settlement resolved a suit brought by the DOJ in the U.S. District Court for the Southern District of Florida alleging that AHC's primary care provider falsely increased the severity of member diagnoses to obtain higher payments from CMS through the risk-adjusted payment system.

In the latest edition of Medicare Advantage News (MAN) published today, an industry consultant is quoted as noting that at least one more MA RADV-based case is now proceeding toward a settlement, this time involving one of the public MCOs. The consultant believes that the settlement in this case will be larger than the one announced with AHC, based on a "nine-digit demand letter". The consultant also noted that while the AHC case involved an investigation in Florida, other large markets such as California, New York, and Texas could "also be vulnerable". The consultant predicts that the settlement involving the public MCO could occur in either 1Q11 or 2Q11. However, we have no indication as to which public MCO the consultant is referencing from the MAN article. Investors will need to stay focused on this issue as we head into the new year. We will revert back with any further details that we gather on the subject of the MA-RADV audits.

Scott Fidel

Research Analyst
(+1) 212 250-3716
scott.fidel@db.com

Justin Bowers, CFA

Research Associate
(+1) 212 250-8564
justin.bowers@db.com

Deutsche Bank Securities Inc.

All prices are those current at the end of the previous trading session unless otherwise indicated. Prices are sourced from local exchanges via Reuters, Bloomberg and other vendors. Data is sourced from Deutsche Bank and subject companies. Deutsche Bank does and seeks to do business with companies covered in its research reports. Thus, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report. Investors should consider this report as only a single factor in making their investment decision.

THE VIEWS EXPRESSED ABOVE ACCURATELY REFLECT PERSONAL VIEWS OF THE AUTHORS ABOUT THE SUBJECT COMPANY(IES) AND ITS(THEIR) SECURITIES. THEY HAVE NOT AND WILL NOT RECEIVE ANY COMPENSATION FOR PROVIDING A SPECIFIC RECOMMENDATION OR VIEW IN THIS REPORT. FOR OTHER DISCLOSURES PLEASE VISIT [HTTP://GM.DB.COM](http://GM.DB.COM) MICA(P) 007/05/2010

**Medicare Advantage Risk Adjustment Data Validation (RADV)
Notice of Payment Error Calculation Methodology for Part C Organizations
Selected for Contract-Level RADV Audits
Request for Comment**

Introduction

Section 1853(a)(3) of the Social Security Act requires that the Centers for Medicare & Medicaid Services (CMS) risk adjust payments to Medicare Advantage (MA) organizations. In general, the current risk adjustment methodology relies on enrollee diagnoses, as specified by the International Classification of Disease, Ninth Revision Clinical Modification guidelines (ICD-9-CM) to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes are used to determine beneficiary risk scores, which in turn determine the risk adjusted reimbursement. MA enrollee risk scores are based on risk adjustment diagnoses that were present on Medicare Fee for Service (FFS) claims and/or submitted to CMS by MA organizations.

CMS annually selects MA organizations for RADV audits. Contract-specific MA organization RADV audits measure individual MA organization-level payment error-rates related to risk adjustment data for payment recovery. RADV audits confirm the presence of risk adjustment conditions based on supporting medical record documentation. As stated in the preamble of the new regulation on Risk Adjustment Data Validation –Dispute and Appeal Procedures at 42 CFR 422.311, CMS intends to provide an annual notice of the RADV payment error calculation methodology with the opportunity for MA organizations to comment on the methodology. This paper describes the sampling and error calculation methodology that CMS utilizes when conducting RADV audits. This sampling and error calculation methodology is used to calculate a payment error estimate and payment recovery amount for each MA contract selected for an audit.

Sampling

Once an MA contract has been selected for a RADV audit, CMS applies criteria for selecting the MA contract's enrollees.

Enrollee Selection

Enrollees are sampled from each selected MA contract for the purpose of estimating payment error related to risk adjustment. The enrollee sample for a RADV contract-level audit will be selected from the cohort of eligible Medicare beneficiaries who were enrolled in the contract (H-number, E-number, or R-number) in January of the payment year— based on monthly member enrollment files. The enrollees who are eligible for RADV sampling are those who were also:

1. Continuously enrolled in the same MA contract for all 12 months of the data collection year;
2. Non-End Stage Renal Disease (non-ESRD) status in or prior to the payment year;

3. Non-hospice between January of the data collection year and January of the payment year, and had less than 12 months of hospice during the payment year;
4. In Medicare Part B coverage for all twelve months during the data collection period (i.e., defined as full risk enrollees for risk adjusted payment); and had
5. At least one risk adjustment diagnosis (ICD-9-CM code) submitted during the data collection period that led to at least one CMS-HCC assignment. These HCCs were present for risk adjusted payments, based on plan-submitted risk adjustment data, and are referred to as the validation HCCs for the sampled enrollees.

CMS will select up to 201 enrollees for medical record review from each contract selected for an audit.

Sample Stratification

Enrollee-based stratification will be used in the process of sampling enrollees. In order to derive the strata, the eligible enrollees, in each contract, will be ranked from lowest to highest based on their community risk score. The enrollees will then be divided into three equal groups based on the total number of eligible enrollees, where the first group will include the third of enrollees with the highest risk scores and the third group will include the third of enrollees with the lowest risk scores. The remaining enrollees will be in the middle stratum. In the case of 201 sampled enrollees, sixty-seven (67) enrollees will be randomly sampled from each group or stratum. The corresponding stratum-based enrollee weights will be computed as the number of RADV-eligible enrollees in the population grouping (or stratum) divided by the number of enrollees selected from that grouping for the sample (or N_h / n_h), where h represents the corresponding stratum. For example, if a contract has 3,000 enrollees, the enrollees would be ranked by risk score, then divided into three equal groups of 1,000 enrollees each (to represent high, medium, and low strata). An equal number of enrollees will be selected from each group. The weight for each enrollee will equal 14.925 (i.e., 1,000/67). The enrollee sampling weights will be used as multipliers to scale-up (or extrapolate) the sample payment error findings to the population which it represents.

Payment Error Calculation

Enrollee-level Payment Error Calculation

The risk scores for each sampled enrollee will be corrected based on the HCCs that are supported by RADV medical record review findings for the enrollee. The RADV (or corrected) risk scores and payments will be calculated for each sampled enrollee. Enrollee-level payment errors will be defined as the difference between the original payment and the corrected payment (i.e., payment error = (original payment minus corrected payment)). The payment error for each enrollee will be either positive-- representing a net overpayment, or negative-- representing a net underpayment. A payment error will be calculated for each sampled enrollee based on the number of months the person was enrolled in the MA selected contract (and was not ESRD or hospice) during the payment year.

Payment Error Extrapolation Calculation

To derive the estimated payment error for each MA contract, the total payment error for each sampled enrollee will be multiplied by the enrollee's sampling weight (computed during the sampling phase as N_h/n_h for each stratum). The weighted enrollee payment errors will be summed across all enrollees in the sample to determine an estimated payment error for the MA contract. The payment recovery amount for each audited MA contract will be determined by the lower bound of the 99% confidence interval around the payment error estimate. The following is an example formula for computing a 99% confidence interval around the payment error estimate for one contract, assuming a sampling method containing three enrollee strata groupings.

The 99% confidence interval lower bound is computed as the estimated payment error (PE) minus (2.575 multiplied by the standard error) or $(PE - (2.575 * SE))$, whereby the standard error can be reproduced as follows:

1. Derive the variance, v_h , (standard deviation squared) of the unweighted enrollee payment errors across the sample enrollees within each of the three strata (h).
2. Calculate the variance of the estimated total (V_T), where N represents the number of enrollees in the RADV-eligible population of the h^{th} (1st, 2nd, 3rd) stratum:

$$v_{\hat{T}} = \sum_{h=1}^3 \frac{N_h^2}{67} v_h$$

3. The standard error is $se_{\hat{T}} = \sqrt{v_{\hat{T}}}$

Request for Comment

CMS is pleased to invite public comment on this document. CMS will review all timely comments and may revise or modify the RADV sampling and payment error calculation methodology based on the comments received. Once all comments have been reviewed and considered, CMS will post a final version of the RADV sampling and payment error calculation methodology at <https://www.cms.gov/HealthPlansGenInfo/>.

Comments must be submitted in writing by Friday, January 21, 2011 to the following email address:

RADV@cms.hhs.gov

Please specify "Comment on RADV sampling and error calculation methodology" in the subject line of your email.

UBS Investment Research

Managed Care – Medicare Advantage

Americas

Healthcare Providers

Sector Comment

Risk Score Decisions Trump Rate For 2012

■ CMS has discretion to get to just about any rate update they want for 2012

CMS will deliver preliminary 2012 Med Adv rates on Feb 18 via Advance Notice w/final rates on April 4th. We expect 2012 trend + prior year will net to -1% to +1% with decision on 2011 restatement (from 0%) main swing factor. Given other moving parts such as IME, FFS normalization and rebasing probably net to another -1% we see reimbursement of 0% to -2% before PPACA cuts of -2% and possible increase in risk coding intensity, leaving net reimbursement anywhere from flat at the high end to down mid-to-high single digits before plan coding improvements.

■ Coding intensity adj and RADV decision may be more important than rate

While rate outcome will be in focus, it is trumped in our mind by getting visibility on agency's intent on risk scores, both in terms of risk coding intensity adj (vs. previous -0.0341) in Advance Notice and final RADV methodology later this spring. Our cautious outlook on Medicare Advantage has been directly tied to uncertainty around risk scores and we see upcoming CMS decisions as binary event for plans such as HUM/HS/UNH as government aggression could lead to NT earnings/margin reset lower for plans while more moderate view would be bullish should it remove overhang and increase sustainability of offering over time.

■ See Figure 1 on Page 7 for detailed overview of moving parts for 2012 rates

Figure 1 on Page 7 gives a concise one-page overview in terms of our est. of moving parts for 2012 rates. We note our est. are derived from most recent USPPC projections, however, these est. will be updated today with release of President's Budget, with updated spending proj. which CMS will use to set 2012 and prior year inflationary trend for Advance Notice. Final rate release expected on Apr 4th.

14 February 2011

www.ubs.com/investmentresearch

Justin Lake, CFA

Analyst

justin.lake@ubs.com

+1-212-713 2765

Ken LaVine, CFA

Associate Analyst

kenneth.lavine@ubs.com

+1-212-713 4237

Andrew Valen

Associate Analyst

andrew.valen@ubs.com

+1 212 713 2717

Dean Poniros, CPA

Associate Analyst

dean.poniros@ubs.com

+1-212-713 3229

Executive Summary

Look for CMS discretion to have major impact on rates for 2012. CMS will have more discretion for 2012 rates than at any time we have seen in recent memory. In addition to decisions on risk score coding intensity adjustment and FFS normalization, the agency will also have to determine whether to positively re-state 2011 rates upward versus legislated 0%, potentially adding about 2.0% to trend by our estimate. Overall we see potential for total reimbursement of anywhere from flat to down mid-to-high single digits, depending on CMS treatment of discretionary items. Typically adjustments such as FFS normalization and rebasing will not come out until final rates, which are expected on April 4th. Given significance of discretionary factors as well as potential for CMS to opine on risk score coding intensity adjustment as well as RADV audits, we think the “signalling” from CMS here will actually be more interesting than the rates themselves in terms of interpreting the intermediate to longer-term outlook for Medicare Advantage growth and margin sustainability.

While potential outcomes are broad in terms of 2012 rates, we look for CMS “signalling” on risk scores/RADV as more important than rates in terms of discerning intermediate term outlook for Medicare Advantage

Table 1: 2012E Medicare Advantage Estimates (Low vs. High), versus 2010 / 2009 Med Adv Reimbursement *

2012 Estimated Med Adv Rate:	LOW	HIGH	2010 Med Adv Rates		2009 Med Adv Rates	
Prior Year Adjustments	2.00%	4.00%	Prior Year Adjustments	1.76%	Prior Year Adjustments	0.50%
2012 Trend Rate	-3.00%	-3.00%	2010 Trend Rate	-0.35%	2009 Trend Rate	3.74%
Total Trend	-1.00%	1.00%	Total Trend	0.81%	Total Trend	4.24%
IME Cuts	-0.50%	-0.30%	IME Cuts	-0.53%	IME Cuts	N/A
B.N. Adjustment	-0.10%	0.00%	B.N. Adjustment	-0.85%	B.N. Adjustment	-0.80%
Re-basing	0.25%	0.50%	Re-basing	N/A	Re-basing	0.20%
Final Rate Trend	-1.35%	1.20%	Final Rate Release	-0.57%	Final Rate Release	3.64%
FFS Normalization	-1.75%	-1.25%	FFS Normalization	-1.10%	FFS Normalization	-1.50%
Risk Coding Adjustment	-3.00%	0.00%	Risk Coding Adjustment	-3.41%	Risk Coding Adjustment	NA
Plan Reimbursement	-6.10%	-0.05%	Plan Reimbursement	-5.08%	Plan Reimbursement	2.14%
PPACA Cuts	-2.50%	-2.50%	PPACA Cuts	N/A	PPACA Cuts	N/A
Star Bonus Payments	0.50%	0.50%	Star Bonus Payments	N/A	Star Bonus Payments	N/A
Net Plan Reimbursement	-8.10%	-2.05%	Net Plan Reimbursement	-5.08%	Net Plan Reimbursement	2.14%

Source: CMS and UBS estimates; * given “frozen” rates for 2011, we excluded 2011 Med Adv Reimbursement analysis from the table

As mentioned above, the key unknowns around 2012 Medicare Advantage rates include risk coding intensity adjustment and the decision on 2011 restatement. Other smaller unknowns include decision on whether to include one or two years of IME cuts since they were not included in last year’s rate and size of FFS normalization and rebasing. Please see page 7 for further detail around the assumptions behind our 2012 Med Adv rate estimate.

Table 2: Key 2012 Med Adv Rate Procedural / CMS Unknowns

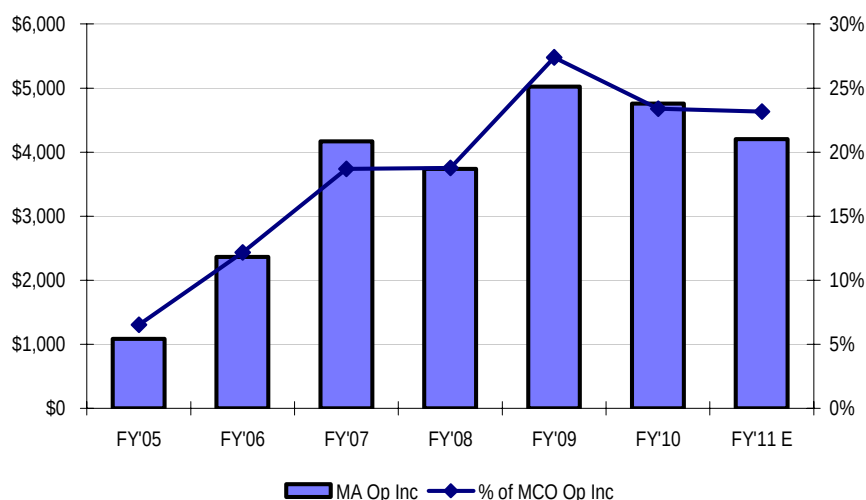
Procedural / CMS Factors	
	Risk coding intensity adjustment
	2011 Trend Adjustment restated from 0% to +2%
	IME cuts for 2011 and for 2010
	Budget Neutral adjustment

Source: UBS estimates

Medicare Advantage growth has been a significant driver of industry earnings over the past five years. Focus on Medicare Advantage economics is a product of the meaningful contribution to sector earnings experienced over the last five years as illustrated in Chart 1 below. A combination of structural arbitrage by the government from a rate perspective and declining commercial segment earnings have left the industry generating an estimated ~25% of operating income from this segment of the business.

Combination of generous Med Adv reimbursement and declining comm'l segment earnings leave industry generating ~25% of operating income from Med Adv

Chart 1: UBS Managed Care Coverage Universe: Est. Med Adv Op Inc and as % of Overall Op Inc, 2005 – 2011E, \$ in millions



Source: Company reports and UBS estimates

Medicare Advantage rates may remain under pressure for next several years due to modest CMS assumptions in terms of Medicare FFS cost trend coupled with PPACA cuts and potential risk score moderation. As illustrated below, in addition to typical low single digit CMS estimate for Medicare FFS cost trend (not including additional physician fee schedule cut pressure) the PPACA cuts passed last year will transition in as a low single digit headwind for the next several years, modestly offset by upside from STAR ratings. Overall, we expect reimbursement flat to down ex-improvements in plan specific risk scores through 2015. In order for plans to manage a “soft landing” in terms of Medicare Advantage growth and margins over next three to five years, versus the 50% cut in membership estimated by CMS actuaries post reform, the ability to continue pushing risk score revenue higher through more accurate coding versus traditional Medicare will be key. This is why, in our eyes, the agency’s actions in terms of risk score coding intensity adjustments and RADV audits are extremely important in ascertaining whether plans can execute through next several years of cuts as reimbursement transitions toward costs in traditional Medicare or not.

CMS actions around risk score coding intensity adjustments and RADV audits are extremely important in ascertaining whether plans can execute thru next several years of cuts as reimbursement transitions towards traditional Medicare costs

Table 3 highlights the estimated industry-wide reimbursement cuts by year and product under healthcare reform, with enrollment based on 2009 membership

Table 3: Med Adv – Estimated Industry-Wide Reimbursement Cuts under Healthcare Reform, by Year and Product (\$ in mm's)

2010 Med Adv Reimbursement (Starting Point)		\$111,672					
MA Reimbursement Cuts	2011	2012	2013	2014	2015	2016	2017
MA - HMO plans	(\$1,042)	(\$2,981)	(\$4,919)	(\$6,654)	(\$8,388)	(\$9,256)	(\$10,124)
MA - PPO plans	(\$185)	(\$510)	(\$836)	(\$1,113)	(\$1,390)	(\$1,516)	(\$1,642)
MA - PFFS plans	(\$314)	(\$826)	(\$1,339)	(\$1,724)	(\$2,109)	(\$2,261)	(\$2,413)
Total Med Adv	(\$1,541)	(\$4,317)	(\$7,094)	(\$9,490)	(\$11,887)	(\$13,033)	(\$14,180)
Incremental YoY Cut	(\$1,541)	(\$2,776)	(\$2,776)	(\$2,397)	(\$2,397)	(\$1,146)	(\$1,146)
Wtd Avg Cut by Year	2011	2012	2013	2014	2015	2016	2017
MA - HMO plans	-1.4%	-4.0%	-6.5%	-8.8%	-11.1%	-12.3%	-13.4%
MA - PPO plans	-1.4%	-3.8%	-6.2%	-8.3%	-10.4%	-11.3%	-12.3%
MA - PFFS plans	-1.4%	-3.6%	-5.9%	-7.6%	-9.3%	-9.9%	-10.6%
Total Med Adv	-1.4%	-3.9%	-6.4%	-8.5%	-10.6%	-11.7%	-12.7%
Incremental YoY Wtd Avg Cut	-1.4%	-2.5%	-2.5%	-2.1%	-2.1%	-1.0%	-1.0%

Source: CMS and UBS estimates

Table 4 highlights the estimated company-specific reimbursement cuts by year and under healthcare reform, with enrollment based on 2009 membership

Table 4: Med Adv – Estimated Company-Specific Reimbursement Cut % by Year under Healthcare Reform *

		2011	2012	2013	2014	2015	2016	2017
AET	Incremental YoY Cuts	-1.38%	-2.43%	-2.43%	-2.18%	-2.18%	-0.95%	-0.95%
	Cumulative Med Adv Cuts	-1.4%	-3.8%	-6.2%	-8.4%	-10.6%	-11.6%	-12.5%
CI	Incremental YoY Cuts	-1.38%	-2.79%	-2.79%	-2.67%	-2.67%	-0.27%	-0.27%
	Cumulative Med Adv Cuts	-1.4%	-4.2%	-7.0%	-9.6%	-12.3%	-12.6%	-12.8%
CVH	Incremental YoY Cuts	-1.38%	-2.26%	-2.26%	-1.97%	-1.97%	-0.93%	-0.93%
	Cumulative Med Adv Cuts	-1.4%	-3.6%	-5.9%	-7.9%	-9.9%	-10.8%	-11.7%
HNT	Incremental YoY Cuts	-1.38%	-2.64%	-2.64%	-2.58%	-2.58%	-1.15%	-1.15%
	Cumulative Med Adv Cuts	-1.4%	-4.0%	-6.7%	-9.2%	-11.8%	-13.0%	-14.1%
HS	Incremental YoY Cuts	-1.38%	-2.42%	-2.42%	-1.76%	-1.76%	-1.05%	-1.05%
	Cumulative Med Adv Cuts	-1.4%	-3.8%	-6.2%	-8.0%	-9.7%	-10.8%	-11.9%
HUM	Incremental YoY Cuts	-1.38%	-2.27%	-2.27%	-1.66%	-1.66%	-0.77%	-0.77%
	Cumulative Med Adv Cuts	-1.4%	-3.7%	-5.9%	-7.6%	-9.2%	-10.0%	-10.8%
UNH	Incremental YoY Cuts	-1.38%	-2.55%	-2.55%	-2.30%	-2.30%	-0.94%	-0.94%
	Cumulative Med Adv Cuts	-1.4%	-3.9%	-6.5%	-8.8%	-11.1%	-12.0%	-13.0%
WLP	Incremental YoY Cuts	-1.38%	-2.32%	-2.32%	-2.03%	-2.03%	-0.61%	-0.61%
	Cumulative Med Adv Cuts	-1.4%	-3.7%	-6.0%	-8.0%	-10.1%	-10.7%	-11.3%
TOTAL	Incremental YoY Cuts	-1.38%	-2.49%	-2.49%	-2.15%	-2.15%	-1.03%	-1.03%
	Cumulative Med Adv Cuts	-1.4%	-3.9%	-6.4%	-8.5%	-10.6%	-11.7%	-12.7%

Source: Company reports, CMS, and UBS estimates; * estimated cuts based on plan 2009 ending Med Adv membership

We have historically held a fairly cautious viewpoint on plans with heavy Medicare Advantage earnings exposure due to concerns on sustainability of earnings and growth rates post cuts in reimbursement rate subsidies and risk scores. Table 5 below highlights our estimates of Medicare Advantage earnings as a percentage of total for our non-Medicaid managed care coverage universe.

We have historically held a fairly cautious view on Med Adv due to concerns on CMS reimbursement cuts putting pressure on growth and margins going forward

Table 5: UBS MCO Universe – Est. 2011 Medicare Advantage Exposure

	HS	HUM	UNH	CVH	HNT	AET
UBS Rating	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral
Current PE (NTM Cons)	8.2x	9.7x	9.7x	9.2x	9.2x	9.5x
FY'11E Med Adv Premiums (\$mil)	\$3,766	\$20,211	\$25,238	\$2,571	\$2,427	\$4,806
MA as % of total Premiums	78.2%	59.8%	27.8%	22.4%	23.2%	17.7%
2011 Med Adv Margin Est. *	8.2%	6.0%	7.2%	5.8%	1.9%	2.3%
Oper. Profits (pre-tax \$mil) *	\$283	\$1,215	\$1,971	\$201	\$64	\$186
MA as % of total Op Profit	75.8%	67.7%	29.4%	33.8%	13.7%	8.2%
MA EPS contribution	\$3.17	\$4.54	\$1.16	\$0.88	\$0.41	\$0.31
EPS estimate	\$3.60	\$6.45	\$3.65	\$2.70	\$2.81	\$3.72
MA as % of EPS	88.1%	72.1%	31.9%	33.3%	14.8%	9.6%
Med Adv HMO Lives	195	636	1,415	137	239	172
Med Adv PPO Lives	3	673	325	88	40	171
Med Adv PFFS Lives	0	455	347	0	0	95
Med Adv Total Lives (000s)	198	1,764	2,086	225	280	438
MA as % of total Membership	60.0%	21.3%	6.2%	6.6%	4.9%	2.5%
Est Med Adv Spread vs. FFS	9.2%	14.0%	15.3%	14.8%	15.9%	13.7%

* 2011 Med Adv estimated margins exclude investment income while Med Adv operating profits include investment income allocation

Note Med Adv lives based on CMS initial 2011 data reflecting 2011 enrollment as of 12/1/10 payment period

Source: Company reports, CMS, FactSet, and UBS estimates

Should CMS decide to take a more measured approach on risk scores going forward, we may be forced to revisit our cautious view on Medicare Advantage segment earnings sustainability. While rates are now legislated to decline toward costs in traditional Medicare, risk score improvement has continued unabated. We have discussed potential CMS action here since 2007, with risks coming into spotlight over last several months as the agency progresses toward final methodology on 2007 RADV audits. However, there also remains risk to reimbursement in terms of risk coding intensity adjustments which lowered reimbursement by about 3.41% in 2010. That said, as illustrated in Table 6 below, plans continue to make progress on risk score coding, with sophisticated Medicare Advantage operators able to keep rates fairly flat through improved risk score coding. While we continue to view changes here by CMS as most significant risk to plans, should CMS decide to back off here, for reasons political or otherwise, this would be extremely bullish for plans, indicating potential ability to manage through PPACA rate pressures over next several years.

We have highlighted potential CMS action here since 2007, with risks coming into spotlight over the last several months as the agency progresses toward final methodology on 2007 RADV audits

Table 6: HS & HUM Benefits of Improved Risk Coding

	2008	2009	2010	2011
HealthSpring				
MA PMPM	\$1,002	\$1,055	\$1,054	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	5.21%	-0.01%	--
Humana				
MA PMPM	\$858	\$917	\$929	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	6.85%	1.36%	--

Source: Company reports and UBS estimates

Table 7 highlights key Med Adv / Part D dates for 2011

Table 7: Med Adv / Part D Events Calendar for 2011

Date	Event
18-Feb	CMS releases "Advance Notice" rates for CY 2012
4-Apr	CMS issues Med Adv Final Rate Notice for CY 2012
6-Jun	Med Adv / Part D bids due for CY 2012
Mid August	CMS releases regional Part D benchmarks for CY 2012
Late Sept.	CMS releases additional Part D benchmark / plan-specific details for CY'12

Source: CMS

Figure 1: UBS Managed Care – 2012 Medicare Advantage Rate Calculation (Low versus High estimate)

UBS Managed Care - 2012 Medicare Advantage Rate Preview			
Category	2012 - Low Est.	2012 - High Est.	Comments
Adj. to Prior Years estimate	2.00%	2.00%	Estimated Prior Year Adjustments from 2010 and prior
Adj. to 2011 estimate	0.00%	2.00%	Estimated 2011 Inflation Trend is 2.00%. Question here is whether CMS will choose to adjust 2011 upward from the 0.00% legislated update last year or leave it intact.
2012 Trend Rate	-3.00%	-3.00%	We estimate 2012 trend rate will be in the -3% range including 31% cut to physician fee schedule which will almost certainly be legislated away later this year.
Total Trend	-1.00%	1.00%	Advance Notice Estimated Trend - (note for 2011, Trend "frozen" per Reconciliation language rather than 1.38% under Advance Notice)
Other Factors Impacting Rates			
Indirect Medical Education Cuts	-0.50%	-0.30%	With no IME cut included in 2011 rate question here will be whether CMS includes one year IME cut or two year cut in order to catch up.
Budget Neutrality Adjustment	-0.10%	0.00%	BN Adjustment slated to be completely phased-out in 2011 - however we are unsure this was assumed to be rolled up into "all-in" flat rate last year or not
Re-basing	0.25%	0.50%	Look for CMS to rebase rates for 2012 - historically rebasing added 20bps in 2009 and 70bps in 2007
Final Rate Trend	-1.35%	1.20%	Final ratebook trend assumption , does not include reimbursement changes due to risk scores, etc.
FFS Normalization	-1.75%	-1.25%	FFS Normalization was 170bps in 2011 and 110bps in 2010. We expect CMS will recalibrate HCC codes for 2012 thus lowering overall FFS normalization vs. 1.058 reported last year, however this will be offset by moderation in actual risk score weights, leaving one year all-in impact in the -1.25% to -1.75% range
Risk Coding Adjustment	-3.00%	0.00%	CMS may continue to defer coding intensity adjustments leaving no impact or include 2 to 3 additional years of adjustment which we estimate would lower scores by up to 3%
Plan Reimbursement (w/FFS Normalization)	-6.10%	-0.05%	Plan reimbursement change, not including PPACA or STAR rating impact as well as impact from specific plan risk score coding improvements or member premium changes
OTHER FACTORS			
PPACA Cuts	-2.50%	-2.50%	UBS est. of average impact to plans from PPACA transition to reimbursement at % of FFS over next 2 to 6 years
Star Bonus Payments	0.50%	0.50%	UBS est. of average impact from CMS STAR bonus payment, phased in at same rate as PPACA cuts with bonus % added to FFS rate
Net Plan Reimbursement (post OTHER)	-8.10%	-2.05%	All-in estimated plan reimbursement change for 2012 before plan risk score improvements or changes in plan-by-plan member premiums
Factors Affecting MA Payments Which Vary Plan-by-Plan			
Change in plan premium collected from beneficiary			Plan specific
Any change in avg risk score for Med Adv membership base			Plan specific, should be positive given most plans have increased risk scores significantly through improved coding
Year-over-year change in competitive bidding recapture			Plan specific, should be slightly positive due to rates below medical cost trend

Source: CMS and UBS estimates

Risk Coding Intensity Adjustment – Look for 2012 Advance Notice to potentially include a risk score coding intensity adjustment (we estimate additional -2% to -3% should CMS include). As we have noted since our 2007 report on plan risk score coding “Risk Score Arbitrage – The Next Shoe to Drop?” we believe the industry has added ~10% above and beyond the current 13% subsidies in Medicare Advantage thru optimizing coding versus traditional Medicare. While CMS looked to address the issue for 2009 but ultimately decided against it, they did follow through with a 3.41% risk score coding intensity adjustment for 2010. As we noted above, this adjustment has no impact on rates but does have a direct impact on reimbursement to plans as plans receive the product of patient risk score x county rate. However, despite signalling with Advance Notice that adjustment factor would embed data from 2007-2008 cohort, CMS ultimately elected to take a “conservative approach” and instead implement an adjustment factor that is based only on coding difference factor on the earliest three cohorts (2004-2005, 2005-2006, 2006-2007) with CMS indicating they will consider data from 2007-2008 and later cohorts in future payment years.

We believe the industry has added ~10% above and beyond the current 13% subsidies in Med Adv thru optimizing coding versus traditional Medicare

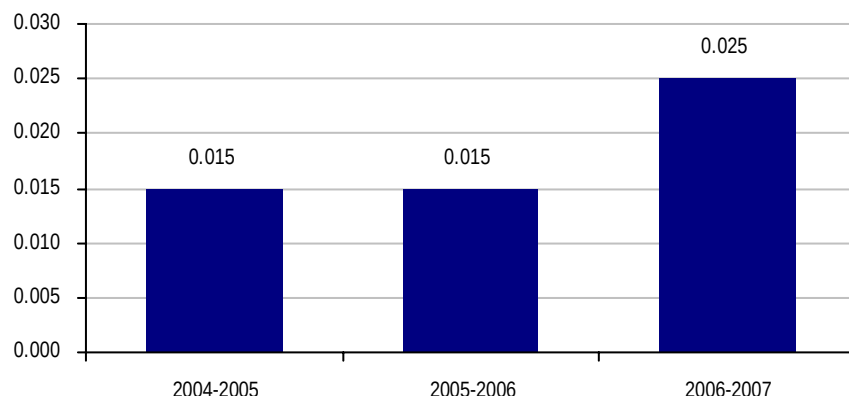
Table 8: 2010 MA Coding Pattern Difference Adjustment Calculations

Components	Calculation	Commentary
Wtd. avg. of Year 2 MA risk scores	0.9806	
Wtd. avg. diff in disease score growth	0.0171	
Avg Annual Difference Factor	1.75%	as % of risk scores
x MA Enrollment Duration Factor	2.38	vs. prior 2.45 under Advance Notice
=MA Coding Pattern Difference Factor	4.16%	
x Stayer Percentage	81.8%	vs. 87.3% prior stayer percentage under Advance Notice
= Risk score adjustment	3.41%	

Source: CMS 2010 Advance Notice

- **CMS analysis of 2007-2008 cohort indicated that coding pattern differences “continue to accelerate”, a clear indication that plans continue to push risk scores higher in Medicare Advantage.** Recall that the absolute difference in “stayers” disease score growth between Med Adv and FFS as calculated by CMS was 0.015 in 2004-2005 and in 2005-2006 time periods, and then increased to 0.025 in 2006-2007 (Chart below). While CMS did not provide specific 2007-2008 cohort data, they did indicate the disease score growth difference accelerated from 0.025 level in 2006-2007, clearly signalling that plans continue to benefit from risk score arbitrage and reinforcing CMS conclusion that coding pattern differences are having a notable impact on payment. Given acceleration versus prior years, we expect further negative adjustment is more likely for 2012 contract year as CMS looks to mitigate plan coding which we estimate has added ~10% to reimbursement. That said, should CMS choose to do nothing here for the second year in a row, it would be a extremely positive signal toward industry going forward.

Coding pattern acceleration in 2007-2008 cohort reinforce CMS conclusion that differences are having notable impact on payment, which we expect will remain in CMS crosshairs in future years (including 2011)

Chart 2: Absolute Difference in Disease Score Growth between Med Adv and FFS

Source: CMS 2010 Advance Notice

Table 9 highlights CMS risk coding commentary included in the 2010 Advance Notice and Final Rate Announcement

Table 9: CMS Commentary on Risk Coding Adjustment Analysis Included in 2010 Advance Notice / Final Rate

2010 ADVANCE NOTICE (2/20/09)
CMS has found that MA stayer disease scores increase faster than FFS stayer disease scores, even after adjusting for age distribution and survivor status. The absolute difference in disease score growth between MA and FFS was about 0.015 in 2004-2005 and in 2005-2006. This difference in disease score growth increased to 0.025 in 2006-2007. We will have the results for the 2007-2008 cohort prior to the publication of the 2010 Announcement.
2010 FINAL RATE ANNOUNCEMENT (4/6/2009)
Our analysis of the 2007-2008 cohort showed that coding pattern differences have accelerated and this finding has strengthened our conclusion that coding pattern differences between MA and FFS are having a notable impact on payment. Because this is the first year that CMS is implementing this MA coding adjustment under the provisions of the DRA, however, CMS is taking a conservative approach and implementing an adjustment factor using a coding difference factor based on the earliest three cohorts (2004-2005, 2005-2006, and 2006-2007). CMS will consider the 2007-2008 data and later cohort data for future MA coding pattern difference factors
Response: The difference factor, which takes into account coding pattern differences from 2004 to 2007, is an average annual difference in the growth of disease scores between MA and FFS. Based on the data that we have, it is clear that coding pattern differences have continuously grown since 2004 and that 2010 risk scores will incorporate repeated years of coding pattern differences. We have decided to maintain for 2010 the use of three cohorts as proposed in the Advance Notice.

Source: CMS

- **Should CMS choose to move forward here, look for Advance Notice announcement to include risk coding adjustment factor based on 2007-2009 cohort**, with Final Rate announcement potentially also embedding data from 2009-2010 cohort. If the 2012 Advance Notice were to include a risk coding intensity adjustment, it would likely be based on data from two cohorts (2007-2008 and 2008-2009) compared to the three cohorts that the 3.41% adjustment for 2010 was based on. However, given commentary from CMS around clear acceleration in disease score growth differential in 2007-2008 cohort, look for potential 2011 adjustment to only be down modestly relative to 2010 despite fewer years of data.

Key unknown here in regards to impact on rates will be whether CMS chooses to include a 2-year adjustment (based on 2007-2008 and 2008-2009 cohorts) or just a one-year impact

Plan specific factors such as rebates and coding optimization will be additive to rates once again in 2012. Competitive bidding requires plans to bid a rate at which they can provide an actuarially equivalent benefit package to traditional fee-for-service Medicare. CMS then recaptures a “rebate” of 25% of the difference between plan bids and actual Medicare Advantage reimbursement. To the extent 2012 rates fall below cost trend, the plan bids will likely increase faster than growth in Medicare Advantage rates, leaving the CMS “rebate” lower year-over-year and thus cushioning the all-in reimbursement change to plans versus 2011. Also, as highlighted in our January 2007 note “Risk Score Arbitrage – The Next Shoe to Drop?” and subsequently updated in our February 2008 note “CMS Pushes Back on Risk Score Arbitrage”, it is no secret that Medicare Advantage plans continue to improve the capture of member risk scores, which works to offset negative risk score adjustments from CMS. We estimate that by working closely with physicians (who have no incentive to submit accurate and complete diagnosis codes under FFS), savvy Med Adv plans have been able to increase their overall risk scores and reimbursement by ~10% to date, with the potential for further upside still possible in our view during the 2012 payment year.

Appendix I – Thoughts on RADV

While Medicare risk score audits remain in the crosshairs, we point out that recent CMS notice (Feb 3rd) suggests that the agency may be looking to calm the waters on RADV audits with CMS posting a very brief notice to plans on February 3rd in response to the RADV audit methodology that was previously published on December 21st. CMS indicates receiving comments from plans and most importantly indicates it is “thoroughly evaluating all comments and anticipates making changes to draft, based on input received”. We have been reading CMS notices for 10 years now and don’t EVER remember the agency indicating explicitly that there were changes coming in between publishing preliminary and final rules such as this. While the brief, 1 paragraph notice (see Table 10 below) does not state what “changes” will be made, it is interesting to note that CMS mentions two industry comment areas specifically: (1) FFS adjuster and (2) RADV audit documentation standards. Plan public comments have made it clear that FFS adjuster is key to making RADV audits “fair” and likely make the potential liability “manageable”. **Importantly**, CMS decisions on RADV audits in “near-term” along with CMS communication on Risk Score Intensity Adjustment w/2012 Advance Notice (Feb 18) will go a long way to understanding potential implications from risk scores to plans as well as provide insight into how CMS will oversee Med Adv in general during period of PPACA reimbursement pressure with a “kindler/gentler” CMS likely to be very bullish for Med Adv names (HUM/UNH/HS).

2/3 CMS notice to plans indicates it is “thoroughly evaluating all comments and anticipates making changes to draft, based on input received”

Table 10: Text CMS Letter to Medicare Advantage Organizations

On Tuesday, December 21, 2010, CMS posted a description of the Agency’s proposed draft RADV sampling and payment error calculation methodology on our website at <https://www.cms.gov/HealthPlansGenInfo/> and invited public comment on this document. To date, we have received comments on a variety of topics, including a proposed FFS adjuster and RADV audit documentation standards. *We are thoroughly evaluating all comments and anticipate making changes to our draft*, based on input we received. We anticipate the final revised RADV sampling and payment error calculation methodology paper will be issued in the near future. CMS also plans to issue a question and answer document that summarizes the comments received on the RADV methodology and the Agency’s response to those comments.

Source: CMS

CMS notice comes on the heels of the agency releasing its RADV audit methodology for comment on December 21st with the 3 page document outlining how the agency has sampled ~ 200 members from select Medicare Advantage plans and calculated a risk score for each member based upon CMS’s review of 2007 medical records and compared that to risk scores submitted by plans and we expect next step would be to request repayment for any difference. While the methodology comment letter indicated that CMS will extrapolate audit findings at the plan level rather than the company level (a clear positive for MCOs), the main risk here is that any broader expansion of audits to greater # of plan contracts could increase repayment significantly. In terms of other key methodological issues CMS’s willingness to include benefit to plans for under-coding found is positive with lack of allowance for any error rate (such as that found in traditional Medicare) the main negative.

Below we've attached an overview of the RADV issue from our previously published December 20th Managed Care report "Thoughts on Medicare Risk Score Audits".

Plan-level Medicare Advantage risk score audits are in the crosshairs lately as the first Federal False Claims Act involving Medicare Advantage is settled. As noted since our 2007 report on plan risk score coding "Risk Score Arbitrage – The Next Shoe to Drop?", it has become apparent to CMS that the industry has seen a materially faster increase in risk scores than the overall FFS population, potentially benefiting plan reimbursement by 5 to 15% over the last several years due to greater coding accuracy. Given significant dollars associated here (overall Medicare Advantage spending in the \$100 billion range), it is not surprising the government has been taking a closer look with CMS announcing in 2008 that they would be conducting plan-level Medicare Advantage risk score audits to ensure reimbursement is supported by the requisite documentation with the Office of Inspector General (OIG) of Health and Human Services (HHS) also involved in plan-level audits as well.

As we have highlighted for past several years, it is apparent to CMS that the Medicare Advantage industry has seen a materially faster increase in risk scores than the overall Medicare FFS population

- **Medicare Advantage plan-level risk adjustment data validation (RADV) audits** entail reviewing medical records maintained by physicians and other providers that are then used by Managed Care plans to submit member level health status to the government for reimbursement. Audits are being performed in order to validate the provider coding practices and related economics paid to Med Adv plans under the risk-adjustment model.
- **The first round of audits** focused on the risk adjustment data for 2006 that were used to determine 2007 payment amounts to Med Adv plans.
- **We see the greatest uncertainty around how CMS will interpret audit results and calculate any potential repayment request.** For instance, it is likely that audits will uncover some level of non-complete provider documentation (such as missing physician signature, etc.) that are also widespread in traditional FFS. The question here is whether or not the plans will be held to a zero error target (hopefully not) or more realistically held to an error target that is in-line with that found in traditional FFS. The other big question is whether any errors are found that would indicate plan "under-coding" (coding that results in lower payment) and if this would be allowed to reduce the audit repayment. Essentially, we would expect any repayment request from the government that does not allow for some normal FFS error rate or net "under-coding" against repayment to be fought by the plans.
- **Notably**, beginning in 2008, most of the companies in our coverage universe with large Medicare Advantage exposure had added broad, non-specific risk statements to their SEC filings indicating potential for negative outcomes related to these audits.
- **Given most industry sources indicate 2007 risk score audits are complete, look for further color / update on plan-level risk audits** potentially in conjunction with the release of preliminary 2012 Medicare Advantage rates in mid-February 2011.

Audits are being undertaken to validate the provider coding practices and related economics paid to Medicare Advantage plans under the risk-adjustment model

Recent data points around plan-level Medicare Advantage risk score audits may provide some color around what we previously highlighted as an indefinable but potentially significant negative catalyst. On November 24th, the Department of Justice announced a \$22.6 million settlement resolving Medicare Advantage fraud allegations with America's Health Choice Medical Plans Inc. with the lawsuit involving claims of fraudulently increasing the severity of beneficiary diagnoses to obtain high Medicare payments under the risk adjusted payment system. Notably, industry consultant John Gorman indicated that he is aware of at least one more MA RADV-based case moving towards settlement – while he did not identify the plan in question, Mr. Gorman did note that it involves a publicly-traded company and, given the “nine-digit” figure opening salvo, the ultimate settlement amount would likely be bigger than the \$23 million settlement for America's Health Choice Medical Plans. We note that unlike America's Health Choice Medical Plans, we don't think that the other audits are turning up fraud.

Dept of Justice announced on 11/24 a \$23 million settlement resolving Medicare Advantage fraud allegations with a small Medicare Advantage plan

Look for potential headlines around another MA RADV-based case moving towards settlement – with industry consultant being quoted as indicating public plan has received “nine-digit” opening salvo via government “demand letter”. While the name of the plan potentially subject to the alleged “nine-figure” demand letter has yet to be released, notably, the sheer size of the figure clearly limits the number of likely prospects with Table 11 highlighting the largest plans by H-code as of 2007. As the OIG results may be folded into the CMS audits, it is possible that this demand letter may never be separately communicated.

The name of the plan allegedly receiving the “nine-digit” demand letter has yet to be identified

Table 11: Top 20 Medicare Advantage Contracts based on 2007 Membership

Parent Organization	Contract #	Organization Name	Plan Type	2007 Membership
Humana Inc.	H1804	HUMANA INSURANCE COMPANY	PFFS	607,985
United HealthCare Group, Inc.	H0543	PACIFICARE OF CALIFORNIA/SECURE HORIZONS	HMO	342,775
Humana Inc.	H1036	HUMANA MEDICAL PLAN, INC.	HMO	249,032
Wellpoint, Inc.	H0540	UNICARE LIFE AND HEALTH INS. COMPANY	PFFS	124,214
Coventry Health Care Inc.	H0846	FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY	PFFS	124,020
United HealthCare Group, Inc.	H4590	PACIFICARE OF TEXAS, INC.	HMO	120,068
Health Net, Inc.	H0562	HEALTH NET OF CA	HMO	105,135
United HealthCare Group, Inc.	H0303	PACIFICARE OF ARIZONA, INC.	HMO	99,199
United HealthCare Group, Inc.	H5435	PACIFICARE LIFE AND HEALTH INSURANCE COMPANY	PFFS	77,277
Wellpoint, Inc.	H3655	COMMUNITY INSURANCE COMPANY	HMO	76,640
United HealthCare Group, Inc.	H3307	OXFORD HEALTH PLANS (NY) INC.	HMO	69,061
Wellpoint, Inc.	H3370	EMPIRE HEALTHCHOICE HMO, INC.	HMO	67,055
United HealthCare Group, Inc.	H0609	PACIFICARE OF COLORADO, INC.	HMO	59,137
United HealthCare Group, Inc.	H3659	UNITED HEALTHCARE OF OHIO, INC.	HMO	53,243
Humana Inc.	H1019	CARE PLUS HEALTH PLAN	HMO	53,034
Aetna Inc.	H5736	AETNA LIFE INSURANCE COMPANY	PFFS	50,762
NewQuest Health Solutions LLC	H4454	HEALTHSPRING OF TENNESSEE, INC.	HMO	50,465
Humana Inc.	H1951	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA INC	HMO	48,477
Health Net, Inc.	H0351	HEALTH NET OF ARIZONA, INC.	HMO	45,467
United HealthCare Group, Inc.	H2654	UNITED HEALTHCARE OF THE MIDWEST, INC.	HMO	44,036
Health Net, Inc.	H0755	HEALTH NET OF CONNECTICUT	HMO	43,629
Humana Inc.	R5826	HUMANA INSURANCE COMPANY	Regional PPO	42,338
Coventry Health Care Inc.	H5227	COVENTRY HEALTH AND LIFE INSURANCE COMPANY	PFFS	41,482
United HealthCare Group, Inc.	H3456	UNITED HEALTHCARE OF NORTH CAROLINA	HMO	40,259
United HealthCare Group, Inc.	H5005	PACIFICARE OF WASHINGTON, INC.	HMO	39,213
United HealthCare Group, Inc.	R5287	UNITED HEALTHCARE INSURANCE COMPANY	Regional PPO	39,061
Aetna Inc.	H3931	AETNA HEALTH INC	HMO	36,741
NewQuest Health Solutions LLC	H4513	TEXAS HEALTHSPRING LLC	HMO	36,546
Coventry Health Care Inc.	H3959	HEALTHAMERICA PENNSYLVANIA, INC.	HMO	36,282
United HealthCare Group, Inc.	H4456	UNITED HEALTHCARE PLAN OF THE RIVER VALLEY, INC.	HMO	33,551
United HealthCare Group, Inc.	H0151	UNITED HEALTHCARE OF ALABAMA, INC.	HMO	33,083
CIGNA	H0354	CIGNA HEALTHCARE OF ARIZONA, INC.	HMO	31,439
NewQuest Health Solutions LLC	H0150	HEALTHSPRING OF ALABAMA, INC.	HMO	30,576
Aetna Inc.	H3152	AETNA HEALTH, INC.	HMO	29,981
Wellpoint, Inc.	R9943	BC LIFE and HEALTH INSURANCE COMPANY	Regional PPO	29,261
Humana Inc.	H1406	HUMANA HEALTH PLAN, INC.	HMO	27,785
United HealthCare Group, Inc.	H2949	PACIFICARE OF NEVADA, INC	HMO	27,216

Source: CMS, UBS Analysis

While we are unclear of what exactly the potential magnitude of the final settlement will be for this yet-to-be identified plan, we anticipate that it will come down meaningfully from the assumed OIG opening recovery request in the “nine-digit” figure range, with ultimate settlement amount potentially having significant impact on total exposure to the plan in question given the potential that it could be extrapolated to the company’s total Medicare Advantage book (rather than just the amount coming from the one plan contract). Table 12 on the following page walks through an illustrative example of our thinking here in terms of how the final settlement amount could ultimately impact the company with key assumptions including:

- The sample company has 1 million total Medicare Advantage lives representing approximately \$10 billion in annual Medicare Advantage revenues (assuming \$10k annual PMPM), of which 200k lives (and \$2 billion of revenues) are derived from a single plan contract.
- For the company’s single plan contract, we assume that the final settlement amount would be in the range of \$20-\$200 million which would represent 1.0-10.0% of the plan contract’s \$2 billion revenue base.
- Next, we size the potential exposure to the total company if the final settlement amount is extrapolated to the company’s total Medicare Advantage book (rather than just the single plan contract) based on the same error rate as the plan originally audited. Using the same range of 1.0-10.0% of revenues and applying it to the company’s total Medicare Advantage revenue base of \$10 billion, this puts the potential exposure in the range of \$100-\$1,000 million (vs. the \$20-\$200 million for just the single-contract).
- As highlighted in the illustrative example, ***both the ultimate final settlement amount as well as the number of lives in the plan contract area clearly key***, with the worst-case scenario being some sort of extrapolation to the company’s total Medicare Advantage book. We also point out that for simplification purposes, when extrapolating the exposure to the company’s total Medicare Advantage book, our example analysis assumes the Medicare Advantage error rates for the entire company’s Medicare Advantage book is in-line with the error rates uncovered for the original plan audit which is highly unlikely.

Ultimate final settlement amount is clearly key given potential for government to extrapolate the amount to the rest of the company’s Medicare Advantage book

Table 12: Illustrative Example – Exposure Sensitivity Assuming Final Settlement Amount Related to Single-Contract with 200k Lives and Extrapolated to the Company's Total 1 million Medicare Advantage Lives

Single Med Adv Plan Contract				
Med Adv Lives (000s)	200	200	200	200
Med Adv Revenues (\$ in mm's)	\$2,000	\$2,000	\$2,000	\$2,000
Final Settlement Amount of Single Med Adv Contract - Sensitivity				
Assumed Final Settlement Amount (\$ in mm's)	\$20	\$50	\$100	\$200
as % of Contract Revenues (above)	1.0%	2.5%	5.0%	10.0%

Total Med Adv Book				
Med Adv Lives Total (000s)	1,000	1000	1000	1000
Med Adv Revenues Total (\$ in mm's)	\$10,000	\$10,000	\$10,000	\$10,000
Final Settlement % - Extrapolated to Total Med Adv Book				
Settlement as % of Revenues (above)	1.0%	2.5%	5.0%	10.0%
Final Settlement Amount (\$ in mm's)	\$100	\$250	\$500	\$1,000

Source: UBS estimates

- **Lastly, we also note that the full impact of ultimate award settlement may be mitigated to an extent by provider capitation arrangements.** In the event the errors uncovered are related to issues with capitated Individual Practice Associations (IPAs) and their documentation, the plan could look to the IPAs for some recourse here to recoup some of the revenues paid to the IPAs that were fully-capitated.

While we believe that it is unlikely that all of the Medicare Advantage contracts will be audited, however, there is no assurance that the audits will not extend beyond one or two contracts per company with Table 13 highlighting each plan's top-5 Medicare Advantage contracts based on 2007 enrollment. We point out that HealthSpring has previously disclosed that their HealthSpring of Tennessee (~50k members in '07) contract was selected for an audit and that Humana indicates that several of its contracts are being audited.

Table 13: Managed Care Plans – Top 5 Medicare Contracts by 2007 Membership

Parent Organization	Contract Number	Organization Name	Final Plan Type	2007 Membership	Total 2007 Membership	% of Total
Aetna Inc.	H5736	AETNA LIFE INSURANCE COMPANY	PFFS	50,762		27%
	H3931	AETNA HEALTH INC.	HMO	36,741		19%
	H3152	AETNA HEALTH, INC.	HMO	29,981		16%
	H0523	AETNA HEALTH OF CALIFORNIA, INC.	HMO	26,006		14%
	H3312	AETNA HEALTH INC.	HMO	12,915		7%
Aetna Inc. Total				156,405	190,431	82%
CIGNA	H0354	CIGNA HEALTHCARE OF ARIZONA, INC.	HMO	31,439		100%
CIGNA Total				31,439	31,439	100%
Coventry Health Care Inc.	H0846	FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY	PFFS	124,020		44%
	H5227	COVENTRY HEALTH AND LIFE INSURANCE COMPANY	PFFS	41,482		15%
	H3959	HEALTHAMERICA PENNSYLVANIA, INC.	HMO	36,282		13%
	H2663	GROUP HEALTH PLAN, INC.	HMO	22,707		8%
	H1013	VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.	HMO	13,453		5%
Coventry Health Care Inc. Total				237,944	282,824	84%
Health Net, Inc.	H0562	HEALTH NET OF CA	HMO	105,135		45%
	H0351	HEALTH NET OF ARIZONA, INC.	HMO	45,467		20%
	H0755	HEALTH NET OF CONNECTICUT	HMO	43,629		19%
	H5520	HEALTH NET LIFE INSURANCE COMPANY	PPO	19,690		8%
	H5996	HEALTH NET LIFE INSURANCE COMPANY, INC.	PFFS	11,571		5%
Health Net, Inc. Total				225,492	232,284	97%
Humana Inc.	H1804	HUMANA INSURANCE COMPANY	PFFS	607,985		53%
	H1036	HUMANA MEDICAL PLAN, INC	HMO	249,032		22%
	H1019	CARE PLUS HEALTH PLAN	HMO	53,034		5%
	H1951	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA INC	HMO	48,477		4%
	R5826	HUMANA INSURANCE COMPANY	Regional PPO	42,338		4%
Humana Inc. Total				1,000,866	1,142,581	88%
Molina Healthcare, Inc.,	H5628	MOLINA HEALTHCARE OF UTAH, INC.	HMO	1,860		37%
	H5926	MOLINA HEALTHCARE OF MICHIGAN	HMO	1,116		22%
	H5810	MOLINA HEALTHCARE OF CALIFORNIA	HMO	1,064		21%
	H5588	MOLINA HEALTHCARE OF NEVADA, INC.	HMO	520		10%
	H5823	MOLINA HEALTHCARE OF WASHINGTON, INC.	HMO	515		10%
Molina Healthcare, Inc., Total				5,075	5,075	100%
NewQuest Health Solutions (HS)	H4454	HEALTHSPRING OF TENNESSEE, INC.	HMO	50,465		40%
	H4513	TEXAS HEALTHSPRING LLC	HMO	36,546		29%
	H0150	HEALTHSPRING OF ALABAMA, INC.	HMO	30,576		24%
	H1415	HEALTHSPRING, INC.	HMO	8,531		7%
	H4407	HEALTHSPRING OF TENNESSEE, INC.	HMO	824		1%
NewQuest Health Solutions (HS) Total				126,942	126,942	100%
United HealthCare Group, Inc.	H0543	PACIFICARE OF CALIFORNIA/SECURE HORIZONS	HMO	342,775		24%
	H4590	PACIFICARE OF TEXAS, INC.	HMO	120,068		9%
	H0303	PACIFICARE OF ARIZONA, INC	HMO	99,199		7%
	H5435	PACIFICARE LIFE AND HEALTH INSURANCE COMPANY	PFFS	77,277		6%
	H3307	OXFORD HEALTH PLANS (NY) INC.	HMO	69,061		5%
United HealthCare Group, Inc. Total				708,380	1,399,370	51%
Wellpoint, Inc.	H0540	UNICARE LIFE AND HEALTH INS. COMPANY	PFFS	124,214		33%
	H3655	COMMUNITY INSURANCE COMPANY	HMO	76,640		21%
	H3370	EMPIRE HEALTHCHOICE HMO, INC.	HMO	67,055		18%
	R9943	BC LIFE and HEALTH INSURANCE COMPANY	Regional PPO	29,261		8%
	H0564	BLUE CROSS OF CALIFORNIA	HMO	22,766		6%
Wellpoint, Inc. Total				319,936	371,909	86%

Source: CMS, UBS Analysis

From the perspective of the publicly-traded Medicare Advantage plans in our coverage universe, there is significant variation in terms of potential company-specific exposure with the biggest Medicare Advantage plans (UnitedHealth and Humana) not surprisingly most exposed here while CIGNA clearly has the least exposure. Given audits currently limited to one or two plans per company (for now), we highlight the potential earnings exposure to every 1% revenue repayment for (1) each company's largest Medicare Advantage contract plan as of 2007, and (2) each company's two largest Medicare Advantage contract plans as of 2007. The initial audits were done for one or two of the largest plans, so the initial exposure depends not only on the size of the total Medicare Advantage book, but also on the portion of that book sitting in the largest one or two contracts. We point out that in these scenarios, the companies with the largest concentration of Medicare Advantage lives among its largest plan contracts are the ones most exposed here.

The companies with the largest concentration of Med Adv lives among its largest plan contracts are the ones most exposed here

Table 14: Exposure from Largest Single and Largest Two Medicare Advantage Contracts (2007)

MCO	2007 MA Premiums (Largest Contract)	% of Company Total	1% Repayment EPS Sensitivity	2007 MA Premiums (Largest Two Contracts)	% of Company Total	1% Repayment EPS Sensitivity
Humana Inc.	\$6,080	24%	(\$0.23)	\$8,570	34%	(\$0.32)
HealthSpring, Inc.	\$505	32%	(\$0.06)	\$870	55%	(\$0.10)
Health Net, Inc.	\$1,051	7%	(\$0.07)	\$1,506	11%	(\$0.10)
Coventry Health Care Inc.	\$1,240	13%	(\$0.05)	\$1,655	17%	(\$0.07)
WellPoint, Inc.	\$1,242	2%	(\$0.02)	\$2,009	3%	(\$0.03)
UnitedHealth Group, Inc.	\$3,428	5%	(\$0.02)	\$4,628	6%	(\$0.03)
Aetna Inc.	\$508	2%	(\$0.01)	\$875	3%	(\$0.01)
CIGNA	\$314	2%	(\$0.01)	\$314	2%	(\$0.01)

Source: CMS, UBS Analysis

That said, with the key question in our view around whether CMS will broaden the audits further beyond the one or two per plan, we also highlight the estimated exposure if the companies' entire Medicare Advantage book was subject to 1% repayment. For both 2007 and 2011, Table 15 highlights company-specific Medicare Advantage revenues and as a % of total company revenues, and highlights the estimated earnings sensitivity by company assuming 1% repayment of Medicare Advantage revenues

Table 15: UBS MCO Coverage Universe – Company-Specific 2007 and 2011 Medicare Advantage Revenues and as % of Total Company Revenues, and Estimated Earnings Sensitivity to 1% Repayment of Medicare Advantage

MCO	2007 MA Premiums	% of Company Total	1% Repayment EPS Sensitivity	2011 Est. MA Premiums	% of Company Total	1% Repayment EPS Sensitivity
Humana Inc.	\$11,173	44%	(\$0.42)	\$20,211	58%	(\$0.76)
HealthSpring, Inc.	\$1,364	87%	(\$0.15)	\$3,932	81%	(\$0.44)
Health Net, Inc.	\$2,387	17%	(\$0.15)	\$2,427	20%	(\$0.16)
UnitedHealth Group, Inc.	\$15,646	21%	(\$0.09)	\$25,238	25%	(\$0.15)
Coventry Health Care Inc.	\$2,108	21%	(\$0.09)	\$2,571	20%	(\$0.11)
WellPoint, Inc.	\$4,759	8%	(\$0.08)	\$5,846	10%	(\$0.10)
Aetna Inc.	\$2,241	8%	(\$0.04)	\$4,806	14%	(\$0.08)
CIGNA	\$349	2%	(\$0.01)	\$709	3%	(\$0.02)

Source: Company Reports and UBS Estimates

Notably, beginning in 2008, most of the companies in our coverage universe with large Medicare Advantage exposure had added risk statements to their SEC filings indicating potential for negative outcomes related to these audits. Language from the 10-Ks/Qs regarding the audits have not changed substantially over the past three years with many indicating that the audits continue and that they are in full compliance with the CMS requests. UnitedHealth specifically notes that risk adjustment data from two of their plans have been selected by the OIG for an audit. Table 16 below contains the language related to the Medicare risk audits from the 2008 and 2009 10Ks.

Table 16: HS, HUM & UNH Risk Audit Commentary from 2008 and 2009 10-Ks

HS - 2008 10-K	Our Tennessee Medicare Advantage plan has been selected by CMS for such a review, which we currently expect to begin in early 2009. CMS has indicated that payment adjustments will not be limited to risk scores for the specific beneficiaries for which errors are found but may be extrapolated to the entire plan. There can be no assurance that our other plans will not be randomly selected or targeted for review by CMS or, in the event that a company plan is selected for a review, that the outcome of such a review will not result in a material adjustment in our revenue and profitability.
HS - 2009 10-K	The Company's Tennessee Medicare Advantage plan has been selected by CMS for a RADV Audit of the 2006 risk adjustment data used to determine 2007 premium rates. In late 2009, the Company's Tennessee plan received from CMS the RADV Audit member sample, which CMS will use to calculate a payment error rate for 2007 Tennessee plan premiums. The Company is in the process of responding to the RADV Audit request, including retrieving and providing medical records supporting diagnoses codes and risk scores and, where appropriate, provider attestations, all of which are due to CMS on February 18, 2010. CMS has indicated that payment adjustments resulting from its RADV Audits will not be limited to risk scores for the specific beneficiaries for which errors are found but will be extrapolated to the relevant plan population. CMS's methodology for extrapolation remains unclear, however. The Company is in the process of gathering records responsive to the RADV Audit and is currently unable to calculate a payment error rate or predict the impact of extrapolating that error rate to 2007 Tennessee plan premiums. There can be no assurance, however, that the conclusion of the Tennessee RADV Audit will not result in a material adverse impact to the Company's results of operations or cash flows, or that the Company's other plans will not be randomly selected or targeted for a RADV Audit by CMS or, in the event that another plan is so selected, that the outcome of such RADV Audit will not result in a material adverse impact to the Company's results of operations and cash flows.
HS - 2010 Q3 10-Q	In connection with CMS's continuing statutory obligation to review risk score coding practices by Medicare Advantage plans, CMS announced that it would regularly audit Medicare Advantage plans, primarily targeted based on risk score growth, for compliance by the plans and their providers with proper coding practices (sometimes referred to as "Risk Adjustment Data Validation Audits" or "RADV Audits"). The Company's Tennessee Medicare Advantage plan was selected by CMS for a RADV Audit of the 2006 risk adjustment data used to determine 2007 premium rates. In late 2009, the Company's Tennessee plan received from CMS the RADV Audit member sample, which CMS will use to calculate a payment error rate for 2007 Tennessee plan premiums. In February 2010, the Company responded to the RADV Audit request by retrieving and submitting medical records supporting diagnoses codes and risk scores and, where appropriate, provider attestations. CMS has not indicated a schedule for processing or otherwise responding to the Company's submissions. CMS has indicated that payment adjustments resulting from its RADV Audits will not be limited to risk scores for the specific beneficiaries for which errors are found but will be extrapolated to the relevant plan population. CMS's methodology for extrapolation remains unclear, however. Because of this lack of clarity from CMS, the Company is also currently unable to calculate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to 2007 Tennessee plan premiums. There can be no assurance, however, that the conclusion of the Tennessee RADV Audit will not result in an adverse impact to the Company's results of operations or cash flows (which may or may not be material), or that the Company's other plans will not be randomly selected or targeted for a RADV Audit by CMS or, in the event that another plan is so selected, that the outcome of such RADV Audit will not result in a material adverse impact to the Company's results of operations or cash flows.
HUM - 2008 10-K	Several Humana contracts are included in audits being undertaken by CMS. If necessary, based on audit results, CMS may make contract-level payment adjustments that may occur during 2009, and adjustments may occur prior to Humana or other Medicare Advantage plans having the opportunity to appeal audit findings. We primarily rely on providers to appropriately document risk-adjustment data in their medical records and appropriately code their claim submissions, which we send to CMS as the basis for our risk-adjustment model premium. We are working with CMS and our industry group to develop an orderly audit process, for which CMS has not yet indicated the complete details. Therefore, we are unable to predict the complete audit methodology to be used by CMS, the outcome of these audits, or whether these audits would result in a payment adjustment. However, it is reasonably possible that a payment adjustment as a result of these audits could occur, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows.
HUM - 2009 10-K	CMS is continuing to perform audits of selected Medicare Advantage plans of various companies to validate the provider coding practices and resulting economics under the actuarial risk-adjustment model used to calculate the individual member capitation paid to Medicare Advantage plans. Several Humana contracts have been selected by CMS for audit and we expect that CMS will continue conducting audits for the 2007 contract year and beyond. We are unable to estimate the financial impact of any audits that may be conducted related to 2007 revenue and beyond and whether any findings would cause a change to our method of estimate future premium revenue in bid submissions made to CMS for future contract years, or compromise premium rate assumptions made in the our bids for prior contract years.
HUM - 2010 Q3 10-Q	CMS is continuing to perform audits of selected Medicare Advantage plans of various companies to validate the provider coding practices and resulting economics under the actuarial risk-adjustment model used to calculate the individual member capitation paid to Medicare Advantage plans. Several Humana contracts have been selected by CMS for audit, and we expect that CMS will continue conducting audits for the 2007 contract year and beyond. We generally rely on providers to appropriately document all medical data including risk-adjustment data in their medical records and appropriately code their claim submissions, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. The CMS audits involve a review of a sample of provider medical records for the contracts being audited. Rates paid to Medicare Advantage plans are established under an actuarial bid model, including a process whereby our premium is based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original

	Medicare program. As a result, we believe that an actuarially sound adjustment of payments from these audits would need to take into account the level of coding accuracy and provider medical record documentation completeness under the government's original Medicare program, since the risk adjustment system, bids, benefit structures and payment rates were premised on that data. This would help to ensure that the audit methodology applied to Medicare Advantage plans accurately calculates the economic impact of the audit findings. Additionally, our payment received from CMS, as well as benefits offered and premiums charged to members, is based on bids that did not, by CMS design, include any assumption of retroactive audit payment adjustments. We believe that applying a retroactive audit adjustment after CMS acceptance of bids would improperly alter this process of establishing member benefits and premiums. CMS has not formally announced its audit payment adjustment methodology, nor has CMS formally indicated whether the audit payment adjustment methodology will be based on a comparison to original Medicare coding accuracy. CMS has further indicated that it may make retroactive contract-level payment adjustments. Any such payment adjustments could occur as early as this year, and could be effected prior to our, or other Medicare Advantage plans, having the opportunity to appeal the underlying payment adjustment methodology. We are unable to estimate the financial impact of any audits that may be conducted related to 2007 revenue and beyond or whether any findings would cause a change to our method of estimating future premium revenue in bid submissions made to CMS for future contract years, or compromise premium rate assumptions made in our bids for prior contract years. At this time, we do not know whether CMS will require payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using its method of extrapolating findings to the entire contract. However, if CMS requires payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using a method of extrapolating findings to the entire contract, and if we are unable to obtain any relief preventing the payment adjustments from being implemented, we believe that such adjustments would have a material adverse effect on our results of operations, financial position, and cash flows.
UNH - 2008 10-K	These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in retrospective or prospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. Certain of our plans have been selected for audit. The first audits focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. We are unable to predict the outcome of the audits. However, a material adjustment could have a material effect on our financial results
UNH - 2009 10-K	CMS announced in 2008 that it will perform audits of selected Medicare health plans each year to validate the coding practices of and supporting documentation maintained by care providers. These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in prospective and retrospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. Certain of our plans have been selected for audit. The first audits focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. The Office of Inspector General for HHS is conducting an audit of our risk adjustment data for two plans. We are unable to predict the outcome of the audits. However, any material adjustments could have a material effect on our results of operations.

Source: Company Reports

Importantly, we note that the estimated plan exposure highlighted above is highly levered to a number of moving parts / assumptions including:

MCO exposure hinges on a number of key unknowns

- **Size of audit repayment** – essentially the amount that the government is asking for (if anything) in terms of repayment of Medicare Advantage plan premiums, with the value of the final settlement clearly key here. Final settlement amount here clearly to be key given potential methodology issues that drive total plan / industry exposure such as the government extrapolating results to broader base of the plan's Medicare Advantage book.
- **Size of population audited** – while size of repayment is important, we would note that all information points to audits being doing at plan level (rather than company level), meaning that any requested dollars would likely not be total potential liability as under worst-case scenario government may move on to other Medicare Advantage plans offered by particular company, thus increasing potential liability.

- **Scope of time period** – In addition to the size of repayment, time period is important although we expect this will be much more simple as audits are likely to pertain to specific plan year, with 2007 currently being year audited. We believe most companies expect government to move forward with audits for 2008 and beyond once finished with 2007, potentially increasing total company liability.
- **How were audit results interpreted and repayment amount calculated** – we believe greatest uncertainty from company perspective (as highlighted by 10-K risk disclosures) is around how CMS will interpret audit results and calculated repayment request. For instance, it is likely that audits will uncover some level of non-complete provider documentation (such as missing physician signature, etc.) that are also widespread in traditional FFS. The question here is whether or not the plans will be held to a zero error target (hopefully not) or more realistically held to an error target that is in-line with that found in traditional FFS. The other big question is whether any errors are found that would indicate plan “under-coding” (coding that results in lower payment) and if this would be allowed to reduce the audit repayment. Essentially, we would expect any repayment request from the government that does not allow for some normal FFS error rate or net “under-coding” against repayment to be fought by the plans.
- **Potential for further plan-level audits and outcomes here.** Notably, success recovering significant repayment from current round of plan-level risk score audits may embolden CMS / OIG to get even more aggressive here, with the Justice Department recently touting that they have recovered over \$4 billion since January 2009 under the False Claims Act.
- **CMS / OIG roles.** While UnitedHealth’s 10-K risk statement indicates separate OIG and CMS risk score audits were underway and we have heard from several smaller plans which have also seen OIG audits take place, it is important to note that OIG as an agency does not have regulatory authority over plans. Any audit results and recommendations from OIG must be brought to CMS and it will be CMS who decides what action to take here. Given CMS is also clearly conducting its own, much broader, risk score audits we are unsure what, if any, impact OIG audit results and potential “demand letters” will have here going forward. Finally, we believe it is possible that investors will never actually see OIG results/recommendations as they may be folded into CMS audits and communicated to plans once CMS settles on final audit methodology.

Appendix II – Revisiting Risk Score Arbitrage

Below we've attached updated select excerpts and updates from our previously published reports on Risk Scores including our analysis of clinical coding and risk score patterns in Medicare Advantage.

Plans have clearly benefited from improved clinical coding since the move to risk adjustment in 2004. It is no secret that Medicare Advantage economics have benefited from what we refer to as a “coding arbitrage”, as plans have focused on improving clinical coding to yield higher risk scores and thus reimbursement under the risk-adjusted payment model introduced through the Medicare Modernization Act of 2003. While nearly every company participating in Medicare Advantage has discussed the benefits of better risk scores to some extent, two companies have actually broke it out in financial statements. Health Net and HealthSpring reported receiving \$80 million and \$12.5 million, respectively, in risk adjustment payments through the third quarter of 2006, representing 5.1% and 1.8% of FY'05 Medicare Advantage revenues.

One way Managed Care plans have offset mediocre Medicare Advantage rates in recent years is by improving reimbursement through higher risk scores. The improvement in the industry's risk scores has been dramatic over the last several years, with other illustrations showing up in company financials. For instance, the Table below compares the CMS stated MA rate change with the actual MA PMPM change. Although MA rates increased 2.14% in 2009, both HealthSpring and Humana were able to more than double that increase through higher risk scores. While the 2010 rate decreased -5.08% these companies were flat or slightly better YoY. **Importantly, this revenue catch-up is not one-time as rates are then based off of these higher member risk scores.**

Plans have seen benefits to reimbursement from improving physician clinical coding and risk scores in Medicare Advantage

Importantly, this revenue catch-up is not one-time in nature as instead rates are based off of the higher member risk scores

Table 17: HS & HUM Benefits of Improved Risk Coding

	2008	2009	2010	2011
HealthSpring				
MA PMPM	\$1,002	\$1,055	\$1,054	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	5.21%	-0.01%	--
Humana				
MA PMPM	\$858	\$917	\$929	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	6.85%	1.36%	--

Source: Company reports and UBS estimates

The increase in risk adjustment payments across the industry is a direct result of plan efforts to improve coding by physicians. Although publicly traded plans have not all been entirely transparent in terms of disclosing changes in overall average risk scores or their broader risk adjustment strategies, public comments from company management indicate that those plans most exposed to the Medicare Advantage program have clearly made improved coding a priority. HealthSpring and Humana, plans with particularly outsized Medicare Advantage exposure, have previously provided some interesting details surrounding their approach to clinical coding, with Humana considering itself “among the best at looking at risk adjustment” and HealthSpring estimating its overall risk score is up between 2.5%-3.0% in 2006 (vs. 2005) across its Medicare Advantage book of roughly 111,000 members.

Although plans have provided few details quantifying overall risk scores, public comments from HUM and HS indicate meaningful benefit from coding improvements

Table 18: Humana and HealthSpring Risk Score Commentary

Company	Quote	Source
HUM	"We did receive some Medicare risk adjuster payments during the quarter. They weren't an unusual amount. Again, we continue to accrue them each month as then we get them each quarter. Generally speaking, most of it related to 2007, and again it's all intra-year."	2Q'07 Earnings Conference Call
HUM	"...we continue to work hard on our encounter data and the submission to CMS. We do it every quarter; it affects every quarter."	2Q'06 Earnings Conference Call
HUM	"I would just say the same thing we've said over the past, which is we are among the best at looking at the risk adjustment work. We collect the data appropriately; we submit it to the CMS."	4Q'05 Earnings Conference Call
HUM	"Meanwhile, government segment revenues and pre-tax continue to be favorable for three reasons. First, the acceptance of our new offerings and our new growth markets have exceeded our initial expectations. Second, our effectiveness in demonstrating the risk profile of our Medicare Advantage plan membership continues."	3Q'05 Earnings Conference Call
HS	"We are encouraged by the improvement in revenue through accurate capture of member risk scores costs thorough more intense medical management, and quality of care metrics."	4Q'07 Earnings Conference Call
HS	"It looks like it (risk scores in '06 vs. '05) is...about where we thought. It is up 2.5 to 3%."	2Q'06 Earnings Conference Call
HS	"We are convinced that we can deliver enhanced service on a patient friendly basis improving clinical outcomes, efficiencies, and accurate code capture which should improve our risk scores and our premium revenues....we are continuing our efforts to hopefully increase the accuracy of coding captures to have more of a positive impact on risk scores."	1Q'06 Earnings Conference Call
HS	"...we seen increases in each of the last 2 years in a magnitude of about 3% to 4%, we're hopeful we can continue to see that but, don't have anything specific at this point."	4Q'05 Earnings Conference Call

Source: Company reports and StreetEvents

A Brief Introduction to CMS-HCC Risk Model

Calculating payments under the CMS-HCC model includes demographic and disease group factors in order to derive a “RAF” (Risk Adjustment Factor) score. Every Medicare beneficiary in both FFS and Medicare Advantage has a risk score calculated by CMS. The risk score uses five demographic factors under the CMS-HCC model, including: age, sex, Medicaid status, disability, and original reason for Medicare entitlement. Clinical factors are then added with disease groups categories based on major diagnoses and are broadly organized into body systems referred to by CMS as “HCCs” (Hierarchical Coexisting Condition). The HCC assigned to a disease is determined by ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modification) diagnosis codes submitted during a data collection period. In calculating the risk score for an individual, the individual score for each HCC is added to the demographic factor and then any relevant disease interaction score is added.

The model incorporates coexisting diseases when calculating payment by recognizing multiple chronic conditions coded for the beneficiary. Certain combinations of coexisting diagnoses are also recognized by the CMS-HCC model as having higher costs and incorporate payments for disease interactions, with the understanding that a person with, for example, diabetes but also congestive heart failure is significantly sicker than a person with either of those conditions. The CMS-HCC model also accounts for disease hierarchies, so that payments are provided for only the most severe manifestation of a disease, even when diagnoses for less severe manifestations are also present in the beneficiary during the period.

More thorough and accurate coding under this model can yield greater reimbursement for Medicare Advantage plans. To illustrate the opportunity, take for example a 72 year-old male who, after several years in traditional Medicare, enrolls in a MA plan. This man suffers from congestive heart failure as well as acute diabetes, conditions which have forced him to visit his physician many times over the years. Now suppose his physician, rather than scan through the ICD-9 code book to locate the code for both conditions as well as any relevant interaction factors, only codes for the congestive heart failure which is the cause of the current visit. Under FFS Medicare, coding for either one of these chronic conditions alone would be sufficient for the doctor to receive the lion’s share of due reimbursement. Therein lies the opportunity. If identified by the new MA plan, the coding of this beneficiary’s diabetes condition (coupled with the interaction factor for CHF and diabetes) represents a significant payment increase to the plan (approximately 70% annually in our simplified example in the table below).

We provide a brief explanation of the CMS-HCC risk adjustment model and illustrations of how improved coding translates into higher payments to Medicare Advantage plans

By identifying members that have been under-coded and submitting more complete codes, MA plans can often see drastic improvements in risk scores and reimbursement

Table 19: Payment Impact of Additional Risk Factors in CMS-HCC Model

Base Rate - Autauga, AL		\$765	
Variable	CMS-HCC Factor	Fee-for-Service	Annual Risk Factor
Age/Sex Factor(s)			
Male 70-74	--	0.416	0.416
Disease Group Factors			
Congestive Heart Failure	HCC80	0.395	0.395
Diabetes with Acute Complications	HCC17	--	0.364
DM*CHF Interaction	INT1	--	0.204
Total RAF Score	--	0.811	1.379
Reimbursement		\$620	\$1,055
% Difference			70%

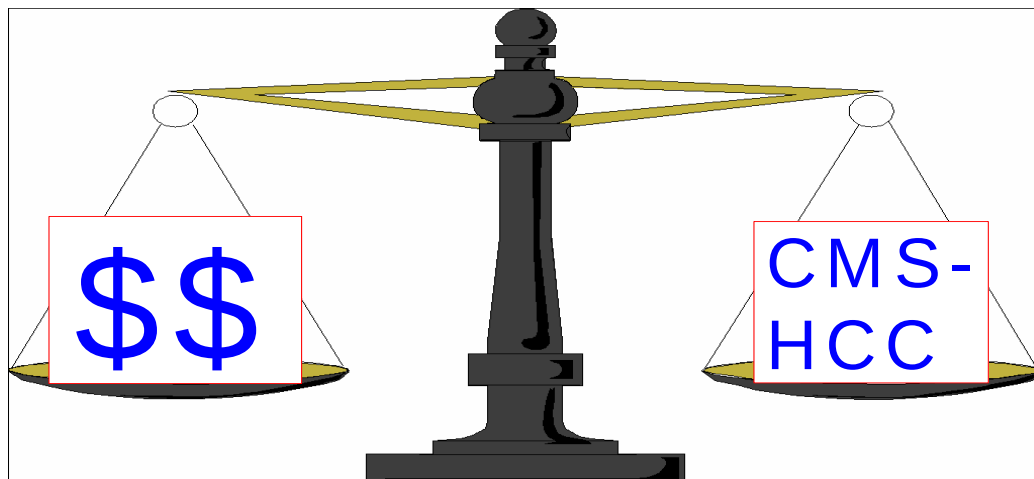
Source: CMS and UBS estimates

We estimate plans have been able to increase their overall risk scores and reimbursement between 5-15% over the past few years. In addition to the example above, there are many other scenarios under which member conditions are likely to be inaccurately or incompletely coded, representing opportunities for plans to raise risk scores (on a *same member basis*) and increase payments. This “coding arbitrage” has spawned somewhat of a cottage industry that consults MA plans on how to identify these opportunities and improve reimbursement. An easy place to start (characterized as the “low-hanging fruit” according to the marketing materials of one coding consultant) is the targeting of persistent conditions in a beneficiary’s medical history that may not be reported every year but are subject to additional payment every year if coded correctly - even if there were no recent claims documenting the diagnosis. Examples of these conditions include the most basic of chronic conditions including diabetes and congestive heart failure. Other opportunities are more difficult to identify and can require complex algorithms to systematically and efficiently review patient charts and histories. Some examples include patients coded for Cirrhosis of the Liver (HCC26) that could potentially also be coded for Alcohol Dependency (HCC52), or an ESRD patient not also coded for Protein Calorie Malnutrition (HCC21).

Clinical coding “arbitrage” is a result of CMS setting risk score weights using Medicare Fee for Service (FFS) data, which is under-coded at the physician level. Physicians under traditional Medicare FFS have little incentive to submit accurate and timely diagnosis codes to Medicare for their patients, since it has zero effect on their reimbursement. This has left patients in traditional FFS “under-coded”, presenting an opportunity for plans to work with physicians to more accurately code patients. Importantly, each additional diagnosis code results in increased revenues under the risk-adjusted payment methodology without much in the way of additional cost. This under-coding of FFS beneficiaries is the essential component of the current risk-score “arbitrage” opportunity, as CMS applies higher weights to risk factors in the model as a result. In essence, HCC codes are “over-weighted” due to too few codes being weighted against the correct level of healthcare spending.

Patients in FFS Medicare are likely under-coded at the physician level, leading to incorrectly valued clinical codes and an opportunity for plans to work w/docs to improve coding/reimb

Figure 2: CMS sets HCC weights by balancing Medicare spending against submitted clinical codes



Source: UBS

■ Statement of Risk

Risks to the Managed Care industry include but are not limited to potentially adverse impact under healthcare reform legislation, changes to Medicare and Medicaid reimbursement policies, potential for acceleration in medical cost trends, and competitive pricing pressures.

■ Analyst Certification

Each research analyst primarily responsible for the content of this research report, in whole or in part, certifies that with respect to each security or issuer that the analyst covered in this report: (1) all of the views expressed accurately reflect his or her personal views about those securities or issuers; and (2) no part of his or her compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views expressed by that research analyst in the research report.

Required Disclosures

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS.

For information on the ways in which UBS manages conflicts and maintains independence of its research product; historical performance information; and certain additional disclosures concerning UBS research recommendations, please visit www.ubs.com/disclosures. The figures contained in performance charts refer to the past; past performance is not a reliable indicator of future results. Additional information will be made available upon request. UBS Securities Co. Limited is licensed to conduct securities investment consultancy businesses by the China Securities Regulatory Commission.

UBS Investment Research: Global Equity Rating Allocations

UBS 12-Month Rating	Rating Category	Coverage ¹	IB Services ²
Buy	Buy	49%	40%
Neutral	Hold/Neutral	42%	35%
Sell	Sell	8%	21%
UBS Short-Term Rating	Rating Category	Coverage ³	IB Services ⁴
Buy	Buy	less than 1%	14%
Sell	Sell	less than 1%	0%

1:Percentage of companies under coverage globally within the 12-month rating category.

2:Percentage of companies within the 12-month rating category for which investment banking (IB) services were provided within the past 12 months.

3:Percentage of companies under coverage globally within the Short-Term rating category.

4:Percentage of companies within the Short-Term rating category for which investment banking (IB) services were provided within the past 12 months.

Source: UBS. Rating allocations are as of 31 December 2010.

UBS Investment Research: Global Equity Rating Definitions

UBS 12-Month Rating	Definition
Buy	FSR is > 6% above the MRA.
Neutral	FSR is between -6% and 6% of the MRA.
Sell	FSR is > 6% below the MRA.
UBS Short-Term Rating	Definition
Buy	Buy: Stock price expected to rise within three months from the time the rating was assigned because of a specific catalyst or event.
Sell	Sell: Stock price expected to fall within three months from the time the rating was assigned because of a specific catalyst or event.

KEY DEFINITIONS

Forecast Stock Return (FSR) is defined as expected percentage price appreciation plus gross dividend yield over the next 12 months.

Market Return Assumption (MRA) is defined as the one-year local market interest rate plus 5% (a proxy for, and not a forecast of, the equity risk premium).

Under Review (UR) Stocks may be flagged as UR by the analyst, indicating that the stock's price target and/or rating are subject to possible change in the near term, usually in response to an event that may affect the investment case or valuation.

Short-Term Ratings reflect the expected near-term (up to three months) performance of the stock and do not reflect any change in the fundamental view or investment case.

Equity Price Targets have an investment horizon of 12 months.

EXCEPTIONS AND SPECIAL CASES

UK and European Investment Fund ratings and definitions are: Buy: Positive on factors such as structure, management, performance record, discount; Neutral: Neutral on factors such as structure, management, performance record, discount; Sell: Negative on factors such as structure, management, performance record, discount.

Core Banding Exceptions (CBE): Exceptions to the standard +/-6% bands may be granted by the Investment Review Committee (IRC). Factors considered by the IRC include the stock's volatility and the credit spread of the respective company's debt. As a result, stocks deemed to be very high or low risk may be subject to higher or lower bands as they relate to the rating. When such exceptions apply, they will be identified in the Company Disclosures table in the relevant research piece.

Research analysts contributing to this report who are employed by any non-US affiliate of UBS Securities LLC are not registered/qualified as research analysts with the NASD and NYSE and therefore are not subject to the restrictions contained in the NASD and NYSE rules on communications with a subject company, public appearances, and trading securities held by a research analyst account. The name of each affiliate and analyst employed by that affiliate contributing to this report, if any, follows.

UBS Securities LLC: Justin Lake, CFA; Ken LaVine, CFA; Andrew Valen; Dean Poniros, CPA.

Company Disclosures

Company Name	Reuters	12-mo rating	Short-term rating	Price	Price date
Aetna Inc. ^{2, 4, 6a, 6b, 6c, 7, 16}	AET.N	Neutral	N/A	US\$37.65	11 Feb 2011
Cigna Corp. ^{2, 4, 6a, 6b, 7, 16}	CI.N	Buy	N/A	US\$42.92	11 Feb 2011
Health Net Inc. ^{6a, 16}	HNT.N	Neutral	N/A	US\$30.69	11 Feb 2011
HealthSpring Inc. ^{4, 5, 6a, 16}	HS.N	Neutral	N/A	US\$32.02	11 Feb 2011
Humana Inc. ^{6b, 7, 16}	HUM.N	Neutral	N/A	US\$58.31	11 Feb 2011
UnitedHealth Group ^{2, 4, 5, 6a, 6b, 6c, 7, 16}	UNH.N	Neutral	N/A	US\$42.38	11 Feb 2011
WellPoint, Inc. ^{2, 4, 5, 6a, 6b, 6c, 7, 16, 22}	WLP.N	Buy	N/A	US\$65.25	11 Feb 2011

Source: UBS. All prices as of local market close.

Ratings in this table are the most current published ratings prior to this report. They may be more recent than the stock pricing date

2. UBS AG, its affiliates or subsidiaries has acted as manager/co-manager in the underwriting or placement of securities of this company/entity or one of its affiliates within the past 12 months.
4. Within the past 12 months, UBS AG, its affiliates or subsidiaries has received compensation for investment banking services from this company/entity.
5. UBS AG, its affiliates or subsidiaries expect to receive or intend to seek compensation for investment banking services from this company/entity within the next three months.
- 6a. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and investment banking services are being, or have been, provided.
- 6b. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-investment banking securities-related services are being, or have been, provided.
- 6c. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-securities services are being, or have been, provided.

- 7. Within the past 12 months, UBS Securities LLC has received compensation for products and services other than investment banking services from this company/entity.
- 16. UBS Securities LLC makes a market in the securities and/or ADRs of this company.
- 22. UBS AG, its affiliates or subsidiaries held other significant financial interests in this company/entity as of last month's end (or the prior month's end if this report is dated less than 10 working days after the most recent month's end).

Unless otherwise indicated, please refer to the Valuation and Risk sections within the body of this report.

For a complete set of disclosure statements associated with the companies discussed in this report, including information on valuation and risk, please contact UBS Securities LLC, 1285 Avenue of Americas, New York, NY 10019, USA, Attention: Publishing Administration.

Global Disclaimer

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS. In certain countries, UBS AG is referred to as UBS SA.

This report is for distribution only under such circumstances as may be permitted by applicable law. Nothing in this report constitutes a representation that any investment strategy or recommendation contained herein is suitable or appropriate to a recipient's individual circumstances or otherwise constitutes a personal recommendation. It is published solely for information purposes, it does not constitute an advertisement and is not to be construed as a solicitation or an offer to buy or sell any securities or related financial instruments in any jurisdiction. No representation or warranty, either express or implied, is provided in relation to the accuracy, completeness or reliability of the information contained herein, except with respect to information concerning UBS AG, its subsidiaries and affiliates, nor is it intended to be a complete statement or summary of the securities, markets or developments referred to in the report. UBS does not undertake that investors will obtain profits, nor will it share with investors any investment profits nor accept any liability for any investment losses. Investments involve risks and investors should exercise prudence in making their investment decisions. The report should not be regarded by recipients as a substitute for the exercise of their own judgement. Past performance is not necessarily a guide to future performance. The value of any investment or income may go down as well as up and you may not get back the full amount invested. Any opinions expressed in this report are subject to change without notice and may differ or be contrary to opinions expressed by other business areas or groups of UBS as a result of using different assumptions and criteria. Research will initiate, update and cease coverage solely at the discretion of UBS Investment Bank Research Management. The analysis contained herein is based on numerous assumptions. Different assumptions could result in materially different results. The analyst(s) responsible for the preparation of this report may interact with trading desk personnel, sales personnel and other constituencies for the purpose of gathering, synthesizing and interpreting market information. UBS is under no obligation to update or keep current the information contained herein. UBS relies on information barriers to control the flow of information contained in one or more areas within UBS, into other areas, units, groups or affiliates of UBS. The compensation of the analyst who prepared this report is determined exclusively by research management and senior management (not including investment banking). Analyst compensation is not based on investment banking revenues, however, compensation may relate to the revenues of UBS Investment Bank as a whole, of which investment banking, sales and trading are a part.

The securities described herein may not be eligible for sale in all jurisdictions or to certain categories of investors. Options, derivative products and futures are not suitable for all investors, and trading in these instruments is considered risky. Mortgage and asset-backed securities may involve a high degree of risk and may be highly volatile in response to fluctuations in interest rates and other market conditions. Past performance is not necessarily indicative of future results. Foreign currency rates of exchange may adversely affect the value, price or income of any security or related instrument mentioned in this report. For investment advice, trade execution or other enquiries, clients should contact their local sales representative. Neither UBS nor any of its affiliates, nor any of UBS' or any of its affiliates, directors, employees or agents accepts any liability for any loss or damage arising out of the use of all or any part of this report. For financial instruments admitted to trading on an EU regulated market: UBS AG, its affiliates or subsidiaries (excluding UBS Securities LLC and/or UBS Capital Markets LP) acts as a market maker or liquidity provider (in accordance with the interpretation of these terms in the UK) in the financial instruments of the issuer save that where the activity of liquidity provider is carried out in accordance with the definition given to it by the laws and regulations of any other EU jurisdictions, such information is separately disclosed in this research report. UBS and its affiliates and employees may have long or short positions, trade as principal and buy and sell in instruments or derivatives identified herein.

Any prices stated in this report are for information purposes only and do not represent valuations for individual securities or other instruments. There is no representation that any transaction can or could have been effected at those prices and any prices do not necessarily reflect UBS's internal books and records or theoretical model-based valuations and may be based on certain assumptions. Different assumptions, by UBS or any other source, may yield substantially different results.

United Kingdom and the rest of Europe: Except as otherwise specified herein, this material is communicated by UBS Limited, a subsidiary of UBS AG, to persons who are eligible counterparties or professional clients and is only available to such persons. The information contained herein does not apply to, and should not be relied upon by, retail clients. UBS Limited is authorised and regulated by the Financial Services Authority (FSA). UBS research complies with all the FSA requirements and laws concerning disclosures and these are indicated on the research where applicable. **France:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities France SA. UBS Securities France S.A. is regulated by the Autorité des Marchés Financiers (AMF). Where an analyst of UBS Securities France S.A. has contributed to this report, the report is also deemed to have been prepared by UBS Securities France S.A. **Germany:** Prepared by UBS Limited and distributed by UBS Limited and UBS Deutschland AG. UBS Deutschland AG is regulated by the Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin). **Spain:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities España SV, SA. UBS Securities España SV, SA is regulated by the Comisión Nacional del Mercado de Valores (CNMV). **Turkey:** Prepared by UBS Menkul Değerler AS on behalf of and distributed by UBS Limited. **Russia:** Prepared and distributed by UBS Securities CJSC. **Switzerland:** Distributed by UBS AG to persons who are institutional investors only. **Italy:** Prepared by UBS Limited and distributed by UBS Limited and UBS Italia Sim S.p.A.. UBS Italia Sim S.p.A. is regulated by the Bank of Italy and by the Commissione Nazionale per le Società e la Borsa (CONSOB). Where an analyst of UBS Italia Sim S.p.A. has contributed to this report, the report is also deemed to have been prepared by UBS Italia Sim S.p.A.. **South Africa:** UBS South Africa (Pty) Limited (Registration No. 1995/011140/07) is a member of the JSE Limited, the South African Futures Exchange and the Bond Exchange of South Africa. UBS South Africa (Pty) Limited is an authorised Financial Services Provider. Details of its postal and physical address and a list of its directors are available on request or may be accessed at <http://www.ubs.co.za>. **United States:** Distributed to US persons by either UBS Securities LLC or by UBS Financial Services Inc., subsidiaries of UBS AG; or by a group, subsidiary or affiliate of UBS AG that is not registered as a US broker-dealer (a "non-US affiliate"), to major US institutional investors only. UBS Securities LLC or UBS Financial Services Inc. accepts responsibility for the content of a report prepared by another non-US affiliate when distributed to US persons by UBS Securities LLC or UBS Financial Services Inc. All transactions by a US person in the securities mentioned in this report must be effected through UBS Securities LLC or UBS Financial Services Inc., and not through a non-US affiliate. **Canada:** Distributed by UBS Securities Canada Inc., a subsidiary of UBS AG and a member of the principal Canadian stock exchanges & CIPF. A statement of its financial condition and a list of its directors and senior officers will be provided upon request. **Hong Kong:** Distributed by UBS Securities Asia Limited. **Singapore:** Distributed by UBS Securities Pte. Ltd [mica (p) 039/11/2009 and Co. Reg. No.: 198500648C] or UBS AG, Singapore Branch. Please contact UBS Securities Pte Ltd, an exempt financial advisor under the Singapore Financial Advisers Act (Cap. 110); or UBS AG Singapore branch, an exempt financial adviser under the Singapore Financial Advisers Act (Cap. 110) and a wholesale bank licensed under the Singapore Banking Act (Cap. 19) regulated by the Monetary Authority of Singapore, in respect of any matters arising from, or in connection with, the analysis or report. The recipient of this report represent and warrant that they are accredited and institutional investors as defined in the Securities and Futures Act (Cap. 289). **Japan:** Distributed by UBS Securities Japan Ltd to institutional investors only. Where this report has been prepared by UBS Securities Japan Ltd, UBS Securities Japan Ltd is the author, publisher and distributor of the report. **Australia:** Distributed by UBS AG (Holder of Australian Financial Services License No. 231087) and UBS Securities Australia Ltd (Holder of Australian Financial Services License No. 231098) only to 'Wholesale' clients as defined by s761G of the Corporations Act 2001. **New Zealand:** Distributed by UBS New Zealand Ltd. An investment adviser and investment broker disclosure statement is available on request and free of charge by writing to PO Box 45, Auckland, NZ. **Dubai:** The research prepared and distributed by UBS AG Dubai Branch, is intended for Professional Clients only and is not for further distribution within the United Arab Emirates. **Korea:** Distributed in Korea by UBS Securities Pte. Ltd., Seoul Branch. This report may have been edited or contributed to from time to time by affiliates of UBS Securities Pte. Ltd., Seoul Branch. **Malaysia:** This material is authorized to be distributed in Malaysia by UBS Securities Malaysia Sdn. Bhd (253825-x). **India :** Prepared by UBS Securities India Private Ltd. 2/F, 2 North Avenue, Maker Maxity, Bandra Kurla Complex, Bandra (East), Mumbai (India) 400051. Phone: +912261556000 SEBI Registration Numbers: NSE (Capital Market Segment): INB230951431, NSE (F&O Segment) INF230951431, BSE (Capital Market Segment) INB010951437.

The disclosures contained in research reports produced by UBS Limited shall be governed by and construed in accordance with English law.

UBS specifically prohibits the redistribution of this material in whole or in part without the written permission of UBS and UBS accepts no liability whatsoever for the actions of third parties in this respect. Images may depict objects or elements which are protected by third party copyright, trademarks and other intellectual property rights. © UBS 2011. The key symbol and UBS are among the registered and unregistered trademarks of UBS. All rights reserved.



UBS Investment Research

Managed Care – Medicare Advantage

Thoughts on Medicare Risk Score Audits

■ Consultant quote highlights Medicare risk score audit uncertainty

While risk score audits have been underway since 2008, a lack of news-flow here has left significant uncertainty as to the timing/impact of potential liability w/plan 10K risk statements highlighting uncertainty. That said, CMS completion of audits coupled w/recent consultant commentary has moved topic front and center.

■ While estimating liability is impossible, we lay out 3 key considerations

Given much will depend on how CMS chooses to interpret and act upon audit results we would highlight the following as keys for investors to focus upon: (1) Size of audit repayment request, (2) Size of population audited and time period as audits thus far have not been all-encompassing from a membership standpoint and focused on 2007 only (3) How were audit results interpreted, w/plans pushing CMS to take into account that FFS also has significant documentation errors.

■ OIG audits unlikely to matter, CMS news-flow will be key going forward

While both CMS and OIG pursue audits, our understanding is that OIG can deliver audit results/recommendation to CMS but does not have regulatory authority over plans. In terms of news-flow we expect CMS audit response in 1H'11 and potential risk score adj cuts (-3.41% for 2010) w/prelim 2012 Med Adv rate release on 2/18.

■ We continue to see risk scores as most significant Med Adv wild-card

Better risk score coding has been significant reimbursement benefit highlighted by plans reporting flat PMPM Med Adv revs despite -5% cut in rates for 2010. Going forward, risk score improvement will either allow plans to offset much of rate cuts or put further pressure on economics, w/CMS aggression level main swing factor.

21 December 2010

www.ubs.com/investmentresearch

Justin Lake, CFA

Analyst

justin.lake@ubs.com

+1-212-713 2765

Ken LaVine, CFA

Associate Analyst

kenneth.lavine@ubs.com

+1-212-713 4237

Dean Poniros, CPA

Associate Analyst

dean.poniros@ubs.com

+1-212-713 3229

Andrew Valen

Associate Analyst

andrew.valen@ubs.com

+1 212 713 2717

Table 1: UBS MCO Universe – Est. 2010 Medicare Advantage Margins and Earnings Exposure by Company

	HS	HUM	UNH	CVH	HNT	AET	WLP	CI
FY'10E Med Adv Premiums (\$mil)	\$2,369	\$19,264	\$24,013	\$2,089	\$2,531	\$5,172	\$5,740	\$1,478
MA as % of total Premiums	80.7%	58.8%	28.2%	20.2%	25.5%	18.8%	10.6%	14.2%
2010 Med Adv Margin Est. *	10.8%	7.0%	8.6%	8.8%	1.9%	4.9%	6.9%	0.0%
MA as % of EPS	92.7%	85.7%	31.0%	21.4%	16.1%	14.0%	10.9%	1.4%

Source: Company reports and UBS estimates; estimated Med Adv margins exclude investment income

This report has been prepared by UBS Securities LLC

ANALYST CERTIFICATION AND REQUIRED DISCLOSURES BEGIN ON PAGE 23.

UBS does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report. Investors should consider this report as only a single factor in making their investment decision.

Executive Summary

An industry consultant's recent quote around potential government "demand letter" for nine-figure audit settlement from public plan has brought Medicare Advantage risk scores into the spotlight. While risk score audits have been underway since 2008, a lack of news-flow here has left significant uncertainty as to the timing of results being communicated much less potential financial repercussions to plans. However, we believe CMS has finally completed audits and recent consultant commentary has moved the topic front and center over the past couple of weeks.

We believe CMS has finally completed audits and recent consultant commentary has moved the topic of risk audits front-and-center over the past couple of weeks

Table 2: Medicare Advantage News (MAN) – Industry Consultant RADV Audit Commentary

Industry consultant John Gorman tells MAN the case is a "clear indication" that DOJ and the HHS Office of Inspector General "are getting impatient with the process" of risk adjustment data validation (RADV) audits of MA plans "and are taking things into their own hands."
Gorman, who is CEO of Gorman Health Group, LLC, says he is aware of at least one more MA RADV-based case proceeding toward settlement, this one involving a publicly held company that he wouldn't identify. The settlement in that case, based on a nine-digit "demand letter" the firm received, is likely to be bigger than the one just announced, he tells MAN.
Gorman predicts that there will be more such cases, including the previously mentioned one involving a publicly owned company.
Gorman says he does not know when the next settlement may come, but theorizes it may be in the first or second quarter of 2011, "and it will go off like a bomb on Wall Street."

Source: Medicare Advantage News Vol 16, No 23

While the potential plan liability here is impossible to estimate given lack of information on audit results and zero visibility into how government will choose to interpret/proceed, we lay out key considerations. Audit results have not been made available and we are unsure of how CMS will choose to proceed in terms of setting any potential plan repayment as well as further audit action. Therefore we attempt to be helpful in terms of outlining key considerations that should be kept in mind upon release of any newsflow regarding risk score audits going forward.

- (1) **Size of audit repayment** – essentially what is government asking for (if anything) in terms of repayment of Medicare Advantage plan premiums.
- (2) **Size of population audited and time period** – while size of repayment is important, we would note that all information points to the audits being done at the plan level (rather than company level). Each company contracts with Medicare through a number of different plans, so any requested dollars for a specific plan may not represent the total potential liability. After an audit on one plan is complete, the government may move on to other Medicare Advantage plans offered by a particular company, thus increasing potential liability. In addition, the time period is important although we expect this will be much more simple as audits are likely to pertain to specific plan year, with 2007 plan year currently being year audited. We believe most companies expect government to move forward with audits for 2008 and beyond once finished with 2007, another factor potentially increasing total company liability.

In our view, most companies expect the government to move forward with audits for 2008 and beyond once finished with 2007, thus potentially increasing total company liability exposure

(3) How audit results were interpreted and the repayment amount calculated – we believe the greatest uncertainty from the company perspective (as highlighted by 10-K risk disclosures illustrated on page 14) is around how CMS will interpret audit results and calculate the repayment request. For instance, it is likely that audits will uncover some level of non-complete provider documentation (such as missing physician signature, etc.) that are also widespread in traditional FFS. The question here is whether or not the plans will be held to a zero error target (hopefully not) or more realistically held to an error target that is in-line with that found in traditional FFS. The other big question is whether any errors are found that would indicate plan “under-coding” (coding that results in lower payment) and if this would be allowed to reduce the audit repayment. Essentially, we would expect any repayment request from the government that does not allow for some normal FFS error rate or net “under-coding” against repayment to be fought by the plans.

We see greatest uncertainty from the company perspective as being around how CMS will interpret audit results and calculate repayment request

Our checks indicate that OIG audits and recommendations won't directly impact plans as CMS is the industry regulator at the end of the day. While UnitedHealth's 10-K risk statement indicates separate OIG and CMS risk score audits were underway and we have heard from several smaller plans which have also seen OIG audits take place, it is important to note that OIG as an agency does not have regulatory authority over plans. Any audit results and recommendations from OIG must be brought to CMS and it will be CMS who decides what action to take here. Given CMS is also clearly conducting its own, much broader, risk score audits we are unsure what, if any, impact OIG audit results and potential “demand letters” will have here going forward. Finally, we believe it is possible that investors will never actually see OIG results/recommendations as they may be folded into CMS audits and communicated to plans once CMS settles on final audit methodology. Below is a strong overview of the issue from Humana's 3Q 2010 10-Q:

Both OIG and CMS are conducting audits, although OIG does not have regulatory authority over the plans

CMS is continuing to perform audits of selected Medicare Advantage plans of various companies to validate the provider coding practices and resulting economics under the actuarial risk-adjustment model used to calculate the individual member capitation paid to Medicare Advantage plans. Several Humana contracts have been selected by CMS for audit, and we expect that CMS will continue conducting audits for the 2007 contract year and beyond. We generally rely on providers to appropriately document all medical data including risk-adjustment data in their medical records and appropriately code their claim submissions, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. The CMS audits involve a review of a sample of provider medical records for the contracts being audited. Rates paid to Medicare Advantage plans are established under an actuarial bid model, including a process whereby our premium is based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original Medicare program. As a result, we believe that an actuarially sound adjustment of payments from these audits would need to take into account the level of coding accuracy and provider medical record documentation completeness under the government's original Medicare program, since the risk adjustment system, bids, benefit structures and payment rates were premised on that data. This would help to ensure that the audit methodology applied to Medicare Advantage plans accurately calculates the economic impact of the audit findings. Additionally, our payment received from CMS, as well as benefits offered and premiums charged to members, is based on bids

that did not, by CMS design, include any assumption of retroactive audit payment adjustments. We believe that applying a retroactive audit adjustment after CMS acceptance of bids would improperly alter this process of establishing member benefits and premiums.

CMS has not formally announced its audit payment adjustment methodology, nor has CMS formally indicated whether the audit payment adjustment methodology will be based on a comparison to original Medicare coding accuracy. CMS has further indicated that it may make retroactive contract-level payment adjustments. Any such payment adjustments could occur as early as this year, and could be effected prior to our, or other Medicare Advantage plans, having the opportunity to appeal the underlying payment adjustment methodology. We are unable to estimate the financial impact of any audits that may be conducted related to 2007 revenue and beyond or whether any findings would cause a change to our method of estimating future premium revenue in bid submissions made to CMS for future contract years, or compromise premium rate assumptions made in our bids for prior contract years. At this time, we do not know whether CMS will require payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using its method of extrapolating findings to the entire contract. However, if CMS requires payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using a method of extrapolating findings to the entire contract, and if we are unable to obtain any relief preventing the payment adjustments from being implemented, we believe that such adjustments would have a material adverse effect on our results of operations, financial position, and cash flows.”

We expect risk score news flow likely to accelerate over next several months via two events. With CMS audit requests met by plans, we would expect some communication here in the first half of next year, with exact timing impossible to nail down (again we note these audits began 2 years ago). In addition, we see potential for further focus on risk scores via forward adjustments that would lower risk scores and reimbursement to plans (such as the -3.41% cut communicated for 2010) with the release of the 45-day letter for preliminary 2012 Medicare Advantage rates, expected on Friday, February 18th 2011, with final rates to be delivered on April 4th.

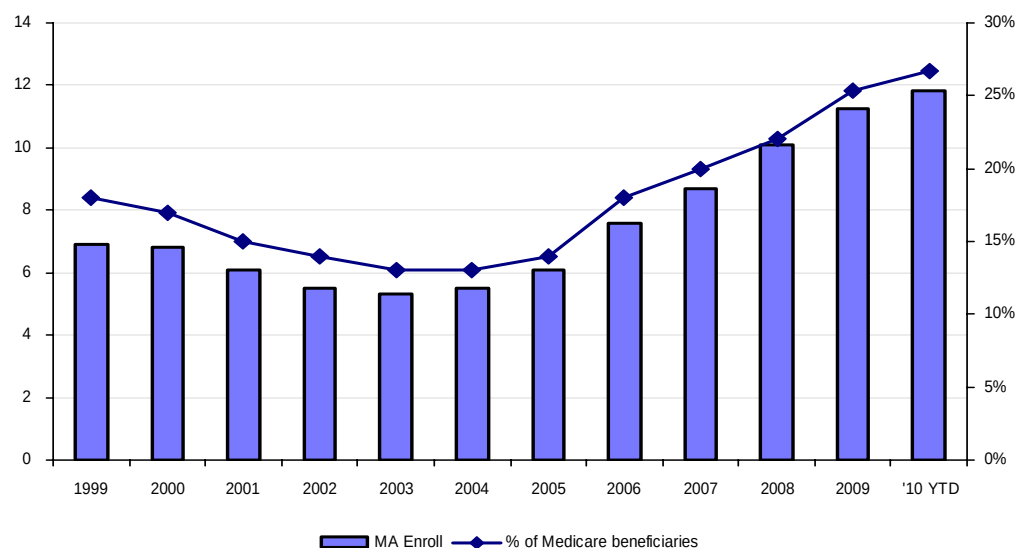
Given that a worst case audit of all plans over multiple years would be an enormous task, we see a fairly high probability that CMS will likely choose to implement any significant risk score adjustments on a forward-looking basis as shown in the 2010 rates. While the risk coding adjustment remained unchanged in the 2011 rate announcement (down 3.41% in 2010), CMS explicitly laid out its view that the agency has the authority to make future adjustments in this area and we would certainly opine that this would be the most efficient way for CMS to implement change here. That said, the more worrisome case would be for CMS to broaden historical risk score audits and potential repayment while concurrently lowering forward risk scores as well.

Medicare Advantage enrollment has grown significantly since 2005 both in absolute terms and as % of total Medicare beneficiaries. As highlighted in Chart 1 below, the number of Medicare Advantage enrollees has nearly doubled over the last five years and now stands at 11.9 million lives, representing 27% of total Medicare beneficiaries.

We anticipate some communication from CMS in the first half of 2011 regarding the RADV audits

Medicare Advantage enrollment now stands at 11.9 million lives

Chart 1: Medicare Advantage Membership and as % of Medicare Beneficiaries, 1999-2010 YTD (lives in millions)

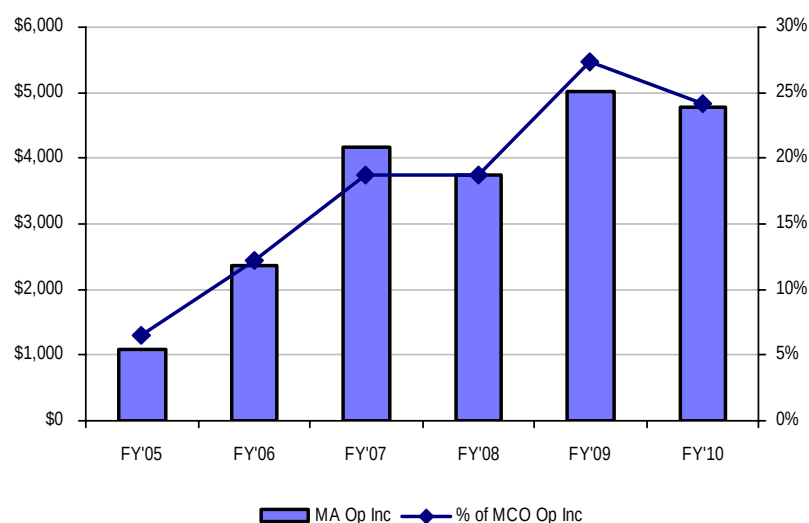


Source: Mathematica, CMS, and UBS estimates

Medicare Advantage has been the primary source of earnings growth for the group over the past five years given the strong enrollment growth coupled with slowing commercial market, and we now estimate it comprises ~25% of industry profits.

We estimate ~25% of industry profits are derived from Medicare Advantage

Chart 2: UBS Managed Care Coverage Universe: Est. Medicare Advantage Op Inc and as % of Overall Op Inc, 2005 – 2010, \$ in millions



Source: Company reports and UBS estimates

Risk score improvement by plans has been a key driver of continued strong Medicare Advantage margins as evidenced by apparent ability to offset 5% rate cut in 2011. While patient mix may have changed, we believe that better than expected reported plan member premiums for 2009 and 2010 have been largely a function of improved coding with Table 3 below comparing the CMS stated Medicare Advantage rate change with the actual Medicare Advantage PMPM change reported by two of the bigger players in the space. Although Medicare Advantage rates increased 2.14% in 2009 based on CMS numbers, both HealthSpring and Humana were able to more than double that increase likely through higher risk scores. While the 2010 rate was down 5.08%, both companies reported flat or slightly better per member premiums YoY.

2010 CMS Medicare Advantage rates declined 5%, but plans were able to offset this through improved coding

Table 3: Est. HS and HUM PMPM Benefits of Risk Score Improvement

	2008	2009	2010	2011
<u>HealthSpring</u>				
MA PMPM	\$1,002	\$1,055	\$1,054	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	5.21%	-0.01%	--
<u>Humana</u>				
MA PMPM	\$858	\$917	\$929	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	6.85%	1.36%	--

Source: CMS, Company Reports, UBS Estimates

We estimate Medicare Advantage margins are generally in the high mid single digit range with HealthSpring approaching 11% and earning more than 90% of EPS from the Medicare Advantage program. Humana is also particularly levered here with ~85% of EPS derived from Medicare Advantage with CIGNA being the least tied to the program. Table 4 below highlights company-specific Medicare Advantage earnings exposure and 2010 estimated margins.

Table 4: UBS MCO Universe – Estimated Medicare Advantage Exposure

	HS	HUM	UNH	CVH	HNT	AET	WLP	CI
UBS Rating	Neutral	Neutral	Neutral	Neutral	Neutral	Neutral	Buy	Buy
Current PE (NTM Cons)	8.2x	9.7x	9.7x	9.2x	9.2x	9.5x	8.7x	8.1x
FY'10E Med Adv Premiums (\$mil)	\$2,369	\$19,264	\$24,013	\$2,089	\$2,531	\$5,172	\$5,740	\$1,478
MA as % of total Premiums	80.7%	58.8%	28.2%	20.2%	25.5%	18.8%	10.6%	14.2%
2010 Med Adv Margin Est. *	10.8%	7.0%	8.6%	8.8%	1.9%	4.9%	6.9%	0.0%
Oper. Profits (pre-tax \$mil) *	\$275	\$1,507	\$2,211	\$199	\$67	\$330	\$454	\$27
MA as % of total Op Profit	87.3%	80.9%	29.1%	21.6%	14.9%	12.2%	9.4%	1.4%
MA EPS contribution	\$3.06	\$5.57	\$1.23	\$0.86	\$0.41	\$0.51	\$0.71	\$0.06
EPS estimate	\$3.30	\$6.50	\$3.97	\$4.00	\$2.57	\$3.62	\$6.50	\$4.50
MA as % of EPS	92.7%	85.7%	31.0%	21.4%	16.1%	14.0%	10.9%	1.4%
Med Adv HMO Lives	195	636	1,415	137	239	172	171	37
Med Adv PPO Lives	3	673	325	88	40	171	193	0
Med Adv PFFS Lives	0	455	347	0	0	95	123	110
Med Adv Total Lives (000s)	198	1,764	2,086	225	280	438	487	147
MA as % of total Membership	99.0%	20.9%	6.4%	6.5%	5.0%	2.4%	1.5%	1.3%
Est Med Adv Spread vs. FFS	9.2%	14.0%	15.3%	14.8%	15.9%	13.7%	14.5%	11.6%

* 2010 Med Adv estimated margins exclude investment income while Med Adv operating profits include investment income allocation; Note MA lives based on CMS Nov 2010 data
Source: Company reports, CMS, FactSet, and UBS estimates

Detailed Overview

Plan-level Medicare Advantage risk score audits are in the crosshairs lately as the first Federal False Claims Act involving Medicare Advantage is settled. As noted since our 2007 report on plan risk score coding “Risk Score Arbitrage – The Next Shoe to Drop?”, it has become apparent to CMS that the industry has seen a materially faster increase in risk scores than the overall FFS population, potentially benefitting plan reimbursement by 5 to 15% over the last several years due to greater coding accuracy. Given significant dollars associated here (overall Medicare Advantage spending in the \$100 billion range), it is not surprising the government has been taking a closer look with CMS announcing in 2008 that they would be conducting plan-level Medicare Advantage risk score audits to ensure reimbursement is supported by the requisite documentation with the Office of Inspector General (OIG) of Health and Human Services (HHS) also involved in plan-level audits as well.

As we have highlighted for past several years, it is apparent to CMS that the Medicare Advantage industry has seen a materially faster increase in risk scores than the overall Medicare FFS population

- **Medicare Advantage plan-level risk adjustment data validation (RADV) audits** entail reviewing medical records maintained by physicians and other providers that are then used by Managed Care plans to submit member level health status to the government for reimbursement. Audits are being performed in order to validate the provider coding practices and related economics paid to Medicare Advantage plans under the risk-adjustment model. Please see Appendix beginning on page 20 for a thorough review of the Medicare Advantage risk adjustment model.
- **The first round of audits** focused on the risk adjustment data for 2006 that were used to determine 2007 payment amounts to Medicare Advantage plans.
- **We see the greatest uncertainty around how CMS will interpret audit results and calculate any potential repayment request.** For instance, it is likely that audits will uncover some level of non-complete provider documentation (such as missing physician signature, etc.) that are also widespread in traditional FFS. The question here is whether or not the plans will be held to a zero error target (hopefully not) or more realistically held to an error target that is in-line with that found in traditional FFS. The other big question is whether any errors are found that would indicate plan “under-coding” (coding that results in lower payment) and if this would be allowed to reduce the audit repayment. Essentially, we would expect any repayment request from the government that does not allow for some normal FFS error rate or net “under-coding” against repayment to be fought by the plans.
- **Notably**, beginning in 2008, most of the companies in our coverage universe with large Medicare Advantage exposure had added broad, non-specific risk statements to their SEC filings indicating potential for negative outcomes related to these audits.
- **Given most industry sources indicate 2007 risk score audits are complete, look for further color / update on plan-level risk audits** potentially in conjunction with the release of preliminary 2012 Medicare Advantage rates in mid-February 2011.

Audits are being undertaken to validate the provider coding practices and related economics paid to Medicare Advantage plans under the risk-adjustment model

Recent data points around plan-level Medicare Advantage risk score audits may provide some color around what we previously highlighted as an indefinable but potentially significant negative catalyst. On November 24th, the Department of Justice announced a \$22.6 million settlement resolving Medicare Advantage fraud allegations with America's Health Choice Medical Plans Inc. with the lawsuit involving claims of fraudulently increasing the severity of beneficiary diagnoses to obtain high Medicare payments under the risk adjusted payment system. Notably, industry consultant John Gorman indicated that he is aware of at least one more MA RADV-based case moving towards settlement – while he did not identify the plan in question, Mr. Gorman did note that it involves a publicly-traded company and, given the “nine-digit” figure opening salvo, the ultimate settlement amount would likely be bigger than the \$23 million settlement for America's Health Choice Medical Plans. We note that unlike America's Health Choice Medical Plans, we don't think that the other audits are turning up fraud.

Dept of Justice announced on 11/24 a \$23 million settlement resolving Medicare Advantage fraud allegations with a small Medicare Advantage plan

Look for potential headlines around another MA RADV-based case moving towards settlement – with industry consultant being quoted as indicating public plan has received “nine-digit” opening salvo via government “demand letter”. While the name of the plan potentially subject to the alleged “nine-figure” demand letter has yet to be released, notably, the sheer size of the figure clearly limits the number of likely prospects with Table 5 highlighting the largest plans by H-code as of 2007. As the OIG results may be folded into the CMS audits, it is possible that this demand letter may never be separately communicated.

The name of the plan allegedly receiving the “nine-digit” demand letter has yet to be identified

Table 5: Top 20 Medicare Advantage Contracts based on 2007 Membership

Parent Organization	Contract #	Organization Name	Plan Type	2007 Membership
Humana Inc.	H1804	HUMANA INSURANCE COMPANY	PFFS	607,985
United HealthCare Group, Inc.	H0543	PACIFICARE OF CALIFORNIA/SECURE HORIZONS	HMO	342,775
Humana Inc.	H1036	HUMANA MEDICAL PLAN, INC.	HMO	249,032
Wellpoint, Inc.	H0540	UNICARE LIFE AND HEALTH INS. COMPANY	PFFS	124,214
Coventry Health Care Inc.	H0846	FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY	PFFS	124,020
United HealthCare Group, Inc.	H4590	PACIFICARE OF TEXAS, INC.	HMO	120,068
Health Net, Inc.	H0562	HEALTH NET OF CA	HMO	105,135
United HealthCare Group, Inc.	H0303	PACIFICARE OF ARIZONA, INC.	HMO	99,199
United HealthCare Group, Inc.	H5435	PACIFICARE LIFE AND HEALTH INSURANCE COMPANY	PFFS	77,277
Wellpoint, Inc.	H3655	COMMUNITY INSURANCE COMPANY	HMO	76,640
United HealthCare Group, Inc.	H3307	OXFORD HEALTH PLANS (NY) INC.	HMO	69,061
Wellpoint, Inc.	H3370	EMPIRE HEALTHCHOICE HMO, INC.	HMO	67,055
United HealthCare Group, Inc.	H0609	PACIFICARE OF COLORADO, INC.	HMO	59,137
United HealthCare Group, Inc.	H3659	UNITED HEALTHCARE OF OHIO, INC.	HMO	53,243
Humana Inc.	H1019	CARE PLUS HEALTH PLAN	HMO	53,034
Aetna Inc.	H5736	AETNA LIFE INSURANCE COMPANY	PFFS	50,762
NewQuest Health Solutions LLC	H4454	HEALTHSPRING OF TENNESSEE, INC.	HMO	50,465
Humana Inc.	H1951	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA INC	HMO	48,477
Health Net, Inc.	H0351	HEALTH NET OF ARIZONA, INC.	HMO	45,467
United HealthCare Group, Inc.	H2654	UNITED HEALTHCARE OF THE MIDWEST, INC.	HMO	44,036
Health Net, Inc.	H0755	HEALTH NET OF CONNECTICUT	HMO	43,629
Humana Inc.	R5826	HUMANA INSURANCE COMPANY	Regional PPO	42,338
Coventry Health Care Inc.	H5227	COVENTRY HEALTH AND LIFE INSURANCE COMPANY	PFFS	41,482
United HealthCare Group, Inc.	H3456	UNITED HEALTHCARE OF NORTH CAROLINA	HMO	40,259
United HealthCare Group, Inc.	H5005	PACIFICARE OF WASHINGTON, INC.	HMO	39,213
United HealthCare Group, Inc.	R5287	UNITED HEALTHCARE INSURANCE COMPANY	Regional PPO	39,061
Aetna Inc.	H3931	AETNA HEALTH INC	HMO	36,741
NewQuest Health Solutions LLC	H4513	TEXAS HEALTHSPRING LLC	HMO	36,546
Coventry Health Care Inc.	H3959	HEALTHAMERICA PENNSYLVANIA, INC.	HMO	36,282
United HealthCare Group, Inc.	H4456	UNITED HEALTHCARE PLAN OF THE RIVER VALLEY, INC.	HMO	33,551
United HealthCare Group, Inc.	H0151	UNITED HEALTHCARE OF ALABAMA, INC.	HMO	33,083
CIGNA	H0354	CIGNA HEALTHCARE OF ARIZONA, INC.	HMO	31,439
NewQuest Health Solutions LLC	H0150	HEALTHSPRING OF ALABAMA, INC.	HMO	30,576
Aetna Inc.	H3152	AETNA HEALTH, INC.	HMO	29,981
Wellpoint, Inc.	R9943	BC LIFE and HEALTH INSURANCE COMPANY	Regional PPO	29,261
Humana Inc.	H1406	HUMANA HEALTH PLAN, INC.	HMO	27,785
United HealthCare Group, Inc.	H2949	PACIFICARE OF NEVADA, INC.	HMO	27,216

Source: CMS, UBS Analysis

While we are unclear of what exactly the potential magnitude of the final settlement will be for this yet-to-be identified plan, we anticipate that it will come down meaningfully from the assumed OIG opening recovery request in the “nine-digit” figure range, with ultimate settlement amount potentially having significant impact on total exposure to the plan in question given the potential that it could be extrapolated to the company’s total Medicare Advantage book (rather than just the amount coming from the one plan contract). Table 6 on the following page walks through an illustrative example of our thinking here in terms of how the final settlement amount could ultimately impact the company with key assumptions including:

- The sample company has 1 million total Medicare Advantage lives representing approximately \$10 billion in annual Medicare Advantage revenues (assuming \$10k annual PMPM), of which 200k lives (and \$2 billion of revenues) are derived from a single plan contract.
- For the company’s single plan contract, we assume that the final settlement amount would be in the range of \$20-\$200 million which would represent 1.0-10.0% of the plan contract’s \$2 billion revenue base.
- Next, we size the potential exposure to the total company if the final settlement amount is extrapolated to the company’s total Medicare Advantage book (rather than just the single plan contract) based on the same error rate as the plan originally audited. Using the same range of 1.0-10.0% of revenues and applying it to the company’s total Medicare Advantage revenue base of \$10 billion, this puts the potential exposure in the range of \$100-\$1,000 million (vs. the \$20-\$200 million for just the single-contract).
- As highlighted in the illustrative example, ***both the ultimate final settlement amount as well as the number of lives in the plan contract area clearly key***, with the worst-case scenario being some sort of extrapolation to the company’s total Medicare Advantage book. We also point out that for simplification purposes, when extrapolating the exposure to the company’s total Medicare Advantage book, our example analysis assumes the Medicare Advantage error rates for the entire company’s Medicare Advantage book is in-line with the error rates uncovered for the original plan audit which is highly unlikely.

Ultimate final settlement amount is clearly key given potential for government to extrapolate the amount to the rest of the company’s Medicare Advantage book

Table 6: Illustrative Example – Exposure Sensitivity Assuming Final Settlement Amount Related to Single-Contract with 200k Lives and Extrapolated to the Company's Total 1 million Medicare Advantage Lives

Single Med Adv Plan Contract				
Med Adv Lives (000s)	200	200	200	200
Med Adv Revenues (\$ in mm's)	\$2,000	\$2,000	\$2,000	\$2,000
Final Settlement Amount of Single Med Adv Contract - Sensitivity				
Assumed Final Settlement Amount (\$ in mm's)	\$20	\$50	\$100	\$200
as % of Contract Revenues (above)	1.0%	2.5%	5.0%	10.0%

Total Med Adv Book				
Med Adv Lives Total (000s)	1,000	1000	1000	1000
Med Adv Revenues Total (\$ in mm's)	\$10,000	\$10,000	\$10,000	\$10,000
Final Settlement % - Extrapolated to Total Med Adv Book				
Settlement as % of Revenues (above)	1.0%	2.5%	5.0%	10.0%
Final Settlement Amount (\$ in mm's)	\$100	\$250	\$500	\$1,000

Source: UBS estimates

- **Lastly, we also note that the full impact of ultimate award settlement may be mitigated to an extent by provider capitation arrangements.** In the event the errors uncovered are related to issues with capitated Individual Practice Associations (IPAs) and their documentation, the plan could look to the IPAs for some recourse here to recoup some of the revenues paid to the IPAs that were fully-capitated.

While we believe that it is unlikely that all of the Medicare Advantage contracts will be audited, however, there is no assurance that the audits will not extend beyond one or two contracts per company with Table 7 highlighting each plan's top-5 Medicare Advantage contracts based on 2007 enrollment. We point out that HealthSpring has previously disclosed that their HealthSpring of Tennessee (~50k members in '07) contract was selected for an audit and that Humana indicates that several of its contracts are being audited.

Table 7: Managed Care Plans – Top 5 Medicare Contracts by 2007 Membership

Parent Organization	Contract Number	Organization Name	Final Plan Type	2007 Membership	Total 2007 Membership	% of Total
Aetna Inc.	H5736	AETNA LIFE INSURANCE COMPANY	PFFS	50,762		27%
	H3931	AETNA HEALTH INC	HMO	36,741		19%
	H3152	AETNA HEALTH, INC.	HMO	29,981		16%
	H0523	AETNA HEALTH OF CALIFORNIA, INC.	HMO	26,006		14%
	H3312	AETNA HEALTH INC.	HMO	12,915		7%
Aetna Inc. Total				156,405	190,431	82%
CIGNA	H0354	CIGNA HEALTHCARE OF ARIZONA, INC.	HMO	31,439		100%
CIGNA Total				31,439	31,439	100%
Coventry Health Care Inc.	H0846	FIRST HEALTH LIFE AND HEALTH INSURANCE COMPANY	PFFS	124,020		44%
	H5227	COVENTRY HEALTH AND LIFE INSURANCE COMPANY	PFFS	41,482		15%
	H3959	HEALTHAMERICA PENNSYLVANIA, INC.	HMO	36,282		13%
	H2663	GROUP HEALTH PLAN, INC.	HMO	22,707		8%
	H1013	VISTA HEALTHPLAN OF SOUTH FLORIDA, INC.	HMO	13,453		5%
Coventry Health Care Inc. Total				237,944	282,824	84%
Health Net, Inc.	H0562	HEALTH NET OF CA	HMO	105,135		45%
	H0351	HEALTH NET OF ARIZONA, INC.	HMO	45,467		20%
	H0755	HEALTH NET OF CONNECTICUT	HMO	43,629		19%
	H5520	HEALTH NET LIFE INSURANCE COMPANY	PPO	19,690		8%
	H5996	HEALTH NET LIFE INSURANCE COMPANY, INC.	PFFS	11,571		5%
Health Net, Inc. Total				225,492	232,284	97%
Humana Inc.	H1804	HUMANA INSURANCE COMPANY	PFFS	607,985		53%
	H1036	HUMANA MEDICAL PLAN, INC	HMO	249,032		22%
	H1019	CARE PLUS HEALTH PLAN	HMO	53,034		5%
	H1951	HUMANA HEALTH BENEFIT PLAN OF LOUISIANA INC	HMO	48,477		4%
	R5826	HUMANA INSURANCE COMPANY	Regional PPO	42,338		4%
Humana Inc. Total				1,000,866	1,142,581	88%
Molina Healthcare, Inc.,	H5628	MOLINA HEALTHCARE OF UTAH, INC.	HMO	1,860		37%
	H5926	MOLINA HEALTHCARE OF MICHIGAN	HMO	1,116		22%
	H5810	MOLINA HEALTHCARE OF CALIFORNIA	HMO	1,064		21%
	H5588	MOLINA HEALTHCARE OF NEVADA, INC.	HMO	520		10%
	H5823	MOLINA HEALTHCARE OF WASHINGTON, INC.	HMO	515		10%
Molina Healthcare, Inc., Total				5,075	5,075	100%
NewQuest Health Solutions (HS)	H4454	HEALTHSPRING OF TENNESSEE, INC.	HMO	50,465		40%
	H4513	TEXAS HEALTHSPRING LLC	HMO	36,546		29%
	H0150	HEALTHSPRING OF ALABAMA, INC.	HMO	30,576		24%
	H1415	HEALTHSPRING, INC.	HMO	8,531		7%
	H4407	HEALTHSPRING OF TENNESSEE, INC.	HMO	824		1%
NewQuest Health Solutions (HS) Total				126,942	126,942	100%
United HealthCare Group, Inc.	H0543	PACIFICARE OF CALIFORNIA/SECURE HORIZONS	HMO	342,775		24%
	H4590	PACIFICARE OF TEXAS, INC.	HMO	120,068		9%
	H0303	PACIFICARE OF ARIZONA, INC	HMO	99,199		7%
	H5435	PACIFICARE LIFE AND HEALTH INSURANCE COMPANY	PFFS	77,277		6%
	H3307	OXFORD HEALTH PLANS (NY) INC.	HMO	69,061		5%
United HealthCare Group, Inc. Total				708,380	1,399,370	51%
Wellpoint, Inc.	H0540	UNICARE LIFE AND HEALTH INS. COMPANY	PFFS	124,214		33%
	H3655	COMMUNITY INSURANCE COMPANY	HMO	76,640		21%
	H3370	EMPIRE HEALTHCHOICE HMO, INC.	HMO	67,055		18%
	R9943	BC LIFE and HEALTH INSURANCE COMPANY	Regional PPO	29,261		8%
	H0564	BLUE CROSS OF CALIFORNIA	HMO	22,766		6%
Wellpoint, Inc. Total				319,936	371,909	86%

Source: CMS, UBS Analysis

From the perspective of the publicly-traded Medicare Advantage plans in our coverage universe, there is significant variation in terms of potential company-specific exposure with the biggest Medicare Advantage plans (UnitedHealth and Humana) not surprisingly most exposed here while CIGNA clearly has the least exposure. Given audits currently limited to one or two plans per company (for now), we highlight the potential earnings exposure to every 1% revenue repayment for (1) each company's largest Medicare Advantage contract plan as of 2007, and (2) each company's two largest Medicare Advantage contract plans as of 2007. The initial audits were done for one or two of the largest plans, so the initial exposure depends not only on the size of the total Medicare Advantage book, but also on the portion of that book sitting in the largest one or two contracts. We point out that in these scenarios, the companies with the largest concentration of Medicare Advantage lives among its largest plan contracts are the ones most exposed here.

Table 8: Exposure from Largest Single and Largest Two Medicare Advantage Contracts (2007)

MCO	2007 MA Premiums (Largest Contract)	% of Company Total	1% Repayment EPS Sensitivity	2007 MA Premiums (Largest Two Contracts)	% of Company Total	1% Repayment EPS Sensitivity
Humana Inc.	\$6,080	24%	(\$0.23)	\$8,570	34%	(\$0.32)
HealthSpring, Inc.	\$505	32%	(\$0.06)	\$870	55%	(\$0.10)
Health Net, Inc.	\$1,051	7%	(\$0.07)	\$1,506	11%	(\$0.10)
Coventry Health Care Inc.	\$1,240	13%	(\$0.05)	\$1,655	17%	(\$0.07)
WellPoint, Inc.	\$1,242	2%	(\$0.02)	\$2,009	3%	(\$0.03)
UnitedHealth Group, Inc.	\$3,428	5%	(\$0.02)	\$4,628	6%	(\$0.03)
Aetna Inc.	\$508	2%	(\$0.01)	\$875	3%	(\$0.01)
CIGNA	\$314	2%	(\$0.01)	\$314	2%	(\$0.01)

Source: CMS, UBS Analysis

That said, with the key question in our view around whether CMS will broaden the audits further beyond the one or two per plan, we also highlight the estimated exposure if the companies' entire Medicare Advantage book was subject to 1% repayment. For both 2007 and 2011, Table 9 highlights company-specific Medicare Advantage revenues and as a % of total company revenues, and highlights the estimated earnings sensitivity by company assuming 1% repayment of Medicare Advantage revenues

Table 9: UBS MCO Coverage Universe – Company-Specific 2007 and 2011 Medicare Advantage Revenues and as % of Total Company Revenues, and Estimated Earnings Sensitivity to 1% Repayment of Medicare Advantage

MCO	2007 MA Premiums	% of Company Total	1% Repayment EPS Sensitivity	2011 Est. MA Premiums	% of Company Total	1% Repayment EPS Sensitivity
Humana Inc.	\$11,173	44%	(\$0.42)	\$20,211	58%	(\$0.76)
HealthSpring, Inc.	\$1,364	87%	(\$0.15)	\$3,932	81%	(\$0.44)
Health Net, Inc.	\$2,387	17%	(\$0.15)	\$2,427	20%	(\$0.16)
UnitedHealth Group, Inc.	\$15,646	21%	(\$0.09)	\$25,238	25%	(\$0.15)
Coventry Health Care Inc.	\$2,108	21%	(\$0.09)	\$2,571	20%	(\$0.11)
WellPoint, Inc.	\$4,759	8%	(\$0.08)	\$5,846	10%	(\$0.10)
Aetna Inc.	\$2,241	8%	(\$0.04)	\$4,806	14%	(\$0.08)
CIGNA	\$349	2%	(\$0.01)	\$709	3%	(\$0.02)

Source: Company Reports and UBS Estimates

Notably, beginning in 2008, most of the companies in our coverage universe with large Medicare Advantage exposure had added risk statements to their SEC filings indicating potential for negative outcomes related to these audits. Language from the 10-Ks/Qs regarding the audits have not changed substantially over the past three years with many indicating that the audits continue and that they are in full compliance with the CMS requests. UnitedHealth specifically notes that risk adjustment data from two of their plans have been selected by the OIG for an audit. Table 10 below contains the language related to the Medicare risk audits from the 2008 and 2009 10Ks.

Table 10: HS, HUM & UNH Risk Audit Commentary from 2008 and 2009 10-Ks

HS - 2008 10-K	Our Tennessee Medicare Advantage plan has been selected by CMS for such a review, which we currently expect to begin in early 2009. CMS has indicated that payment adjustments will not be limited to risk scores for the specific beneficiaries for which errors are found but may be extrapolated to the entire plan. There can be no assurance that our other plans will not be randomly selected or targeted for review by CMS or, in the event that a company plan is selected for a review, that the outcome of such a review will not result in a material adjustment in our revenue and profitability.
HS - 2009 10-K	The Company's Tennessee Medicare Advantage plan has been selected by CMS for a RADV Audit of the 2006 risk adjustment data used to determine 2007 premium rates. In late 2009, the Company's Tennessee plan received from CMS the RADV Audit member sample, which CMS will use to calculate a payment error rate for 2007 Tennessee plan premiums. The Company is in the process of responding to the RADV Audit request, including retrieving and providing medical records supporting diagnoses codes and risk scores and, where appropriate, provider attestations, all of which are due to CMS on February 18, 2010. CMS has indicated that payment adjustments resulting from its RADV Audits will not be limited to risk scores for the specific beneficiaries for which errors are found but will be extrapolated to the relevant plan population. CMS's methodology for extrapolation remains unclear, however. The Company is in the process of gathering records responsive to the RADV Audit and is currently unable to calculate a payment error rate or predict the impact of extrapolating that error rate to 2007 Tennessee plan premiums. There can be no assurance, however, that the conclusion of the Tennessee RADV Audit will not result in a material adverse impact to the Company's results of operations or cash flows, or that the Company's other plans will not be randomly selected or targeted for a RADV Audit by CMS or, in the event that another plan is so selected, that the outcome of such RADV Audit will not result in a material adverse impact to the Company's results of operations and cash flows.
HS - 2010 Q3 10-Q	In connection with CMS's continuing statutory obligation to review risk score coding practices by Medicare Advantage plans, CMS announced that it would regularly audit Medicare Advantage plans, primarily targeted based on risk score growth, for compliance by the plans and their providers with proper coding practices (sometimes referred to as "Risk Adjustment Data Validation Audits" or "RADV Audits"). The Company's Tennessee Medicare Advantage plan was selected by CMS for a RADV Audit of the 2006 risk adjustment data used to determine 2007 premium rates. In late 2009, the Company's Tennessee plan received from CMS the RADV Audit member sample, which CMS will use to calculate a payment error rate for 2007 Tennessee plan premiums. In February 2010, the Company responded to the RADV Audit request by retrieving and submitting medical records supporting diagnoses codes and risk scores and, where appropriate, provider attestations. CMS has not indicated a schedule for processing or otherwise responding to the Company's submissions. CMS has indicated that payment adjustments resulting from its RADV Audits will not be limited to risk scores for the specific beneficiaries for which errors are found but will be extrapolated to the relevant plan population. CMS's methodology for extrapolation remains unclear, however. Because of this lack of clarity from CMS, the Company is also currently unable to calculate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to 2007 Tennessee plan premiums. There can be no assurance, however, that the conclusion of the Tennessee RADV Audit will not result in an adverse impact to the Company's results of operations or cash flows (which may or may not be material), or that the Company's other plans will not be randomly selected or targeted for a RADV Audit by CMS or, in the event that another plan is so selected, that the outcome of such RADV Audit will not result in a material adverse impact to the Company's results of operations or cash flows.
HUM - 2008 10-K	Several Humana contracts are included in audits being undertaken by CMS. If necessary, based on audit results, CMS may make contract-level payment adjustments that may occur during 2009, and adjustments may occur prior to Humana or other Medicare Advantage plans having the opportunity to appeal audit findings. We primarily rely on providers to appropriately document risk-adjustment data in their medical records and appropriately code their claim submissions, which we send to CMS as the basis for our risk-adjustment model premium. We are working with CMS and our industry group to develop an orderly audit process, for which CMS has not yet indicated the complete details. Therefore, we are unable to predict the complete audit methodology to be used by CMS, the outcome of these audits, or whether these audits would result in a payment adjustment. However, it is reasonably possible that a payment adjustment as a result of these audits could occur, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows.
HUM - 2009 10-K	CMS is continuing to perform audits of selected Medicare Advantage plans of various companies to validate the provider coding practices and resulting economics under the actuarial risk-adjustment model used to calculate the individual member capitation paid to Medicare Advantage plans. Several Humana contracts have been selected by CMS for audit and we expect that CMS will continue conducting audits for the 2007 contract year and beyond. We are unable to estimate the financial impact of any audits that may be conducted related to 2007 revenue and beyond and whether any findings would cause a change to our method of estimate future premium revenue in bid submissions made to CMS for future contract years, or compromise premium rate assumptions made in the our bids for prior contract years.
HUM - 2010 Q3 10-Q	CMS is continuing to perform audits of selected Medicare Advantage plans of various companies to validate the provider coding practices and resulting economics under the actuarial risk-adjustment model used to calculate the individual member capitation paid to Medicare Advantage plans. Several Humana contracts have been selected by CMS for audit, and we expect that CMS will continue conducting audits for the 2007 contract year and beyond. We generally rely on providers to appropriately document all medical data including risk-adjustment data in their medical records and appropriately code their claim submissions, which we send to CMS as the basis for our payment received from CMS under the actuarial risk-adjustment model. The CMS audits involve a review of a sample of provider medical records for the contracts being audited. Rates paid to Medicare Advantage plans are established under an actuarial bid model, including a process whereby our premium is based on a comparison of our beneficiaries' risk scores, derived from medical diagnoses, to those enrolled in the government's original

	Medicare program. As a result, we believe that an actuarially sound adjustment of payments from these audits would need to take into account the level of coding accuracy and provider medical record documentation completeness under the government's original Medicare program, since the risk adjustment system, bids, benefit structures and payment rates were premised on that data. This would help to ensure that the audit methodology applied to Medicare Advantage plans accurately calculates the economic impact of the audit findings. Additionally, our payment received from CMS, as well as benefits offered and premiums charged to members, is based on bids that did not, by CMS design, include any assumption of retroactive audit payment adjustments. We believe that applying a retroactive audit adjustment after CMS acceptance of bids would improperly alter this process of establishing member benefits and premiums. CMS has not formally announced its audit payment adjustment methodology, nor has CMS formally indicated whether the audit payment adjustment methodology will be based on a comparison to original Medicare coding accuracy. CMS has further indicated that it may make retroactive contract-level payment adjustments. Any such payment adjustments could occur as early as this year, and could be effected prior to our, or other Medicare Advantage plans, having the opportunity to appeal the underlying payment adjustment methodology. We are unable to estimate the financial impact of any audits that may be conducted related to 2007 revenue and beyond or whether any findings would cause a change to our method of estimating future premium revenue in bid submissions made to CMS for future contract years, or compromise premium rate assumptions made in our bids for prior contract years. At this time, we do not know whether CMS will require payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using its method of extrapolating findings to the entire contract. However, if CMS requires payment adjustments to be made using an audit methodology without comparison to original Medicare coding, and using a method of extrapolating findings to the entire contract, and if we are unable to obtain any relief preventing the payment adjustments from being implemented, we believe that such adjustments would have a material adverse effect on our results of operations, financial position, and cash flows.
UNH - 2008 10-K	These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in retrospective or prospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. Certain of our plans have been selected for audit. The first audits focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. We are unable to predict the outcome of the audits. However, a material adjustment could have a material effect on our financial results
UNH - 2009 10-K	CMS announced in 2008 that it will perform audits of selected Medicare health plans each year to validate the coding practices of and supporting documentation maintained by care providers. These audits involve a review of medical records maintained by providers, including those in and out of network, and may result in prospective and retrospective adjustments to payments made to health plans pursuant to CMS Medicare contracts. Certain of our plans have been selected for audit. The first audits focused on medical records supporting risk adjustment data for 2006 that were used to determine 2007 payment amounts. The Office of Inspector General for HHS is conducting an audit of our risk adjustment data for two plans. We are unable to predict the outcome of the audits. However, any material adjustments could have a material effect on our results of operations.

Source: Company Reports

Importantly, we note that the estimated plan exposure highlighted above is highly levered to a number of moving parts / assumptions including:

MCO exposure hinges on a number of key unknowns

- **Size of audit repayment** – essentially the amount that the government is asking for (if anything) in terms of repayment of Medicare Advantage plan premiums, with the value of the final settlement clearly key here. Final settlement amount here clearly to be key given potential methodology issues that drive total plan / industry exposure such as the government extrapolating results to broader base of the plan's Medicare Advantage book.
- **Size of population audited** – while size of repayment is important, we would note that all information points to audits being doing at plan level (rather than company level), meaning that any requested dollars would likely not be total potential liability as under worst-case scenario government may move on to other Medicare Advantage plans offered by particular company, thus increasing potential liability.

- **Scope of time period** – In addition to the size of repayment, time period is important although we expect this will be much more simple as audits are likely to pertain to specific plan year, with 2007 currently being year audited. We believe most companies expect government to move forward with audits for 2008 and beyond once finished with 2007, potentially increasing total company liability.
- **How were audit results interpreted and repayment amount calculated** – we believe greatest uncertainty from company perspective (as highlighted by 10-K risk disclosures) is around how CMS will interpret audit results and calculated repayment request. For instance, it is likely that audits will uncover some level of non-complete provider documentation (such as missing physician signature, etc.) that are also widespread in traditional FFS. The question here is whether or not the plans will be held to a zero error target (hopefully not) or more realistically held to an error target that is in-line with that found in traditional FFS. The other big question is whether any errors are found that would indicate plan “under-coding” (coding that results in lower payment) and if this would be allowed to reduce the audit repayment. Essentially, we would expect any repayment request from the government that does not allow for some normal FFS error rate or net “under-coding” against repayment to be fought by the plans.
- **Potential for further plan-level audits and outcomes here.** Notably, success recovering significant repayment from current round of plan-level risk score audits may embolden CMS / OIG to get even more aggressive here, with the Justice Department recently touting that they have recovered over \$4 billion since January 2009 under the False Claims Act.
- **CMS / OIG roles.** While UnitedHealth’s 10-K risk statement indicates separate OIG and CMS risk score audits were underway and we have heard from several smaller plans which have also seen OIG audits take place, it is important to note that OIG as an agency does not have regulatory authority over plans. Any audit results and recommendations from OIG must be brought to CMS and it will be CMS who decides what action to take here. Given CMS is also clearly conducting its own, much broader, risk score audits we are unsure what, if any, impact OIG audit results and potential “demand letters” will have here going forward. Finally, we believe it is possible that investors will never actually see OIG results/recommendations as they may be folded into CMS audits and communicated to plans once CMS settles on final audit methodology.

Look for noise around risk adjustment / coding to persist through Q1’11 given potential headlines around ongoing plan-level risk audits as well as CMS decision here for 2012 Medicare Advantage rates (final rates released in early April, with preliminary notice in mid-February). As highlighted in further detail above, we expect increasing headlines around audits as we move into 2011. In addition, look for potential scrutiny on any risk coding intensity adjustments for 2012 Medicare Advantage rates with CMS previously explicitly laying out its view that the agency has the authority to make further adjustments in this area at their discretion (we point

CMS believes that it has the authority to make further risk coding intensity adjustments at their discretion

out that based on prior CMS rate trajectory, look for preliminary 2012 Medicare Advantage 45-day Advance Notice to be released on Friday February 18th, 2011).

- **2011 Medicare Advantage rates include risk score coding intensity adjustment of 3.41% which was unchanged YoY versus adjustment for 2010.** As we have noted since our 2007 report on plan risk score coding “Risk Score Arbitrage – The Next Shoe to Drop?” we believe the industry has added approximately 5 - 15% in incremental reimbursement thru better risk score coding in Medicare Advantage versus traditional Medicare. With CMS following through on the proposed risk score coding intensity adjustment for 2010, there was concern heading into the Advance Notice / Final Announcement they would look to take another bite out of coding for 2011 although that did not occur for 2011 at least.

- **However, CMS may potentially look to implement further coding adjustment for 2012,** with the agency explicitly indicating in the final 2011 rate announcement that they believe they have the ability to implement further coding intensity adjustments going forward. Furthermore, with regard to CMS’ authority to implement coding intensity adjustments, the final rate announcement also highlighted that “Section 1102 of the Reconciliation Act requires CMS to make an adjustment to risk scores for years subsequent to 2010 if a difference in Medicare Advantage and FFS coding patterns is found”. Please page 20 for further background around risk coding intensity adjustments.

CMS explicitly indicated view that they have the ability to implement further coding intensity adjustments going forward

Table 11: CMS Select Commentary on Risk Coding Intensity Adjustment Included in 2011 Final Rate Announcement

Response: The DRA amendments to Section 1853(a)(1)(C) expressly mandated that CMS make an adjustment to the risk scores in 2008, 2009, and 2010, if a difference in MA and FFS coding patterns was found.
Although the DRA used the phrase “only for 2008, 2009 and 2010,” this limitation applies only to that mandate for an adjustment. Independent of this DRA language, CMS has broad authority under Section 1853(a)(3) to develop and implement a methodology for risk adjusting MA capitation payments “that accounts for variations in per capita costs based on health status....”
Moreover, Section 1102 of the Reconciliation Act requires CMS to make an adjustment to risk scores for years subsequent to 2010 if a difference in MA and FFS coding patterns is found

Source: CMS 2011 Final Medicare Advantage Rate Announcement

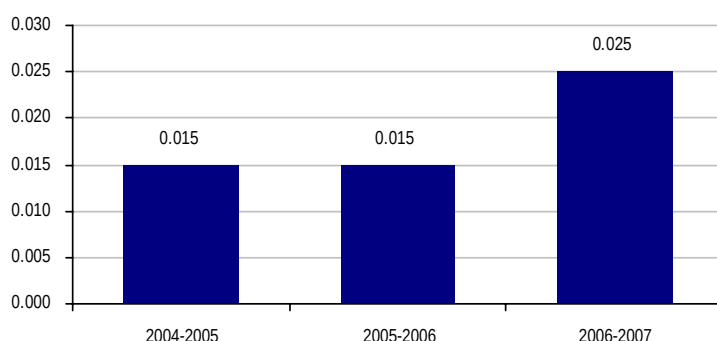
- **Furthermore, CMS expected to re-caliberate / implement the new HCC risk adjustment model for 2012** after taking a pass for 2011 contract year. While impact in 2012 likely be plan-specific, we point out it has historically been in the -2% to -3% range according to plans.

Background on Coding Intensity Adj from 2010 Rate Announcement

- **CMS analysis of 2007-2008 cohort indicated that coding pattern differences continue to accelerate, a clear indication that the momentum continues for risk score arbitrage.** Recall that the absolute difference in “stayers” disease score growth between Medicare Advantage and FFS as calculated by CMS was 0.015 in 2004-2005 and in 2005-2006 time periods, and then increased to 0.025 in 2006-2007 (Chart below). While CMS has yet to provide specific 2007-2008 cohort data, they did previously indicate that disease score growth difference accelerated, clearly signalling that plans continue to benefit from risk score arbitrage and reinforcing CMS conclusion that coding pattern differences are having a notable impact on payment.

Coding pattern acceleration in 2007-2008 cohort reinforce CMS conclusion that differences are having notable impact on payment, which we expect will remain in CMS crosshairs in future years

Chart 3: Absolute Difference in Disease Score Growth between Med Adv and FFS



Source: CMS 2010 Advance Notice

- **CMS lowered 2010 Medicare Advantage risk scores by 0.0341, although adjustment factor did not embed coding pattern differences for 2007-2008 cohort.** We note CMS highlighted last year that they elected to take a “conservative approach” to 2010 Medicare Advantage coding intensity adjustment in the first year of implementation with the adjustment factor based on data from the three earliest cohorts (and not for 2007-2008). While CMS again implemented a coding pattern adjustment of 3.41% for 2011, this does not represent any incremental impact on 2011 rates although it is unclear if CMS may look to implement further adjustment for 2012.

Adjustment to risk scores effectively lower reimbursement by a similar percentage (assuming plan risk scores in the 1.0 range)

Table 12: 2010 MA Coding Pattern Difference Adjustment Calculations

Components	Calculation	Commentary
Wtd. avg. of Year 2 MA risk scores	0.9806	
Wtd. avg. diff in disease score growth	0.0171	
Avg Annual Difference Factor	1.75%	as % of risk scores
x MA Enrollment Duration Factor	2.38	vs. prior 2.45 under Advance Notice
=MA Coding Pattern Difference Factor	4.16%	
x Stayer Percentage	81.8%	vs. 87.3% prior stayer percentage under Advance Notice
= Risk score adjustment	3.41%	

Source: CMS 2010 Advance Notice

For further details around potential coding intensity adjustment and estimated plan-specific exposure, please see the Appendix at the back of this report

Appendix - Revisiting Risk Score Arbitrage

Below we've attached updated select excerpts and updates from our previously published reports on Risk Scores including our analysis of clinical coding and risk score patterns in Medicare Advantage.

Plans have clearly benefited from improved clinical coding since the move to risk adjustment in 2004. It is no secret that Medicare Advantage economics have benefited from what we refer to as a “coding arbitrage”, as plans have focused on improving clinical coding to yield higher risk scores and thus reimbursement under the risk-adjusted payment model introduced through the Medicare Modernization Act of 2003. While nearly every company participating in Medicare Advantage has discussed the benefits of better risk scores to some extent, two companies have actually broke it out in financial statements. Health Net and HealthSpring reported receiving \$80 million and \$12.5 million, respectively, in risk adjustment payments through the third quarter of 2006, representing 5.1% and 1.8% of FY'05 Medicare Advantage revenues.

One way Managed Care plans have offset mediocre Medicare Advantage rates in recent years is by improving reimbursement through higher risk scores. The improvement in the industry's risk scores has been dramatic over the last several years, with other illustrations showing up in company financials. For instance, the Table below compares the CMS stated MA rate change with the actual MA PMPM change. Although MA rates increased 2.14% in 2009, both HealthSpring and Humana were able to more than double that increase through higher risk scores. While the 2010 rate decreased -5.08% these companies were flat or slightly better YoY. ***Importantly, this revenue catch-up is not one-time as rates are then based off of these higher member risk scores.***

Plans have seen benefits to reimbursement from improving physician clinical coding and risk scores in Medicare Advantage

Importantly, this revenue catch-up is not one-time in nature as instead rates are based off of the higher member risk scores

Table 13: HS & HUM Benefits of Improved Risk Coding

	2008	2009	2010	2011
HealthSpring				
MA PMPM	\$1,002	\$1,055	\$1,054	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	5.21%	-0.01%	--
Humana				
MA PMPM	\$858	\$917	\$929	--
CMS Stated Rate Change	--	2.14%	-5.08%	-1.70%
Actual Change	--	6.85%	1.36%	--

Source: Company reports and UBS estimates

The increase in risk adjustment payments across the industry is a direct result of plan efforts to improve coding by physicians. Although publicly traded plans have not all been entirely transparent in terms of disclosing changes in overall average risk scores or their broader risk adjustment strategies, public comments from company management indicate that those plans most exposed to the Medicare Advantage program have clearly made improved coding a priority. HealthSpring and Humana, plans with particularly outsized Medicare Advantage exposure, have previously provided some interesting details surrounding their approach to clinical coding, with Humana considering itself “among the best at looking at risk adjustment” and HealthSpring estimating its overall risk score is up between 2.5%-3.0% in 2006 (vs. 2005) across its Medicare Advantage book of roughly 111,000 members.

Although plans have provided few details quantifying overall risk scores, public comments from HUM and HS indicate meaningful benefit from coding improvements

Table 14: Humana and HealthSpring Risk Score Commentary

Company	Quote	Source
HUM	"We did receive some Medicare risk adjuster payments during the quarter. They weren't an unusual amount. Again, we continue to accrue them each month as then we get them each quarter. Generally speaking, most of it related to 2007, and again it's all intra-year."	2Q'07 Earnings Conference Call
HUM	"...we continue to work hard on our encounter data and the submission to CMS. We do it every quarter; it affects every quarter."	2Q'06 Earnings Conference Call
HUM	"I would just say the same thing we've said over the past, which is we are among the best at looking at the risk adjustment work. We collect the data appropriately; we submit it to the CMS."	4Q'05 Earnings Conference Call
HUM	"Meanwhile, government segment revenues and pre-tax continue to be favorable for three reasons. First, the acceptance of our new offerings and our new growth markets have exceeded our initial expectations. Second, our effectiveness in demonstrating the risk profile of our Medicare Advantage plan membership continues."	3Q'05 Earnings Conference Call
HS	"We are encouraged by the improvement in revenue through accurate capture of member risk scores costs thorough more intense medical management, and quality of care metrics."	4Q'07 Earnings Conference Call
HS	"It looks like it (risk scores in '06 vs. '05) is...about where we thought. It is up 2.5 to 3%."	2Q'06 Earnings Conference Call
HS	"We are convinced that we can deliver enhanced service on a patient friendly basis improving clinical outcomes, efficiencies, and accurate code capture which should improve our risk scores and our premium revenues....we are continuing our efforts to hopefully increase the accuracy of coding captures to have more of a positive impact on risk scores."	1Q'06 Earnings Conference Call
HS	"...we seen increases in each of the last 2 years in a magnitude of about 3% to 4%, we're hopeful we can continue to see that but, don't have anything specific at this point."	4Q'05 Earnings Conference Call

Source: Company reports and StreetEvents

A Brief Introduction to CMS-HCC Risk Model

Calculating payments under the CMS-HCC model includes demographic and disease group factors in order to derive a “RAF” (Risk Adjustment Factor) score. Every Medicare beneficiary in both FFS and Medicare Advantage has a risk score calculated by CMS. The risk score uses five demographic factors under the CMS-HCC model, including: age, sex, Medicaid status, disability, and original reason for Medicare entitlement. Clinical factors are then added with disease groups categories based on major diagnoses and are broadly organized into body systems referred to by CMS as “HCCs” (Hierarchical Coexisting Condition). The HCC assigned to a disease is determined by ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modification) diagnosis codes submitted during a data collection period. In calculating the risk score for an individual, the individual score for each HCC is added to the demographic factor and then any relevant disease interaction score is added.

The model incorporates coexisting diseases when calculating payment by recognizing multiple chronic conditions coded for the beneficiary. Certain combinations of coexisting diagnoses are also recognized by the CMS-HCC model as having higher costs and incorporate payments for disease interactions, with the understanding that a person with, for example, diabetes but also congestive heart failure is significantly sicker than a person with either of those conditions. The CMS-HCC model also accounts for disease hierarchies, so that payments are provided for only the most severe manifestation of a disease, even when diagnoses for less severe manifestations are also present in the beneficiary during the period.

More thorough and accurate coding under this model can yield greater reimbursement for Medicare Advantage plans. To illustrate the opportunity, take for example a 72 year-old male who, after several years in traditional Medicare, enrolls in a MA plan. This man suffers from congestive heart failure as well as acute diabetes, conditions which have forced him to visit his physician many times over the years. Now suppose his physician, rather than scan through the ICD-9 code book to locate the code for both conditions as well as any relevant interaction factors, only codes for the congestive heart failure which is the cause of the current visit. Under FFS Medicare, coding for either one of these chronic conditions alone would be sufficient for the doctor to receive the lion’s share of due reimbursement. Therein lies the opportunity. If identified by the new MA plan, the coding of this beneficiary’s diabetes condition (coupled with the interaction factor for CHF and diabetes) represents a significant payment increase to the plan (approximately 70% annually in our simplified example in the table below).

We provide a brief explanation of the CMS-HCC risk adjustment model and illustrations of how improved coding translates into higher payments to Medicare Advantage plans

By identifying members that have been under-coded and submitting more complete codes, MA plans can often see drastic improvements in risk scores and reimbursement

Table 15: Payment Impact of Additional Risk Factors in CMS-HCC Model

Base Rate - Autauga, AL		\$765	
Variable	CMS-HCC Factor	Fee-for-Service	Annual Risk Factor
Age/Sex Factor(s)			
Male 70-74	--	0.416	0.416
Disease Group Factors			
Congestive Heart Failure	HCC80	0.395	0.395
Diabetes with Acute Complications	HCC17	--	0.364
DM*CHF Interaction	INT1	--	0.204
Total RAF Score	--	0.811	1.379
Reimbursement		\$620	\$1,055
% Difference			70%

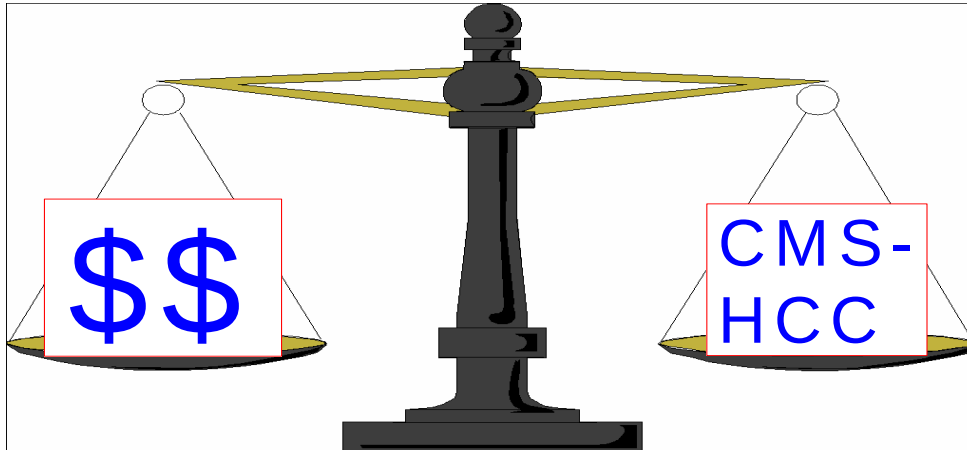
Source: CMS and UBS estimates

We estimate plans have been able to increase their overall risk scores and reimbursement between 5-15% over the past few years. In addition to the example above, there are many other scenarios under which member conditions are likely to be inaccurately or incompletely coded, representing opportunities for plans to raise risk scores (on a *same member basis*) and increase payments. This “coding arbitrage” has spawned somewhat of a cottage industry that consults MA plans on how to identify these opportunities and improve reimbursement. An easy place to start (characterized as the “low-hanging fruit” according to the marketing materials of one coding consultant) is the targeting of persistent conditions in a beneficiary’s medical history that may not be reported every year but are subject to additional payment every year if coded correctly - even if there were no recent claims documenting the diagnosis. Examples of these conditions include the most basic of chronic conditions including diabetes and congestive heart failure. Other opportunities are more difficult to identify and can require complex algorithms to systematically and efficiently review patient charts and histories. Some examples include patients coded for Cirrhosis of the Liver (HCC26) that could potentially also be coded for Alcohol Dependency (HCC52), or an ESRD patient not also coded for Protein Calorie Malnutrition (HCC21).

Clinical coding “arbitrage” is a result of CMS setting risk score weights using Medicare Fee for Service (FFS) data, which is under-coded at the physician level. Physicians under traditional Medicare FFS have little incentive to submit accurate and timely diagnosis codes to Medicare for their patients, since it has zero effect on their reimbursement. This has left patients in traditional FFS “under-coded”, presenting an opportunity for plans to work with physicians to more accurately code patients. Importantly, each additional diagnosis code results in increased revenues under the risk-adjusted payment methodology without much in the way of additional cost. This under-coding of FFS beneficiaries is the essential component of the current risk-score “arbitrage” opportunity, as CMS applies higher weights to risk factors in the model as a result. In essence, HCC codes are “over-weighted” due to too few codes being weighted against the correct level of healthcare spending.

Patients in FFS Medicare are likely under-coded at the physician level, leading to incorrectly valued clinical codes and an opportunity for plans to work w/docs to improve coding/reimb

Figure 2: CMS sets HCC weights by balancing Medicare spending against submitted clinical codes



Source: UBS

■ Statement of Risk

Risks to the Managed Care industry include but are not limited to potentially adverse impact under recently passed healthcare reform legislation, changes to Medicare and Medicaid reimbursement policies, potential for acceleration in medical cost trends and competitive pricing pressures.

■ Analyst Certification

Each research analyst primarily responsible for the content of this research report, in whole or in part, certifies that with respect to each security or issuer that the analyst covered in this report: (1) all of the views expressed accurately reflect his or her personal views about those securities or issuers; and (2) no part of his or her compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views expressed by that research analyst in the research report.

Required Disclosures

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS.

For information on the ways in which UBS manages conflicts and maintains independence of its research product; historical performance information; and certain additional disclosures concerning UBS research recommendations, please visit www.ubs.com/disclosures. The figures contained in performance charts refer to the past; past performance is not a reliable indicator of future results. Additional information will be made available upon request.

UBS Securities Co. Limited is licensed to conduct securities investment consultancy businesses by the China Securities Regulatory Commission.

UBS Investment Research: Global Equity Rating Allocations

UBS 12-Month Rating	Rating Category	Coverage ¹	IB Services ²
Buy	Buy	51%	37%
Neutral	Hold/Neutral	40%	33%
Sell	Sell	9%	22%
UBS Short-Term Rating	Rating Category	Coverage ³	IB Services ⁴
Buy	Buy	less than 1%	20%
Sell	Sell	less than 1%	0%

1:Percentage of companies under coverage globally within the 12-month rating category.

2:Percentage of companies within the 12-month rating category for which investment banking (IB) services were provided within the past 12 months.

3:Percentage of companies under coverage globally within the Short-Term rating category.

4:Percentage of companies within the Short-Term rating category for which investment banking (IB) services were provided within the past 12 months.

Source: UBS. Rating allocations are as of 30 September 2010.

UBS Investment Research: Global Equity Rating Definitions

UBS 12-Month Rating	Definition
Buy	FSR is > 6% above the MRA.
Neutral	FSR is between -6% and 6% of the MRA.
Sell	FSR is > 6% below the MRA.
UBS Short-Term Rating	Definition
Buy	Buy: Stock price expected to rise within three months from the time the rating was assigned because of a specific catalyst or event.
Sell	Sell: Stock price expected to fall within three months from the time the rating was assigned because of a specific catalyst or event.

KEY DEFINITIONS

Forecast Stock Return (FSR) is defined as expected percentage price appreciation plus gross dividend yield over the next 12 months.

Market Return Assumption (MRA) is defined as the one-year local market interest rate plus 5% (a proxy for, and not a forecast of, the equity risk premium).

Under Review (UR) Stocks may be flagged as UR by the analyst, indicating that the stock's price target and/or rating are subject to possible change in the near term, usually in response to an event that may affect the investment case or valuation.

Short-Term Ratings reflect the expected near-term (up to three months) performance of the stock and do not reflect any change in the fundamental view or investment case.

Equity Price Targets have an investment horizon of 12 months.

EXCEPTIONS AND SPECIAL CASES

UK and European Investment Fund ratings and definitions are: Buy: Positive on factors such as structure, management, performance record, discount; Neutral: Neutral on factors such as structure, management, performance record, discount; Sell: Negative on factors such as structure, management, performance record, discount.

Core Banding Exceptions (CBE): Exceptions to the standard +/-6% bands may be granted by the Investment Review Committee (IRC). Factors considered by the IRC include the stock's volatility and the credit spread of the respective company's debt. As a result, stocks deemed to be very high or low risk may be subject to higher or lower bands as they relate to the rating. When such exceptions apply, they will be identified in the Company Disclosures table in the relevant research piece.

Research analysts contributing to this report who are employed by any non-US affiliate of UBS Securities LLC are not registered/qualified as research analysts with the NASD and NYSE and therefore are not subject to the restrictions contained in the NASD and NYSE rules on communications with a subject company, public appearances, and trading securities held by a research analyst account. The name of each affiliate and analyst employed by that affiliate contributing to this report, if any, follows.

UBS Securities LLC: Justin Lake, CFA; Ken LaVine, CFA; Dean Poniro, CPA; Andrew Valen.

Company Disclosures

Company Name	Reuters	12-mo rating	Short-term rating	Price	Price date
Aetna Inc. ^{2, 4, 5, 6a, 6b, 6c, 7, 16}	AET.N	Neutral	N/A	US\$30.30	20 Dec 2010
Cigna Corp. ^{2, 4, 5, 6a, 6b, 7, 16}	CI.N	Buy	N/A	US\$36.76	20 Dec 2010
Coventry Health Care ^{6b, 6c, 7, 16}	CVH.N	Neutral	N/A	US\$26.54	20 Dec 2010
Health Net Inc. ^{6a, 16}	HNT.N	Neutral	N/A	US\$26.61	20 Dec 2010
HealthSpring Inc. ^{4, 5, 6a, 16}	HS.N	Neutral	N/A	US\$26.70	20 Dec 2010
Humana Inc. ^{6b, 7, 16}	HUM.N	Neutral	N/A	US\$54.84	20 Dec 2010
Molina Healthcare, Inc. ^{2, 4, 5, 6a, 16}	MOH.N	Neutral	N/A	US\$27.71	20 Dec 2010
Triple-S Management Corporation ¹⁶	GTS.N	Neutral	N/A	US\$18.66	20 Dec 2010
UnitedHealth Group ^{2, 3, 4, 5, 6a, 6b, 6c, 7, 16}	UNH.N	Neutral	N/A	US\$35.18	20 Dec 2010
WellPoint, Inc. ^{2, 4, 5, 6a, 6b, 6c, 7, 16}	WLP.N	Buy	N/A	US\$56.10	20 Dec 2010

Source: UBS. All prices as of local market close.

Ratings in this table are the most current published ratings prior to this report. They may be more recent than the stock pricing date

- UBS AG, its affiliates or subsidiaries has acted as manager/co-manager in the underwriting or placement of securities of this company/entity or one of its affiliates within the past 12 months.
- UBS Securities LLC is acting as advisor to Executive Health Resources Inc on its announced agreement to be acquired by UnitedHealth group Inc.
- Within the past 12 months, UBS AG, its affiliates or subsidiaries has received compensation for investment banking services from this company/entity.
- UBS AG, its affiliates or subsidiaries expect to receive or intend to seek compensation for investment banking services from this company/entity within the next three months.

- 6a. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and investment banking services are being, or have been, provided.
- 6b. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-investment banking securities-related services are being, or have been, provided.
- 6c. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-securities services are being, or have been, provided.
- 7. Within the past 12 months, UBS Securities LLC has received compensation for products and services other than investment banking services from this company/entity.
- 16. UBS Securities LLC makes a market in the securities and/or ADRs of this company.

Unless otherwise indicated, please refer to the Valuation and Risk sections within the body of this report.

For a complete set of disclosure statements associated with the companies discussed in this report, including information on valuation and risk, please contact UBS Securities LLC, 1285 Avenue of Americas, New York, NY 10019, USA, Attention: Publishing Administration.

Global Disclaimer

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS. In certain countries, UBS AG is referred to as UBS SA.

This report is for distribution only under such circumstances as may be permitted by applicable law. Nothing in this report constitutes a representation that any investment strategy or recommendation contained herein is suitable or appropriate to a recipient's individual circumstances or otherwise constitutes a personal recommendation. It is published solely for information purposes, it does not constitute an advertisement and is not to be construed as a solicitation or an offer to buy or sell any securities or related financial instruments in any jurisdiction. No representation or warranty, either express or implied, is provided in relation to the accuracy, completeness or reliability of the information contained herein, except with respect to information concerning UBS AG, its subsidiaries and affiliates, nor is it intended to be a complete statement or summary of the securities, markets or developments referred to in the report. UBS does not undertake that investors will obtain profits, nor will it share with investors any investment profits nor accept any liability for any investment losses. Investments involve risks and investors should exercise prudence in making their investment decisions. The report should not be regarded by recipients as a substitute for the exercise of their own judgement. Past performance is not necessarily a guide to future performance. The value of any investment or income may go down as well as up and you may not get back the full amount invested. Any opinions expressed in this report are subject to change without notice and may differ or be contrary to opinions expressed by other business areas or groups of UBS as a result of using different assumptions and criteria. Research will initiate, update and cease coverage solely at the discretion of UBS Investment Bank Research Management. The analysis contained herein is based on numerous assumptions. Different assumptions could result in materially different results. The analyst(s) responsible for the preparation of this report may interact with trading desk personnel, sales personnel and other constituencies for the purpose of gathering, synthesizing and interpreting market information. UBS is under no obligation to update or keep current the information contained herein. UBS relies on information barriers to control the flow of information contained in one or more areas within UBS, into other areas, units, groups or affiliates of UBS. The compensation of the analyst who prepared this report is determined exclusively by research management and senior management (not including investment banking). Analyst compensation is not based on investment banking revenues, however, compensation may relate to the revenues of UBS Investment Bank as a whole, of which investment banking, sales and trading are a part.

The securities described herein may not be eligible for sale in all jurisdictions or to certain categories of investors. Options, derivative products and futures are not suitable for all investors, and trading in these instruments is considered risky. Mortgage and asset-backed securities may involve a high degree of risk and may be highly volatile in response to fluctuations in interest rates and other market conditions. Past performance is not necessarily indicative of future results. Foreign currency rates of exchange may adversely affect the value, price or income of any security or related instrument mentioned in this report. For investment advice, trade execution or other enquiries, clients should contact their local sales representative. Neither UBS nor any of its affiliates, nor any of UBS' or any of its affiliates, directors, employees or agents accepts any liability for any loss or damage arising out of the use of all or any part of this report. For financial instruments admitted to trading on an EU regulated market: UBS AG, its affiliates or subsidiaries (excluding UBS Securities LLC and/or UBS Capital Markets LP) acts as a market maker or liquidity provider (in accordance with the interpretation of these terms in the UK) in the financial instruments of the issuer save that where the activity of liquidity provider is carried out in accordance with the definition given to it by the laws and regulations of any other EU jurisdictions, such information is separately disclosed in this research report. UBS and its affiliates and employees may have long or short positions, trade as principal and buy and sell in instruments or derivatives identified herein.

Any prices stated in this report are for information purposes only and do not represent valuations for individual securities or other instruments. There is no representation that any transaction can or could have been effected at those prices and any prices do not necessarily reflect UBS's internal books and records or theoretical model-based valuations and may be based on certain assumptions. Different assumptions, by UBS or any other source, may yield substantially different results.

United Kingdom and the rest of Europe: Except as otherwise specified herein, this material is communicated by UBS Limited, a subsidiary of UBS AG, to persons who are eligible counterparties or professional clients and is only available to such persons. The information contained herein does not apply to, and should not be relied upon by, retail clients. UBS Limited is authorised and regulated by the Financial Services Authority (FSA). UBS research complies with all the FSA requirements and laws concerning disclosures and these are indicated on the research where applicable. **France:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities France SA. UBS Securities France S.A. is regulated by the Autorité des Marchés Financiers (AMF). Where an analyst of UBS Securities France S.A. has contributed to this report, the report is also deemed to have been prepared by UBS Securities France S.A. **Germany:** Prepared by UBS Limited and distributed by UBS Limited and UBS Deutschland AG. UBS Deutschland AG is regulated by the Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin). **Spain:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities España SV, SA. UBS Securities España SV, SA is regulated by the Comisión Nacional del Mercado de Valores (CNMV). **Turkey:** Prepared by UBS Menkul Degerler AS on behalf of and distributed by UBS Limited. **Russia:** Prepared and distributed by UBS Securities CJSC. **Switzerland:** Distributed by UBS AG to persons who are institutional investors only. **Italy:** Prepared by UBS Limited and distributed by UBS Limited and UBS Italia Sim S.p.A.. UBS Italia Sim S.p.A. is regulated by the Bank of Italy and by the Commissione Nazionale per le Società e la Borsa (CONSOB). Where an analyst of UBS Italia Sim S.p.A. has contributed to this report, the report is also deemed to have been prepared by UBS Italia Sim S.p.A.. **South Africa:** UBS South Africa (Pty) Limited (Registration No. 1995/011140/07) is a member of the JSE Limited, the South African Futures Exchange and the Bond Exchange of South Africa. UBS South Africa (Pty) Limited is an authorised Financial Services Provider. Details of its postal and physical address and a list of its directors are available on request or may be accessed at <http://www.ubs.co.za>. **United States:** Distributed to US persons by either UBS Securities LLC or by UBS Financial Services Inc., subsidiaries of UBS AG; or by a group, subsidiary or affiliate of UBS AG that is not registered as a US broker-dealer (a 'non-US affiliate'), to major US institutional investors only. UBS Securities LLC or UBS Financial Services Inc. accepts responsibility for the content of a report prepared by another non-US affiliate when distributed to US persons by UBS Securities LLC or UBS Financial Services Inc. All transactions by a US person in the securities mentioned in this report must be effected through UBS Securities LLC or UBS Financial Services Inc., and not through a non-US affiliate. **Canada:** Distributed by UBS Securities Canada Inc., a subsidiary of UBS AG and a member of the principal Canadian stock exchanges & CIPF. A statement of its financial condition and a list of its directors and senior officers will be provided upon request. **Hong Kong:** Distributed by UBS Securities Asia Limited. **Singapore:** Distributed by UBS Securities Pte. Ltd [mica (p) 039/11/2009 and Co. Reg. No.: 198500648C] or UBS AG, Singapore Branch. Please contact UBS Securities Pte Ltd, an exempt financial advisor under the Singapore Financial Advisers Act (Cap. 110); or UBS AG Singapore branch, an exempt financial adviser under the Singapore Financial Advisers Act (Cap. 110) and a wholesale bank licensed under the Singapore Banking Act (Cap. 19) regulated by the Monetary Authority of Singapore, in respect of any matters arising from, or in connection with, the analysis or report. The recipient of this report represent and warrant that they are accredited and institutional investors as defined in the Securities and Futures Act (Cap. 289). **Japan:** Distributed by UBS Securities Japan Ltd to institutional investors only. Where this report has been prepared by UBS Securities Japan Ltd, UBS Securities Japan Ltd is the author, publisher and distributor of the report. **Australia:** Distributed by UBS AG (Holder of Australian Financial Services License No. 231087) and UBS Securities Australia Ltd (Holder of Australian Financial Services License No. 231098) only to 'Wholesale' clients as defined by s761G of the Corporations Act 2001. **New Zealand:** Distributed by UBS New Zealand Ltd. An investment adviser and investment broker disclosure statement is available on request and free of charge by writing to PO Box 45, Auckland, NZ. **Dubai:** The research prepared and distributed by UBS AG Dubai Branch, is intended for Professional Clients only and is not for further distribution within the United Arab Emirates. **Korea:** Distributed in Korea by UBS Securities Pte. Ltd., Seoul Branch. This report may have been edited or contributed to from time to time by affiliates of UBS Securities Pte. Ltd., Seoul Branch. **Malaysia:** This material is authorized to be distributed in Malaysia by UBS Securities Malaysia Sdn. Bhd (253825-x).

The disclosures contained in research reports produced by UBS Limited shall be governed by and construed in accordance with English law.

UBS specifically prohibits the redistribution of this material in whole or in part without the written permission of UBS and UBS accepts no liability whatsoever for the actions of third parties in this respect. Images may depict objects or elements which are protected by third party copyright, trademarks and other intellectual property rights. © UBS 2010. The key symbol and UBS are among the registered and unregistered trademarks of UBS. All rights reserved.



U.S. HEALTH CARE- MANAGED CARE

Potential Progress on CMS RADV Audits

CMS issued a letter this morning to all Medicare Advantage organizations regarding its ongoing RADV audits. The February 3, 2011 memo came from Cheri Rice, Acting Director of the Medicare Plan Payment Group. The official subject of the memo is "CMS Response to Risk Adjustment Data Validation (RADV) Sampling and Payment Error-Calculation Methodology Questions." The memo provides a very terse (one paragraph) update to the CMS proposed draft RADV sampling and payment error calculation methodology posted on December 21, 2010. A copy of that document can be found at: <https://www.cms.gov/HealthPlansGenInfo/Downloads/RADVSamplingPaymentErrorDescription.pdf>

We believe that there are three takeaways from today's correspondence:

1) CMS appears to be making progress and expects to have a more definitive say in the near term. In the letter CMS stated that "[CMS] anticipate the final revised RADV sampling and payment error calculation methodology paper will be issued in the near future." The obvious question is what "near future" means to CMS. We believe that this likely will be included in the 45-day notice to MA plans expected on February 18, 2011.

2) We believe that CMS is clearly open to suggestions and it appears that the methodology will change in its final notice. Again from the letter, CMS stated "We are thoroughly evaluating all comments and anticipate making changes to our draft, based on input we received." We read this to mean that there are pretty clear changes coming. As a reminder, a majority of the backlash and comments centered on the fact that there was no control group or comparison to the traditional FFS program, as well as many other comments on the methodology. We viewed the original methodology to be very burdensome on the MA plans and would suggest that any changes would likely lessen the negative impact on the plans.

3) This letter suggests that CMS is bringing the RADV audits back into the official process of regulating MA plans. There was some perturbation in the industry around the whimsical nature of the methodology's release and content. If CMS incorporates this into the call letter on February 18, 2011, it appears that the industry could have less of an opportunity to challenge the procedure used by CMS.

Overall, we view this as a modest positive for the managed care plans with meaningful dependence on Medicare Advantage, including HealthSpring, WellCare, Humana and UnitedHealth. It appears that the methodology will change based on the comments and that more visibility will come in the near term.

Please contact us for a copy of today's correspondence.

Barclays Capital does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of this report.

Investors should consider this report as only a single factor in making their investment decision.

PLEASE SEE ANALYST(S) CERTIFICATION(S) AND IMPORTANT DISCLOSURES BEGINNING ON PAGE 3.

INDUSTRY UPDATE

U.S. Health Care- Managed Care

1-POSITIVE

Unchanged

U.S. Health Care- Managed Care

Joshua R. Raskin, CFA

1.212.526.2279

joshua.raskin@barcap.com

BCI, New York

Joseph Kuhns

1.212.526.3302

joseph.kuhns@barcap.com

BCI, New York

Jack Meehan

1.212.526.3909

jack.meehan@barcap.com

BCI, New York

This morning, February 3, 2011, the Centers for Medicare & Medicaid Services (CMS) issued a letter to all Medicare Advantage (MA) organizations regarding its ongoing RADV audits. The memo came from Cheri Rice, Acting Director of the Medicare Plan Payment Group. The official subject of the memo is “CMS Response to Risk Adjustment Data Validation (RADV) Sampling and Payment Error-Calculation Methodology Questions”. The memo provides a very terse (one paragraph) update to the CMS proposed draft RADV sampling and payment error calculation methodology posted on December 21, 2010.

A copy of that document can be found at:

<https://www.cms.gov/HealthPlansGenInfo/Downloads/RADVSamplingPaymentErrorDescription.pdf>

We believe that there are three takeaways from today’s correspondence:

1) It appears that CMS is making progress and expects to have a more definitive say in the near term. In the letter CMS stated that “[CMS] anticipate the final revised RADV sampling and payment error calculation methodology paper will be issued in the near future.” The obvious question is what “near future” means to CMS. We believe that this likely will be included in the 45-day notice to MA plans expected on February 18, 2011.

2) We believe that CMS is clearly open to suggestions and it appears that the methodology will change in its final notice. Again from the letter, CMS stated “We are thoroughly evaluating all comments and anticipate making changes to our draft, based on input we received.” We read this to mean that there are pretty clear changes coming. As a reminder, a majority of the backlash and comments centered on the fact that there was no control group or comparison to the traditional FFS program, as well as many other comments on the methodology. We viewed the original methodology to be very burdensome on the MA plans and would suggest that any changes would likely lessen the negative impact on the plans.

3) This letter suggests that CMS is bringing the RADV audits back into the official process of regulating MA plans. There was some perturbation in the industry around the whimsical nature of the methodology’s release and content. If CMS incorporates this into the call letter on February 18, 2011, it appears that the industry will have less of an opportunity to challenge the procedure used by CMS.

Overall, we view this as a modest positive for the managed care plans with meaningful dependence on Medicare Advantage, including HealthSpring, WellCare, Humana and UnitedHealth. It appears that the methodology will change based on the comments and that more visibility will come in the near term.

Please contact us for a copy of today’s correspondence.

ANALYST(S) CERTIFICATION(S)

I, Joshua R. Raskin, CFA, hereby certify (1) that the views expressed in this research report accurately reflect my personal views about any or all of the subject securities or issuers referred to in this research report and (2) no part of my compensation was, is or will be directly or indirectly related to the specific recommendations or views expressed in this research report.

IMPORTANT DISCLOSURES

For current important disclosures, including, where relevant, price target charts, regarding companies that are the subject of this research report, please send a written request to: Barclays Capital Research Compliance, 745 Seventh Avenue, 17th Floor, New York, NY 10019 or refer to <http://publicresearch.barcap.com> or call 1-212-526-1072.

The analysts responsible for preparing this research report have received compensation based upon various factors including the firm's total revenues, a portion of which is generated by investment banking activities.

On September 20, 2008, Barclays Capital acquired Lehman Brothers' North American investment banking, capital markets, and private investment management businesses. All ratings and price targets prior to this date relate to coverage under Lehman Brothers Inc.

Barclays Capital produces a variety of research products including, but not limited to, fundamental analysis, equity-linked analysis, quantitative analysis, and trade ideas. Recommendations contained in one type of research product may differ from recommendations contained in other types of research products, whether as a result of differing time horizons, methodologies, or otherwise.

Materially Mentioned Stocks (Ticker, Date, Price)

HealthSpring Inc. (HS, 02-Feb-2011, USD 31.27), 1-Overweight/1-Positive

Humana Inc. (HUM, 02-Feb-2011, USD 58.95), 2-Equal Weight/1-Positive

UnitedHealth Group (UNH, 02-Feb-2011, USD 41.95), 1-Overweight/1-Positive

WellCare Health Plans (WCG, 02-Feb-2011, USD 30.72), 2-Equal Weight/1-Positive

Guide to the Barclays Capital Fundamental Equity Research Rating System:

Our coverage analysts use a relative rating system in which they rate stocks as 1-Overweight, 2-Equal Weight or 3-Underweight (see definitions below) relative to other companies covered by the analyst or a team of analysts that are deemed to be in the same industry sector (the "sector coverage universe").

In addition to the stock rating, we provide sector views which rate the outlook for the sector coverage universe as 1-Positive, 2-Neutral or 3-Negative (see definitions below). A rating system using terms such as buy, hold and sell is not the equivalent of our rating system. Investors should carefully read the entire research report including the definitions of all ratings and not infer its contents from ratings alone.

Stock Rating

1-Overweight - The stock is expected to outperform the unweighted expected total return of the sector coverage universe over a 12-month investment horizon.

2-Equal Weight - The stock is expected to perform in line with the unweighted expected total return of the sector coverage universe over a 12-month investment horizon.

3-Underweight - The stock is expected to underperform the unweighted expected total return of the sector coverage universe over a 12-month investment horizon.

RS-Rating Suspended - The rating and target price have been suspended temporarily due to market events that made coverage impracticable or to comply with applicable regulations and/or firm policies in certain circumstances including when Barclays Capital is acting in an advisory capacity in a merger or strategic transaction involving the company.

Sector View

1-Positive - sector coverage universe fundamentals/valuations are improving.

2-Neutral - sector coverage universe fundamentals/valuations are steady, neither improving nor deteriorating.

3-Negative - sector coverage universe fundamentals/valuations are deteriorating.

Below is the list of companies that constitute the "sector coverage universe":

U.S. Health Care- Managed Care

Aetna Inc. (AET)	AMERIGROUP Corp. (AGP)	Centene Corp. (CNC)
CIGNA Corp. (CI)	Coventry Health Care (CVH)	Health Net (HNT)
HealthSpring Inc. (HS)	Healthways Inc. (HWAY)	Humana Inc. (HUM)
Magellan Health Services (MGLN)	Molina Healthcare (MOH)	UnitedHealth Group (UNH)
Universal American Corp. (UAM)	WellCare Health Plans (WCG)	WellPoint, Inc. (WLP)

Distribution of Ratings:

IMPORTANT DISCLOSURES CONTINUED

Barclays Capital Inc. Equity Research has 1720 companies under coverage.

42% have been assigned a 1-Overweight rating which, for purposes of mandatory regulatory disclosures, is classified as a Buy rating; 54% of companies with this rating are investment banking clients of the Firm.

43% have been assigned a 2-Equal Weight rating which, for purposes of mandatory regulatory disclosures, is classified as a Hold rating; 45% of companies with this rating are investment banking clients of the Firm.

12% have been assigned a 3-Underweight rating which, for purposes of mandatory regulatory disclosures, is classified as a Sell rating; 38% of companies with this rating are investment banking clients of the Firm.

Barclays Capital offices involved in the production of equity research:

London

Barclays Capital, the investment banking division of Barclays Bank PLC (Barclays Capital, London)

New York

Barclays Capital Inc. (BCI, New York)

Tokyo

Barclays Capital Japan Limited (BCJL, Tokyo)

São Paulo

Banco Barclays S.A. (BBSA, São Paulo)

Hong Kong

Barclays Bank PLC, Hong Kong branch (Barclays Bank, Hong Kong)

Toronto

Barclays Capital Canada Inc. (BCC, Toronto)

Johannesburg

Absa Capital, a division of Absa Bank Limited (Absa Capital, Johannesburg)

IMPORTANT DISCLOSURES CONTINUED

HealthSpring Inc. (HS)

USD 31.27 (02-Feb-2011)

Stock Rating

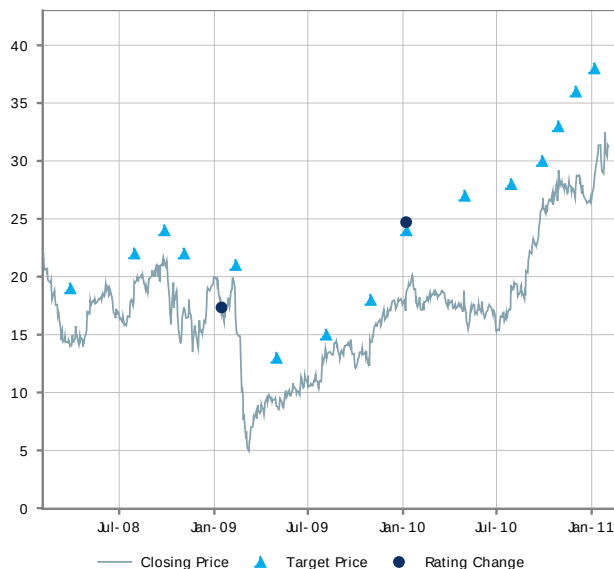
1-OVERWEIGHT

Sector View

1-POSITIVE

Rating and Price Target Chart - USD (as of 02-Feb-2011)

Currency=USD



Date	Closing Price	Rating	Price Target
06-Jan-2011	28.24		38.00
01-Dec-2010	27.84		36.00
28-Oct-2010	27.44		33.00
27-Sep-2010	25.88		30.00
29-Jul-2010	19.27		28.00
30-Apr-2010	17.60		27.00
07-Jan-2010	18.52	1-Overweight	24.00
30-Oct-2009	14.33		18.00
05-Aug-2009	13.49		15.00
01-May-2009	8.83		13.00
11-Feb-2009	16.58		21.00
15-Jan-2009	16.84	2-Equal Weight	
03-Nov-2008	17.30		22.00
26-Sep-2008	21.31		24.00
30-Jul-2008	19.56		22.00
28-Mar-2008	13.98		19.00

[Link to Barclays Capital Live for interactive charting](#)

Barclays Bank PLC and/or an affiliate trades regularly in the shares of HealthSpring Inc..

Barclays Bank PLC and/or an affiliate has received non-investment banking related compensation from HealthSpring Inc. within the past 12 months.

HealthSpring Inc. is, or during the past 12 months has been, a non-investment banking client (securities related services) of Barclays Bank PLC and/or an affiliate.

Valuation Methodology: Our twelve month price target of \$38 represents a target multiple of 10x our 2011 EPS estimate of \$3.80 per share. This represents a -6% discount to the current peer group multiple of 10.6x estimates, and represents a 37% premium to its current multiple of 7.3x 2011 EPS.

Risks which May Impede the Achievement of the Price Target: 1) HealthSpring is a relatively new company to the public market so we have less historical data to review. 2) The company has shown volatile results over the last two years. 3) The restrictive network model tends to reduce opportunities for growth. 4) There has been some management turnover in recent years.

IMPORTANT DISCLOSURES CONTINUED

Humana Inc. (HUM)

USD 58.95 (02-Feb-2011)

Stock Rating

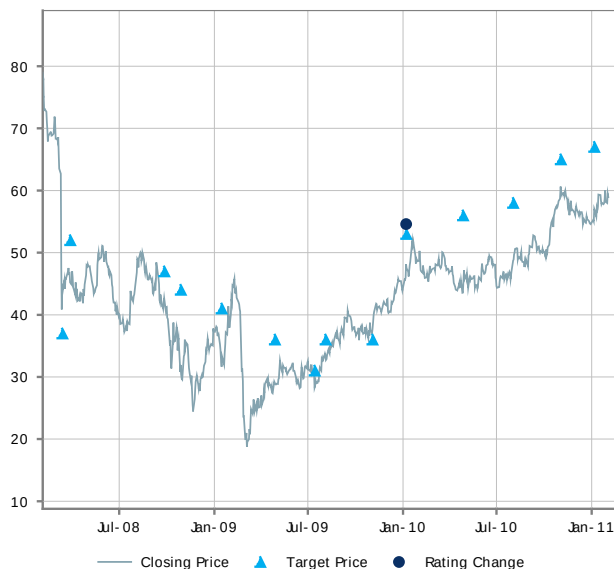
2-EQUAL WEIGHT

Sector View

1-POSITIVE

Rating and Price Target Chart - USD (as of 02-Feb-2011)

Currency=USD


[Link to Barclays Capital Live for interactive charting](#)

Date	Closing Price	Rating	Price Target
06-Jan-2011	57.06		67.00
02-Nov-2010	60.64		65.00
02-Aug-2010	48.73		58.00
27-Apr-2010	43.57		56.00
07-Jan-2010	48.12	2-Equal Weight	53.00
03-Nov-2009	37.67		36.00
04-Aug-2009	33.50		36.00
14-Jul-2009	28.28		31.00
28-Apr-2009	28.99		36.00
15-Jan-2009	31.65		41.00
28-Oct-2008	31.92		44.00
26-Sep-2008	42.70		47.00
28-Mar-2008	45.20		52.00
13-Mar-2008	44.98		37.00

Barclays Bank PLC and/or an affiliate is a market-maker and/or liquidity provider in securities issued by Humana Inc. or one of its affiliates.

Barclays Bank PLC and/or an affiliate expects to receive or intends to seek compensation for investment banking services from Humana Inc. within the next 3 months.

Barclays Bank PLC and/or an affiliate trades regularly in the shares of Humana Inc..

Humana Inc. is, or during the past 12 months has been, an investment banking client of Barclays Bank PLC and/or an affiliate.

Barclays Bank PLC is associated with specialist firm Barclays Capital Market Makers, which makes a market in Humana Inc. stock. At any given time, the associated specialist may have "long" or "short" inventory position in the stock; and the associated specialist may be on the opposite side of orders executed on the Floor of the Exchange in the stock.

Valuation Methodology: Our twelve month price target of \$67 represents a target multiple of 12.1x our 2011 EPS estimate of \$5.55 per share. This represents a 10% premium to the current peer group multiple of 11.0x estimates, and represents a 20% premium to its current multiple of 10.1x 2011 EPS.

Risks which May Impede the Achievement of the Price Target: 1) While we believe the Senior sector represents the most attractive long-term segment of health insurance, we believe that the market is underestimating the potential short-term difficulties in the Medicare Advantage program. 2) Humana has shown much strength in PFFS members, an area where we see greater risk in the future. 3) Because the dependence on the Government segment, we believe that visibility into Humana's earnings is below the industry average. 4) Humana has had a mixed history with its commercial operations, and we simply believe that this segment is insufficient to absorb potential declines in Medicare related earnings. 5) Valuations still remain above historical norms. 6) With a higher degree of capital spending, mostly related to technology initiatives, there remains pressure on earnings. (7) The company has a vast geographical breadth but is still without full national coverage. (8) There is and could continue to be near-term negative sentiment toward managed care companies and concern about industry pricing trends, and cost trends, as well as potential litigation noise.

Other Material Conflicts: Barclays Capital is acting as financial advisor to Concentra Inc. in the company's potential acquisition by Humana Inc.

IMPORTANT DISCLOSURES CONTINUED

UnitedHealth Group (UNH)

USD 41.95 (02-Feb-2011)

Stock Rating

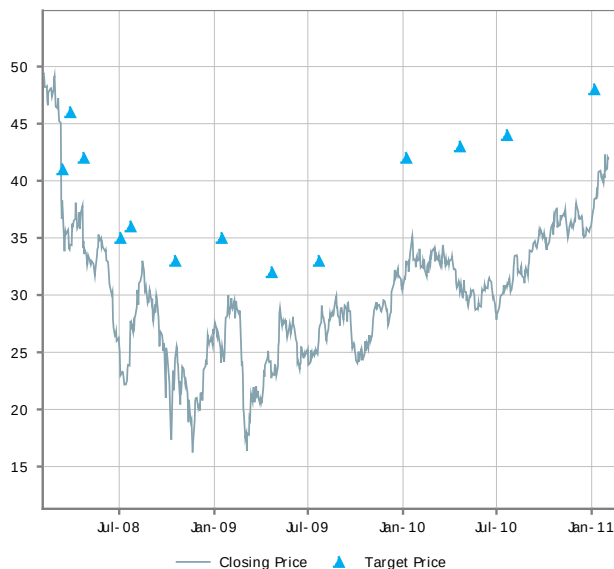
1-OVERWEIGHT

Sector View

1-POSITIVE

Rating and Price Target Chart - USD (as of 02-Feb-2011)

Currency=USD


[Link to Barclays Capital Live for interactive charting](#)

Barclays Bank PLC and/or an affiliate has been lead manager or co-lead manager of a publicly disclosed offer of securities of UnitedHealth Group in the previous 12 months.

Barclays Bank PLC and/or an affiliate has received compensation for investment banking services from UnitedHealth Group in the past 12 months.

Barclays Bank PLC and/or an affiliate expects to receive or intends to seek compensation for investment banking services from UnitedHealth Group within the next 3 months.

Barclays Bank PLC and/or an affiliate trades regularly in the shares of UnitedHealth Group.

Barclays Bank PLC and/or an affiliate has received non-investment banking related compensation from UnitedHealth Group within the past 12 months.

UnitedHealth Group is, or during the past 12 months has been, an investment banking client of Barclays Bank PLC and/or an affiliate.

UnitedHealth Group is, or during the past 12 months has been, a non-investment banking client (securities related services) of Barclays Bank PLC and/or an affiliate.

Valuation Methodology: Our twelve month price target of \$48 represents a target multiple of 13x our 2011 EPS estimate of \$3.70 per share. This represents a 18% premium to the current peer group multiple of 11.0x estimates, and represents a 20% premium to its current multiple of 10.8x 2011 EPS.

Risks which May Impede the Achievement of the Price Target: 1) UnitedHealth's Uniprise segment operates in the increasingly competitive market for self-funded national accounts. 2) Recent acquisitions have increased UnitedHealth's exposure to risk-based insurance products. 3) An acquisition strategy, as is being pursued by UnitedHealth, potentially subjects companies to greater risks. 4) With an impressive five-year EPS CAGR of about 30%, we estimate that as much as 5% of that growth is from share repurchases, which will be difficult to replicate going forward. 5) That impressive track record has created some very "greedy" expectations on ever-more difficult comparison periods. 6) There is, and could continue to be, near-term negative sentiment toward managed care companies, concern about industry pricing trends (as opposed to cost trends), and potential litigation noise.

IMPORTANT DISCLOSURES CONTINUED

WellCare Health Plans (WCG)

USD 30.72 (02-Feb-2011)

Stock Rating

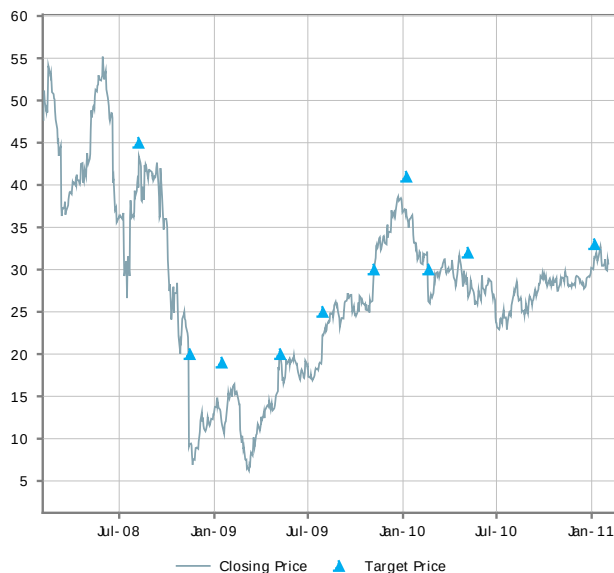
Sector View

2-EQUAL WEIGHT

1-POSITIVE

Rating and Price Target Chart - USD (as of 02-Feb-2011)

Currency=USD



Date	Closing Price	Rating	Price Target
06-Jan-2011	31.39		33.00
06-May-2010	27.76		32.00
19-Feb-2010	26.25		30.00
07-Jan-2010	37.18		41.00
05-Nov-2009	29.26		30.00
29-Jul-2009	22.24		25.00
08-May-2009	20.15		20.00
15-Jan-2009	11.94		19.00
14-Nov-2008	9.36		20.00
07-Aug-2008	39.71		45.00

Barclays Bank PLC and/or an affiliate trades regularly in the shares of WellCare Health Plans.

Barclays Bank PLC and/or an affiliate has received non-investment banking related compensation from WellCare Health Plans within the past 12 months.

WellCare Health Plans is, or during the past 12 months has been, a non-investment banking client (securities related services) of Barclays Bank PLC and/or an affiliate.

Valuation Methodology: Our twelve month price target of \$33 represents a target multiple of 13.8x our 2011 EPS estimate of \$2.40 per share. This represents a 25% premium to the current peer group multiple of 11.0x estimates, and represents a 3% premium to its current multiple of 13.3x 2011 EPS.

Risks which May Impede the Achievement of the Price Target: 1) The company remains under investigation for potential violations of Medicaid and/or Medicare regulations. 2) There has been a high level of management turnover. 3) The company maintains a large dependence on PFFS plans, a product that we have long term concerns over. 4) We believe the opportunity to take share from competitors in four of its five Medicaid markets, particularly Florida, is limited barring legislative changes. 5) We highlight that Medicare disease states are decidedly more complex and heterogeneous than those associated with the traditional Medicaid managed care population.

This publication has been prepared by Barclays Capital; the investment banking division of Barclays Bank PLC, and/or one or more of its affiliates as provided below. This publication is provided to you for information purposes only, and Barclays Capital makes no express or implied warranties, and expressly disclaims all warranties of merchantability or fitness for a particular purpose or use with respect to any data included in this publication. Prices shown in this publication are indicative and Barclays Capital is not offering to buy or sell or soliciting offers to buy or sell any financial instrument.

Without limiting any of the foregoing and to the extent permitted by law, in no event shall Barclays Capital, nor any affiliate, nor any of their respective officers, directors, partners, or employees have any liability for (a) any special, punitive, indirect, or consequential damages; or (b) any lost profits, lost revenue, loss of anticipated savings or loss of opportunity or other financial loss, even if notified of the possibility of such damages, arising from any use of this publication or its contents.

Other than disclosures relating to Barclays Capital, the information contained in this publication has been obtained from sources that Barclays Capital believes to be reliable, but Barclays Capital does not represent or warrant that it is accurate or complete. The views in this publication are those of Barclays Capital and are subject to change, and Barclays Capital has no obligation to update its opinions or the information in this publication.

The analyst recommendations in this report reflect solely and exclusively those of the author(s), and such opinions were prepared independently of any other interests, including those of Barclays Capital and/or its affiliates.

The securities discussed in this publication may not be suitable for all investors. Barclays Capital recommends that investors independently evaluate each issuer, security or instrument discussed in this publication and consult any independent advisors they believe necessary. The value of and income from any investment may fluctuate from day to day as a result of changes in relevant economic markets (including changes in market liquidity). The information in this publication is not intended to predict actual results, which may differ substantially from those reflected. Past performance is not necessarily indicative of future results.

This communication is being made available in the UK and Europe primarily to persons who are investment professionals as that term is defined in Article 19 of the Financial Services and Markets Act 2000 (Financial Promotion Order) 2005. It is directed at, and therefore should only be relied upon by, persons who have professional experience in matters relating to investments. The investments to which it relates are available only to such persons and will be entered into only with such persons. Barclays Capital is authorized and regulated by the Financial Services Authority ('FSA') and member of the London Stock Exchange.

Barclays Capital Inc., US registered broker/dealer and member of FINRA (www.finra.org), is distributing this material in the United States and, in connection therewith accepts responsibility for its contents. Any U.S. person wishing to effect a transaction in any security discussed herein should do so only by contacting a representative of Barclays Capital Inc. in the U.S. at 745 Seventh Avenue, New York, New York 10019.

Non-U.S. persons should contact and execute transactions through a Barclays Bank PLC branch or affiliate in their home jurisdiction unless local regulations permit otherwise.

This material is distributed in Canada by Barclays Capital Canada Inc., a registered investment dealer and member of IIROC (www.iroc.ca).

Subject to the conditions of this publication as set out above, Absa Capital, the Investment Banking Division of Absa Bank Limited, an authorised financial services provider (Registration No.: 1986/004794/06), is distributing this material in South Africa. Absa Bank Limited is regulated by the South African Reserve Bank. This publication is not, nor is it intended to be, advice as defined and/or contemplated in the (South African) Financial Advisory and Intermediary Services Act, 37 of 2002, or any other financial, investment, trading, tax, legal, accounting, retirement, actuarial or other professional advice or service whatsoever. Any South African person or entity wishing to effect a transaction in any security discussed herein should do so only by contacting a representative of Absa Capital in South Africa, 15 Alice Lane, Sandton, Johannesburg, Gauteng 2196. Absa Capital is an affiliate of Barclays Capital.

In Japan, foreign exchange research reports are prepared and distributed by Barclays Bank PLC Tokyo Branch. Other research reports are distributed to institutional investors in Japan by Barclays Capital Japan Limited. Barclays Capital Japan Limited is a joint-stock company incorporated in Japan with registered office of 6-10-1 Roppongi, Minato-ku, Tokyo 106-6131, Japan. It is a subsidiary of Barclays Bank PLC and a registered financial instruments firm regulated by the Financial Services Agency of Japan. Registered Number: Kanto Zaimukyokuchō (kinsho) No. 143.

Barclays Bank PLC, Hong Kong Branch is distributing this material in Hong Kong as an authorised institution regulated by the Hong Kong Monetary Authority. Registered Office: 41/F, Cheung Kong Center, 2 Queen's Road Central, Hong Kong.

Barclays Bank PLC Frankfurt Branch is distributing this material in Germany under the supervision of Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin).

This material is distributed in Malaysia by Barclays Capital Markets Malaysia Sdn Bhd.

This material is distributed in Brazil by Banco Barclays S.A.

Barclays Bank PLC in the Dubai International Financial Centre (Registered No. 0060) is regulated by the Dubai Financial Services Authority (DFSA). Barclays Bank PLC-DIFC Branch, may only undertake the financial services activities that fall within the scope of its existing DFSA licence.

Barclays Bank PLC in the UAE is regulated by the Central Bank of the UAE and is licensed to conduct business activities as a branch of a commercial bank incorporated outside the UAE in Dubai (Licence No.: 13/1844/2008, Registered Office: Building No. 6, Burj Dubai Business Hub, Sheikh Zayed Road, Dubai City) and Abu Dhabi (Licence No.: 13/952/2008, Registered Office: Al Jazira Towers, Hamdan Street, PO Box 2734, Abu Dhabi).

Barclays Bank PLC in the Qatar Financial Centre (Registered No. 00018) is authorised by the Qatar Financial Centre Regulatory Authority (QFCRA). Barclays Bank PLC-QFC Branch may only undertake the regulated activities that fall within the scope of its existing QFCRA licence. Principal place of business in Qatar: Qatar Financial Centre, Office 1002, 10th Floor, QFC Tower, Diplomatic Area, West Bay, PO Box 15891, Doha, Qatar.

This material is distributed in Dubai, the UAE and Qatar by Barclays Bank PLC. Related financial products or services are only available to Professional Clients as defined by the DFSA, and Business Customers as defined by the QFCRA.

This material is distributed in Saudi Arabia by Barclays Saudi Arabia ('BSA'). It is not the intention of the Publication to be used or deemed as recommendation, option or advice for any action (s) that may take place in future. Barclays Saudi Arabia is a Closed Joint Stock Company, (CMA License No. 09141-37). Registered office Al Faisaliah Tower | Level 18 | Riyadh 11311 | Kingdom of Saudi Arabia. Authorised and regulated by the Capital Market Authority, Commercial Registration Number: 1010283024.

This material is distributed in Russia by Barclays Capital, affiliated company of Barclays Bank PLC, registered and regulated in Russia by the FSFM. Broker License #177-11850-100000; Dealer License #177-11855-010000. Registered address in Russia: 125047 Moscow, 1st Tverskaya-Yamskaya str. 21.

This material is distributed in India by Barclays Bank PLC, India Branch.

This material is distributed in Singapore by the Singapore branch of Barclays Bank PLC, a bank licensed in Singapore by the Monetary Authority of Singapore. For matters in connection with this report, recipients in Singapore may contact the Singapore branch of Barclays Bank PLC, whose registered address is One Raffles Quay Level 28, South Tower, Singapore 048583.

Barclays Bank PLC, Australia Branch (ARBN 062 449 585, AFSL 246617) is distributing this material in Australia. It is directed at 'wholesale clients' as defined by

Australian Corporations Act 2001.

IRS Circular 230 Prepared Materials Disclaimer: Barclays Capital and its affiliates do not provide tax advice and nothing contained herein should be construed to be tax advice. Please be advised that any discussion of U.S. tax matters contained herein (including any attachments) (i) is not intended or written to be used, and cannot be used, by you for the purpose of avoiding U.S. tax-related penalties; and (ii) was written to support the promotion or marketing of the transactions or other matters addressed herein. Accordingly, you should seek advice based on your particular circumstances from an independent tax advisor.

© Copyright Barclays Bank PLC (2011). All rights reserved. No part of this publication may be reproduced in any manner without the prior written permission of Barclays Capital or any of its affiliates. Barclays Bank PLC is registered in England No. 1026167. Registered office 1 Churchill Place, London, E14 5HP. Additional information regarding this publication will be furnished upon request.

UBS Investment Research

Medicare Advantage Error Rates

Americas

Healthcare Providers

Sector Comment

CMS Error Rates Incremental + for RADV

■ CMS announces 2011 Medicare Advantage payment error rate of 11%

Series of CMS announcements today included 2011 Medicare Advantage payment error rate of 11.0% (based on CY2009 payments), down from 14.1% for last year, compared to the Medicare fee for service (FFS) error rate 8.6% while the Part D rate came in at only 3.2%. We note that Med Adv error rate of 11% was in line with our expectations. On the Medicaid side, overall payment error rate of 8.1% also decreased vs. 2010, when it was 9.4%.

■ Key to RADV is if CMS gives plan FFS adjuster – i.e. grades on curve

Recall that key question to be answered is if CMS will penalize plans for their total payment errors or just include the error rate above and beyond CMS' own FFS error rate. While not definitive, today's announcement is another step in the right direction (recall in Feb CMS said they would make changes to preliminary audit regs) as it gives CMS the perfect tool to set FFS adjuster. While RADV calculated on 2007 data, we est. FFS adjuster would eliminate 60%-80% of risk vs. a zero error target. Finally, Med Adv error rate has come down over the past few years (15.4% in '09, 14.1% in '10) with ratio vs. FFS remaining roughly similar.

■ Risk manageable w/ FFS adjuster; look to hear more post supercommittee

We expect repayment requests will be manageable should CMS include a FFS error rate adjuster coupled with the fact that RADV review will be limited to the plan level, as opposed to extrapolating to entire company. Expect to hear more on RADV in early 2012, once the Supercommittee process is complete. We remain positive on the Med Adv fundamentals given growth and rate visibility over next 18 months with any positive news most relevant for Buy rated HUM and UNH.

15 November 2011

www.ubs.com/investmentresearch

Justin Lake, CFA

Analyst

justin.lake@ubs.com

+1-212-713 2765

Ken LaVine, CFA

Analyst

kenneth.lavine@ubs.com

+1-212-713 4237

Andrew Valen

Associate Analyst

andrew.valen@ubs.com

+1-212-713 2717

Brittany Commins

Associate Analyst

brittany.commins@ubs.com

+1-212-713 2458

■ Statement of Risk

Risks to the Managed Care sector include but are not limited to potentially adverse impact of healthcare reform legislation, changes to Medicare and Medicaid reimbursement policies, potential for acceleration of medical cost trends, and competitive pricing pressures.

■ Analyst Certification

Each research analyst primarily responsible for the content of this research report, in whole or in part, certifies that with respect to each security or issuer that the analyst covered in this report: (1) all of the views expressed accurately reflect his or her personal views about those securities or issuers and were prepared in an independent manner, including with respect to UBS, and (2) no part of his or her compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views expressed by that research analyst in the research report.

Required Disclosures

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS.

For information on the ways in which UBS manages conflicts and maintains independence of its research product; historical performance information; and certain additional disclosures concerning UBS research recommendations, please visit www.ubs.com/disclosures. The figures contained in performance charts refer to the past; past performance is not a reliable indicator of future results. Additional information will be made available upon request. UBS Securities Co. Limited is licensed to conduct securities investment consultancy businesses by the China Securities Regulatory Commission.

UBS Investment Research: Global Equity Rating Allocations

UBS 12-Month Rating	Rating Category	Coverage ¹	IB Services ²
Buy	Buy	59%	35%
Neutral	Hold/Neutral	35%	33%
Sell	Sell	6%	14%
UBS Short-Term Rating	Rating Category	Coverage ³	IB Services ⁴
Buy	Buy	less than 1%	0%
Sell	Sell	less than 1%	20%

1:Percentage of companies under coverage globally within the 12-month rating category.

2:Percentage of companies within the 12-month rating category for which investment banking (IB) services were provided within the past 12 months.

3:Percentage of companies under coverage globally within the Short-Term rating category.

4:Percentage of companies within the Short-Term rating category for which investment banking (IB) services were provided within the past 12 months.

Source: UBS. Rating allocations are as of 30 September 2011.

UBS Investment Research: Global Equity Rating Definitions

UBS 12-Month Rating	Definition
Buy	FSR is > 6% above the MRA.
Neutral	FSR is between -6% and 6% of the MRA.
Sell	FSR is > 6% below the MRA.
UBS Short-Term Rating	Definition
Buy	Buy: Stock price expected to rise within three months from the time the rating was assigned because of a specific catalyst or event.
Sell	Sell: Stock price expected to fall within three months from the time the rating was assigned because of a specific catalyst or event.

KEY DEFINITIONS

Forecast Stock Return (FSR) is defined as expected percentage price appreciation plus gross dividend yield over the next 12 months.

Market Return Assumption (MRA) is defined as the one-year local market interest rate plus 5% (a proxy for, and not a forecast of, the equity risk premium).

Under Review (UR) Stocks may be flagged as UR by the analyst, indicating that the stock's price target and/or rating are subject to possible change in the near term, usually in response to an event that may affect the investment case or valuation.

Short-Term Ratings reflect the expected near-term (up to three months) performance of the stock and do not reflect any change in the fundamental view or investment case.

Equity Price Targets have an investment horizon of 12 months.

EXCEPTIONS AND SPECIAL CASES

UK and European Investment Fund ratings and definitions are: Buy: Positive on factors such as structure, management, performance record, discount; Neutral: Neutral on factors such as structure, management, performance record, discount; Sell: Negative on factors such as structure, management, performance record, discount.

Core Banding Exceptions (CBE): Exceptions to the standard +/-6% bands may be granted by the Investment Review Committee (IRC). Factors considered by the IRC include the stock's volatility and the credit spread of the respective company's debt. As a result, stocks deemed to be very high or low risk may be subject to higher or lower bands as they relate to the rating. When such exceptions apply, they will be identified in the Company Disclosures table in the relevant research piece.

Research analysts contributing to this report who are employed by any non-US affiliate of UBS Securities LLC are not registered/qualified as research analysts with the NASD and NYSE and therefore are not subject to the restrictions contained in the NASD and NYSE rules on communications with a subject company, public appearances, and trading securities held by a research analyst account. The name of each affiliate and analyst employed by that affiliate contributing to this report, if any, follows.

UBS Securities LLC: Justin Lake, CFA; Ken LaVine, CFA; Andrew Valen; Brittany Commins.

Company Disclosures

Company Name	Reuters	12-mo rating	Short-term rating	Price	Price date
Humana Inc. ^{6b, 7, 13, 16}	HUM.N	Buy	N/A	US\$88.66	15 Nov 2011
UnitedHealth Group ^{2, 4, 5, 6a, 6b, 6c, 7, 16}	UNH.N	Buy	N/A	US\$46.55	15 Nov 2011

Source: UBS. All prices as of local market close.

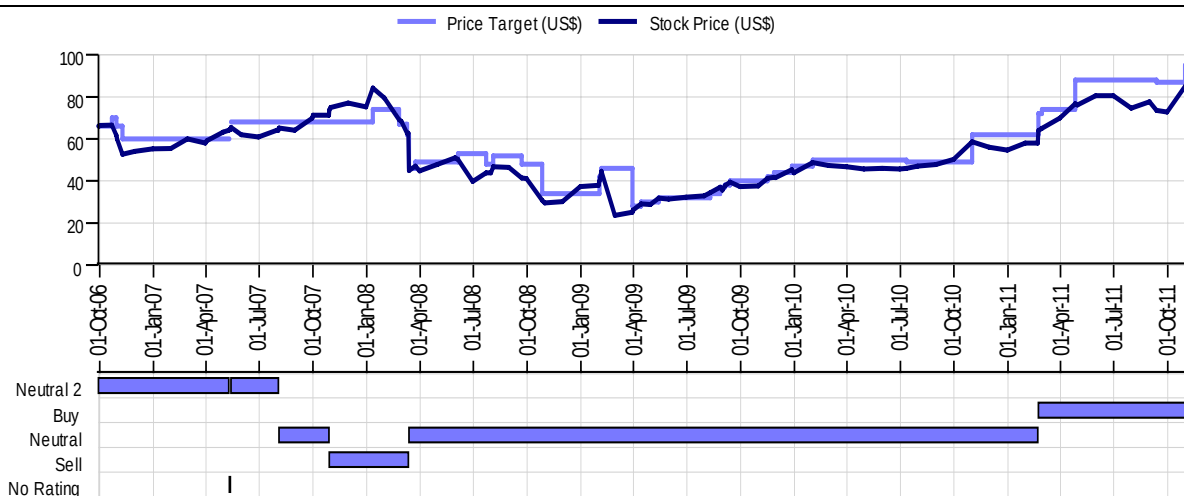
Ratings in this table are the most current published ratings prior to this report. They may be more recent than the stock pricing date

2. UBS AG, its affiliates or subsidiaries has acted as manager/co-manager in the underwriting or placement of securities of this company/entity or one of its affiliates within the past 12 months.
4. Within the past 12 months, UBS AG, its affiliates or subsidiaries has received compensation for investment banking services from this company/entity.
5. UBS AG, its affiliates or subsidiaries expect to receive or intend to seek compensation for investment banking services from this company/entity within the next three months.
- 6a. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and investment banking services are being, or have been, provided.
- 6b. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-investment banking securities-related services are being, or have been, provided.
- 6c. This company/entity is, or within the past 12 months has been, a client of UBS Securities LLC, and non-securities services are being, or have been, provided.
7. Within the past 12 months, UBS Securities LLC has received compensation for products and services other than investment banking services from this company/entity.
13. UBS AG, its affiliates or subsidiaries beneficially owned 1% or more of a class of this company's common equity securities as of last month's end (or the prior month's end if this report is dated less than 10 days after the most recent month's end).

16. UBS Securities LLC makes a market in the securities and/or ADRs of this company.

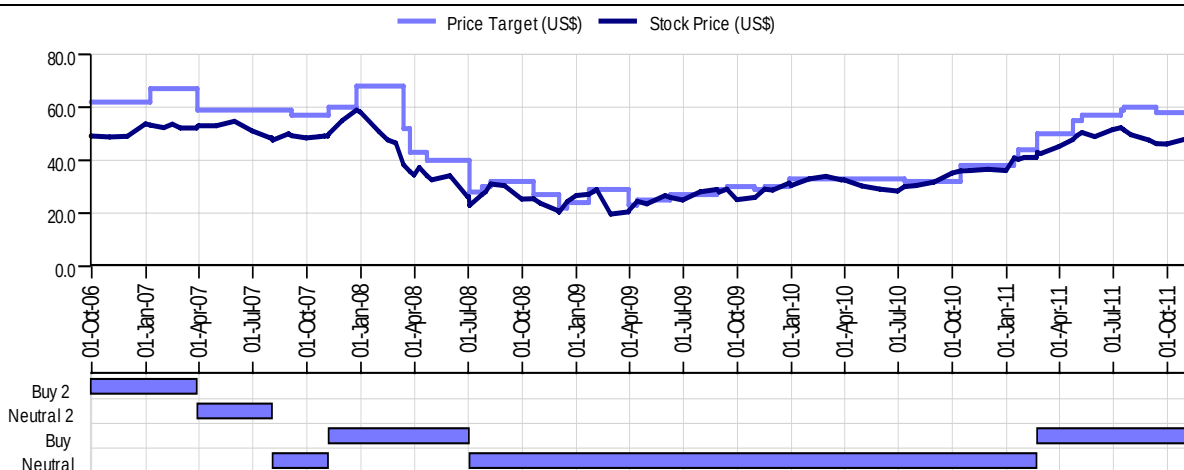
Unless otherwise indicated, please refer to the Valuation and Risk sections within the body of this report.

Humana Inc. (US\$)



Source: UBS; as of 15 Nov 2011

UnitedHealth Group (US\$)



Source: UBS; as of 15 Nov 2011

Note: On August 4, 2007 UBS revised its rating system. (See 'UBS Investment Research: Global Equity Rating Definitions' table for details). From September 9, 2006 through August 3, 2007 the UBS ratings and their definitions were: Buy 1 = FSR is > 6% above the MRA, higher degree of predictability; Buy 2 = FSR is > 6% above the MRA, lower degree of predictability; Neutral 1 = FSR is between -6% and 6% of the MRA, higher degree of predictability; Neutral 2 = FSR is between -6% and 6% of the MRA, lower degree of predictability; Reduce 1 = FSR is > 6% below the MRA, higher degree of predictability; Reduce 2 = FSR is > 6% below the MRA, lower degree of predictability. The predictability level indicates an analyst's conviction in the FSR. A predictability level of '1' means that the analyst's estimate of FSR is in the middle of a narrower, or smaller, range of possibilities. A predictability level of '2' means that the analyst's estimate of FSR is in the middle of a broader, or larger, range of possibilities. From October 13, 2003 through September 8, 2006 the percentage band criteria used in the rating system was 10%.

Global Disclaimer

This report has been prepared by UBS Securities LLC, an affiliate of UBS AG. UBS AG, its subsidiaries, branches and affiliates are referred to herein as UBS. In certain countries, UBS AG is referred to as UBS SA.

This report is for distribution only under such circumstances as may be permitted by applicable law. Nothing in this report constitutes a representation that any investment strategy or recommendation contained herein is suitable or appropriate to a recipient's individual circumstances or otherwise constitutes a personal recommendation. It is published solely for information purposes, it does not constitute an advertisement and is not to be construed as a solicitation or an offer to buy or sell any securities or related financial instruments in any jurisdiction. No representation or warranty, either express or implied, is provided in relation to the accuracy, completeness or reliability of the information contained herein, except with respect to information concerning UBS AG, its subsidiaries and affiliates, nor is it intended to be a complete statement or summary of the securities, markets or developments referred to in the report. UBS does not undertake that investors will obtain profits, nor will it share with investors any investment profits nor accept any liability for any investment losses. Investments involve risks and investors should exercise prudence in making their investment decisions. The report should not be regarded by recipients as a substitute for the exercise of their own judgement. Past performance is not necessarily a guide to future performance. The value of any investment or income may go down as well as up and you may not get back the full amount invested. Any opinions expressed in this report are subject to change without notice and may differ or be contrary to opinions expressed by other business areas or groups of UBS as a result of using different assumptions and criteria. Research will initiate, update and cease coverage solely at the discretion of UBS Investment Bank Research Management. The analysis contained herein is based on numerous assumptions. Different assumptions could result in materially different results. The analyst(s) responsible for the preparation of this report may interact with trading desk personnel, sales personnel and other constituencies for the purpose of gathering, synthesizing and interpreting market information. UBS is under no obligation to update or keep current the information contained herein. UBS relies on information barriers to control the flow of information contained in one or more areas within UBS, into other areas, units, groups or affiliates of UBS. The compensation of the analyst who prepared this report is determined exclusively by research management and senior management (not including investment banking). Analyst compensation is not based on investment banking revenues, however, compensation may relate to the revenues of UBS Investment Bank as a whole, of which investment banking, sales and trading are a part.

The securities described herein may not be eligible for sale in all jurisdictions or to certain categories of investors. Options, derivative products and futures are not suitable for all investors, and trading in these instruments is considered risky. Mortgage and asset-backed securities may involve a high degree of risk and may be highly volatile in response to fluctuations in interest rates and other market conditions. Past performance is not necessarily indicative of future results. Foreign currency rates of exchange may adversely affect the value, price or income of any security or related instrument mentioned in this report. For investment advice, trade execution or other enquiries, clients should contact their local sales representative. Neither UBS nor any of its affiliates, nor any of UBS' or any of its affiliates, directors, employees or agents accepts any liability for any loss or damage arising out of the use of all or any part of this report. For financial instruments admitted to trading on an EU regulated market: UBS AG, its affiliates or subsidiaries (excluding UBS Securities LLC and/or UBS Capital Markets LP) acts as a market maker or liquidity provider (in accordance with the interpretation of these terms in the UK) in the financial instruments of the issuer save that where the activity of liquidity provider is carried out in accordance with the definition given to it by the laws and regulations of any other EU jurisdictions, such information is separately disclosed in this research report. UBS and its affiliates and employees may have long or short positions, trade as principal and buy and sell in instruments or derivatives identified herein.

Any prices stated in this report are for information purposes only and do not represent valuations for individual securities or other instruments. There is no representation that any transaction can or could have been effected at those prices and any prices do not necessarily reflect UBS's internal books and records or theoretical model-based valuations and may be based on certain assumptions. Different assumptions, by UBS or any other source, may yield substantially different results.

United Kingdom and the rest of Europe: Except as otherwise specified herein, this material is communicated by UBS Limited, a subsidiary of UBS AG, to persons who are eligible counterparties or professional clients and is only available to such persons. The information contained herein does not apply to, and should not be relied upon by, retail clients. UBS Limited is authorised and regulated by the Financial Services Authority (FSA). UBS research complies with all the FSA requirements and laws concerning disclosures and these are indicated on the research where applicable. **France:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities France SA. UBS Securities France S.A. is regulated by the Autorité des Marchés Financiers (AMF). Where an analyst of UBS Securities France S.A. has contributed to this report, the report is also deemed to have been prepared by UBS Securities France S.A. **Germany:** Prepared by UBS Limited and distributed by UBS Limited and UBS Deutschland AG. UBS Deutschland AG is regulated by the Bundesanstalt für Finanzdienstleistungsaufsicht (BaFin). **Spain:** Prepared by UBS Limited and distributed by UBS Limited and UBS Securities España SV, SA. UBS Securities España SV, SA is regulated by the Comisión Nacional del Mercado de Valores (CNMV). **Turkey:** Prepared by UBS Menkul Değerler AS on behalf of and distributed by UBS Limited. **Russia:** Prepared and distributed by UBS Securities CJSC. **Switzerland:** Distributed by UBS AG to persons who are institutional investors only. **Italy:** Prepared by UBS Limited and distributed by UBS Limited and UBS Italia Sim S.p.A.. UBS Italia Sim S.p.A. is regulated by the Bank of Italy and by the Commissione Nazionale per le Società e la Borsa (CONSOB). Where an analyst of UBS Italia Sim S.p.A. has contributed to this report, the report is also deemed to have been prepared by UBS Italia Sim S.p.A.. **South Africa:** UBS South Africa (Pty) Limited (Registration No. 1995/011140/07) is a member of the JSE Limited, the South African Futures Exchange and the Bond Exchange of South Africa. UBS South Africa (Pty) Limited is an authorised Financial Services Provider. Details of its postal and physical address and a list of its directors are available on request or may be accessed at <http://www.ubs.co.za>. **United States:** Distributed to US persons by either UBS Securities LLC or by UBS Financial Services Inc., subsidiaries of UBS AG; or by a group, subsidiary or affiliate of UBS AG that is not registered as a US broker-dealer (a "non-US affiliate"), to major US institutional investors only. UBS Securities LLC or UBS Financial Services Inc. accepts responsibility for the content of a report prepared by another non-US affiliate when distributed to US persons by UBS Securities LLC or UBS Financial Services Inc. All transactions by a US person in the securities mentioned in this report must be effected through UBS Securities LLC or UBS Financial Services Inc., and not through a non-US affiliate. **Canada:** Distributed by UBS Securities Canada Inc., a subsidiary of UBS AG and a member of the principal Canadian stock exchanges & CIPF. A statement of its financial condition and a list of its directors and senior officers will be provided upon request. **Hong Kong:** Distributed by UBS Securities Asia Limited. **Singapore:** Distributed by UBS Securities Pte. Ltd [mica (p) 039/11/2009 and Co. Reg. No.: 198500648C] or UBS AG, Singapore Branch. Please contact UBS Securities Pte Ltd, an exempt financial advisor under the Singapore Financial Advisers Act (Cap. 110); or UBS AG Singapore branch, an exempt financial adviser under the Singapore Financial Advisers Act (Cap. 110) and a wholesale bank licensed under the Singapore Banking Act (Cap. 19) regulated by the Monetary Authority of Singapore, in respect of any matters arising from, or in connection with, the analysis or report. The recipient of this report represent and warrant that they are accredited and institutional investors as defined in the Securities and Futures Act (Cap. 289). **Japan:** Distributed by UBS Securities Japan Ltd to institutional investors only. Where this report has been prepared by UBS Securities Japan Ltd, UBS Securities Japan Ltd is the author, publisher and distributor of the report. **Australia:** Distributed by UBS AG (Holder of Australian Financial Services License No. 231087) and UBS Securities Australia Ltd (Holder of Australian Financial Services License No. 231098) only to 'Wholesale' clients as defined by s761G of the Corporations Act 2001. **New Zealand:** Distributed by UBS New Zealand Ltd. An investment adviser and investment broker disclosure statement is available on request and free of charge by writing to PO Box 45, Auckland, NZ. **Dubai:** The research prepared and distributed by UBS AG Dubai Branch, is intended for Professional Clients only and is not for further distribution within the United Arab Emirates. **Korea:** Distributed in Korea by UBS Securities Pte. Ltd., Seoul Branch. This report may have been edited or contributed to from time to time by affiliates of UBS Securities Pte. Ltd., Seoul Branch. **Malaysia:** This material is authorized to be distributed in Malaysia by UBS Securities Malaysia Sdn. Bhd (253825-x). **India :** Prepared by UBS Securities India Private Ltd. 2/F, 2 North Avenue, Maker Maxity, Bandra Kurla Complex, Bandra (East), Mumbai (India) 400051. Phone: +912261556000 SEBI Registration Numbers: NSE (Capital Market Segment): INB230951431, NSE (F&O Segment) INF230951431, BSE (Capital Market Segment) INB010951437.

The disclosures contained in research reports produced by UBS Limited shall be governed by and construed in accordance with English law.

UBS specifically prohibits the redistribution of this material in whole or in part without the written permission of UBS and UBS accepts no liability whatsoever for the actions of third parties in this respect. Images may depict objects or elements which are protected by third party copyright, trademarks and other intellectual property rights. © UBS 2011. The key symbol and UBS are among the registered and unregistered trademarks of UBS. All rights reserved.



RADV Audits - Contender or Pretender?**Sector Rating: Managed Care, Market Weight**

		Price	FY EPS		FY P/E	
Company Name	Rating	01/05/11	2010E	2011E	2010	2011
Managed Care						
Aetna Inc. (AET)	1 V	\$31.50	\$3.61	\$3.30	8.7x	9.6x
AMERIGROUP Corp. (AGP)	1 V	44.32	4.93	4.00	9.0x	11.1x
CIGNA Corp. (CI)	2 V	37.63	4.50	4.50	8.4x	8.4x
Coventry Health Care, Inc. (CVH)	1 V	28.67	3.62	3.10	7.9x	9.3x
Health Net, Inc. (HNT)	1 V	27.24	2.57	2.95	10.6x	9.2x
Humana Inc. (HUM)	1	55.04	7.03	6.35	7.8x	8.7x
Triple-S Management Corp. (GTS)	1	18.93	2.06	2.00	9.2x	9.5x
UnitedHealth Group Inc. (UNH)	1 V	37.59	3.96	3.80	9.5x	9.9x
WellCare Health Plans, Inc. (WCG)	2 V	30.57	2.73	3.18	11.2x	9.6x
WellPoint, Inc. (WLP)	2	58.48	6.44	6.60	9.1x	8.9x

Source: Company data and Wells Fargo Securities, LLC estimates 1= Outperform, 2 = Market Perform, 3 = Underperform, V = Volatile,
 * = Company is on the Priority Stock List NA = Not Available, NC = No Change, NE = No Estimate, NM = Not Meaningful

- Summary: Medicare health insurers' share prices have suffered recently partly due to potential consequences from the Risk Adjustment Data Validation audits. We expect eventually fines will be assessed either in 2011 or 2012. While we expect CMS to only extrapolate the audit results to the Medicare contract for the year audited, we believe it is possible that health insurers could further extrapolate the results to all its plans and for additional years to set up a reserve for future audits, which would magnify the earnings effect from the fines. While this would make the absolute size of the RADV charges more substantial, it would remove the concern of them causing recurring volatility to future earnings. We believe these charges, when they occur, should be viewed as one-time charges, and in the future, plans will adapt to minimize the impact.
- On December 21, 2010, HHS released a "request for comment" on the methodology for calculating the fines which reveals that a standard error will be subtracted from the payment error to determine the fine. This subtraction could substantially reduce plan fines. If the comments returned are substantial enough, or if the process outlined differs from what was already conducted, we believe the prior audits may not be extrapolated. We also believe the more clearly outlined process, the newly established appeal process, and the additional experience in seeing how audit results are reviewed will allow plans and physicians to better comply, reducing the future discrepancies and fines.
- In recent years, Humana and other Medicare insurers have underperformed frequently in the first quarter of the year due to fears of the following year's Medicare rates. We believe some of that typical underperformance may have moved into the last part of 2010's fourth quarter due to the fears of the RADV audit results and their potential impact on Medicare rates or revenues.
- We ran scenarios at 6%, 10%, and 14% error rates in this note and the resulting charges or restatements could be material at the higher levels. The group may have difficulty performing until the overhang is truly lifted as the year progresses and CMS defines exactly what will be done. However, if CMS recognizes the role of health plans as mostly middlemen passing the physician coding errors along to CMS and that similar coding problems likely exist in original Medicare or if the error rate is relatively low, then it remains possible that the charges would be less significant than some anticipate, setting the group up for a potential rally.

Please see page 13 for rating definitions, important disclosures and required analyst certifications

Wells Fargo Securities, LLC does and seeks to do business with companies covered in its research reports. As a result, investors should be aware that the firm may have a conflict of interest that could affect the objectivity of the report and investors should consider this report as only a single factor in making their investment decision.

Peter Costa, Senior Analyst
 (617) 603-4222 / peter.costa@wachovia.com

Together we'll go far



CMS0001652

Discussion

The noise around the Risk Adjustment Data Validation (RADV) audits continues to rise. While these have been disclosed in 10Qs and 10Ks for over a year now, we sense the greater noise is perhaps indicating some progress toward resolution is nearer. Several items have boosted the noise level. First, the recently released “request for comment” suggests to us that there is progress, but perhaps still a long way to go before this issue resolves. However, with an appeals process now in place and the sampling methodology available for comment, we believe some results may start to be seen in 2011. Other issues that have accelerated the noise level in our opinion are nearness of the 2012 rate releases, a fraud suit settlement that may have involved a RADV audit, and comments by an industry consultant in a trade newsletter that a large fine against a publicly traded company could result. While we believe Humana has the most risk, UnitedHealth seems to have attracted the most investor concern. However, any insurer that participates in Medicare Advantage has some risk and may have been audited or could be audited in the future.

As we approach the release of the 45 day advance notice of the 2012 Medicare rates (the advance notice should be out on February 18, 2011 and the final rates should be out on April 4, 2011), we believe some caution by investors is warranted. The 45 day advance notice may provide some clarity on how the results of the audits will be resolved. In the advance notice we believe that CMS (Centers for Medicare and Medicaid Services) will discuss its plans for more RADV audits in 2011 (probably of 2007 plan year data for plan year 2008 payments) that may be extrapolated and could result in fines to plans affecting 2012 payments. We believe CMS has been actively discussing the overall RADV audit topic with the industry, and that it understands many of the issues surrounding this topic. We also believe the recently released “request for comment” suggests they are nearing their decision on how to proceed.

Weaker future rates or fines are possible. While no one yet knows exactly what the resolution will be, we have believed that the RADV audits would eventually result in weaker payments from Medicare to health plans. It is unclear to us if that means fines, lower rates, HCC (Hierarchical Condition Categories) risk score revaluations, or increased reserves. It is also unclear if the earnings impact is limited to the audited plan, the company, or the industry. In further uncertainty, it is also not clear if the results would be applied only to the audited year or if following years would also be affected. Hopefully, our following thoughts provide some improved level of clarity around this uncertainty. It is possible that the RADV audits result in fines in 2012 or perhaps in 2011, if the procedure for extrapolating the results outlined in the “request for comment” is mostly unchanged and the likely appeals of any fines by health plans reach conclusion faster. An early 2011 result would also imply that the audits already done conform to the appeal process laid out in mid 2010 in the federal register and the extrapolation process laid out in the December “request for comment”. We believe it is most likely that fines would be derived from the extrapolated samples to the audited plan level, but not beyond that to the company or the industry. However, it would still be possible that the health insurers themselves could decide to extrapolate the results to all of that year or even the following years perhaps as a settlement with CMS or as a reserve against future audits. This could result in restatements of historical performance. We believe restatements would only occur if the fines were larger. In the case of smaller fines, we expect health insurers would book the fines as revenue offsets in 2011 and reserve for future audits going forward. It is also possible that CMS could decide to extrapolate the results of all the audits into a reduction in Medicare Advantage rates for all plans or be implemented as HCC risk score adjustments in a recalibration. We believe this could occur as early 2012 since we believe CMS has a significant pool of data that could be used to adjust rates for 2012. If 2012 rates were adjusted, CMS would need to discuss this on the upcoming advance notice in February or in the final rate announcement in April.

Regardless of the RADV audits, we already anticipate a weak 2012 Medicare Advantage rate increase. We anticipate rates that rise between zero and 1%, but this is still an improvement from the flat rates in 2011 and rates that were down about 4.5% in 2010. A component of that rate increase is that we expect plans will be dealing with another cut in their payments for Medicare physician payments, since the “doc fix” passed in 2010 was only for one more year and it expires at the end of 2011. This means plans will receive a further negative adjustment to their premiums of about 2% more for 2011 and 2012 (on top of the already negative 4.5% taken in 2010) for the physician sustainable growth rate formula and the lack of long term fixes passed for many years now. This is despite the high likelihood that plans will generally need to pay physicians the higher rates as the rates paid by traditional Medicare to physicians will likely be fixed before 2012. In addition to weak rates, we expect other modestly negative adjustments to risk scores including fee-for-service normalization (usually negative 1%), coding intensity (it was negative 3.41% in both 2010 and 2011), and the expected CMS-HCC risk adjustment recalibration that was not done in 2011, but planned for 2012. However, the RADV audits could add to these factors already driving payments lower, either in the rates, the risk scores, or in fines. Combining the weak rates, negative risk score adjustments, and RADV fines, it will likely mean plans will see very weak payments for 2012. The weakness from the RADV fines is the biggest unknown, in our opinion.

RADV Audits - Contender or Pretender?

Interestingly, we see some of these items as perhaps offsetting. While we expect more coding intensity adjustments going forward, also we believe this adjustment captures some of the differential that the RADV audits are also attempting to capture – in effect we believe this coding adjustment and extrapolating audit results to all Medicare Advantage plan members could partly double count some of the coding issues. Therefore, if the RADV adjustments are larger, we would expect the coding intensity adjustments to be smaller (or in a more fair world perhaps even the two 3.41 negative adjustments could be reversed to positives offsetting plan specific RADV cuts).

It appears likely from the HHS (U.S. Dept. of Health and Human Services) “request for comment” and other prior notices that the RADV audits will mostly result in a penalty at the Medicare contract level (and perhaps not to the entire program or entire company level). If the result is just to extrapolate to the contract level then the result would likely be a contra-revenue being booked in 2011 or perhaps 2012 if the companies and CMS can’t finish the appeals process earlier. This is much the way a risk score true-up is handled now, on a beneficiary-by-beneficiary scale. It is also possible, that the audits could result in a restatement of historical earnings for all the payment years in the years following an audit year that had significant difficulties. This would be most likely if the companies decided that future audits would find similar issues with future year data. Since we suspect the problem will be resolved with a more modest correction than a massive restatement, we believe it will be handled like a typical true-up payment, but if the payment differential was larger we would not rule out a restatement of multiple years since health plans might need to reflect the likelihood that another audit could find similar issues in other contracts or other prior years. It is unlikely the health plans would have significant enough relief from capitation contracts or other physician incentive payments to mute the significance of any fines.

The potential impact of the audits going forward can be muted by plans. We expect health plans may have already started reserving for likely audit results going forward but it could grow depending on how they determine how the audit results will be extrapolated. This could have a negative impact on 2011 earnings performance, but by 2012 we expect plans to price for the higher reserves needed for expected future coding issues. The health insurers’ increased awareness of the potential audit results may cause them to increase overhead costs to police the physician coding, but we suspect that would be a relatively minor cost increase. The more significant change would likely be physician contracts that penalize physicians for poor record keeping, requirements that physicians turn over more medical records to provide plans with an ability to monitor the physicians, and higher premiums/lower benefits for seniors.

We believe a modest resolution to the audits seems the most consistent and fair. We believe the RADV audits completed so far have mostly uncovered that physicians keep poor records and not that plans have been systematically misstating medical records to inflate premiums. We believe this is why HHS built a multistep appeal process in 2010, which will now allow physicians to attest to past medical records that originally lacked their signature. This can help correct for the reality that the poor record keeping may have resulted in higher payments to health plans than can be documented by a valid medical record, but perhaps not higher payments than the plan deserved based on the beneficiary’s true health or when compared to a similarly poor traditional Medicare record for the value of the risk score or for claims paid by traditional Medicare and used to establish traditional county level costs.

We believe one factor in understanding what could happen is attempting to gauge what level of pain to the program and to seniors CMS is willing to unleash for these audits, which we believe have mostly uncovered a documentation shortfall due to omissions and to a lesser extent coding mistakes, but not fraud or systemic diagnosis “upcoding” (coding diagnoses to a level that results in higher payments). We also note that health plans could be viewed as relative middlemen in this, since the physicians keep the charts, the physicians code the claim forms, and the health plans mostly just forward the claim forms to CMS, who then is mostly responsible for assigning the HCC codes and risk scores. While this process affects how plans are paid, they are not primarily responsible for maintaining the data or coding the diagnoses. While we agree plans should not be overpaid for coding errors or fraud, we believe omissions of chronic conditions or unsigned medical records may not be as good a reason to reduce plan payments. However, the problem for health plans could be worse than we expect, if CMS views a particular health plans as negligent in collecting enough information, insufficient in deleting old information, or overly aggressive in finding higher HCC codes that might apply, then we could envision CMS fairly wanting to punish the plans to make the record keeping improve. If this is the case we would envision one year of higher penalties, followed by improved record keeping which would reduce the penalties in the future.

Given the current political environment against Medicare Advantage plans “consistent and fair” may not be what happens. If the coding problem is viewed by CMS as the plan’s fault, or their responsibility regardless of whose fault, and if the plans can’t improve the record keeping by the physicians, then we anticipate plans starting to bid higher for Medicare contracts and charging seniors higher premiums

with lower benefits to price for ongoing audit fines. We believe this will be a bigger issue for plans with more open access to physicians and less of an issue in more closed access HMO plans. We believe larger fines has been investors' greater fear from the resolution of the RADV audits. If the resolution includes large assessments to health plans, or to the industry for Hierarchical Condition Categories that are found to be consistently miscoded, then the size of the potential fines could be much greater and have greater future implications.

We believe the publicly available historical data argues the problem is larger, but we believe it might overstate the problem since we believe the audits that were done in the past did not have a clear appeal process, may not have been randomly sampled (we believe the audits of 2004 data targeted the most suspected Hierarchical Condition Category codes), and the method of extrapolating the sample data to the results of the entire plan may not be completely vetted. It is not clear to us if the 2006 sample data selected for audits was truly random, or would not receive comments, but we believe extrapolating it could still be argued. In the 2004 pilot audit (which specifically targeted suspected HCC codes and was not a random sample) only two codes, HCC 19 (diabetes without complications) and HCC 80 (congestive heart failure), showed significant discrepancies. Other targeted HCC codes (HCC 83, HCC 105 and HCC 108) showed moderate discrepancies (less than 10%). Some of these HCC codes do not coincide with the HCC codes that Humana posted to educate physicians as the most problematic in its audits (which were from the 2007 payment year audit series). Humana identified HCC 105, HCC 16, HCC 71, HCC 82, HCC 92, HCC 10, HCC 9, HCC 96, HCC 108, and HCC 31 as the most problematic HCCs; Exhibit 1 shows the impact of each of these HCCs on risk scores. Since there was a difference between Humana's top 10 and the top few in the 2004 audits, we believe the audits used different sampling mechanisms and plans learned from one audit year to the next how to better provide valid medical record support to justify audit requests. In any case, each of these rounds of audits has been an opportunity for plans to learn. We cannot tell if the 2006 data sample was random, though we believe CMS has planned to extrapolate the data, and therefore, we believe that CMS should have selected a random sample. However, if it was not random it is less likely that it could be extrapolated fairly. The recently released "request for comment" appears to be consistent with the method of selecting records for the 2006 data, but even this leaves some elements of the actual record selection as potentially not random.

Exhibit 1. Risk Score Impact of Humana's list of 10 Most Common HCC Coding Errors

	HCC #	Risk Score Impact
Vascular Disease	105	0.316
Diabetes w/Neurological Manifestations	16	0.408
Polyneuropathy	71	0.327
Unstable Angina/Acute Ischemic	82	0.284
Specified Heart Arrhythmias	92	0.293
Breast, Prostate, other Cancers (154 codes in this HCC)	10	0.208
Lymphatic, Head and Neck, other Cancers	9	0.794
Ischemic or Unspecified Stroke	96	0.265
COPD	108	0.399
Intestinal Obstruction	31	0.311
	Average	0.3605
	Median	0.3135

Source: Wells Fargo Securities, LLC

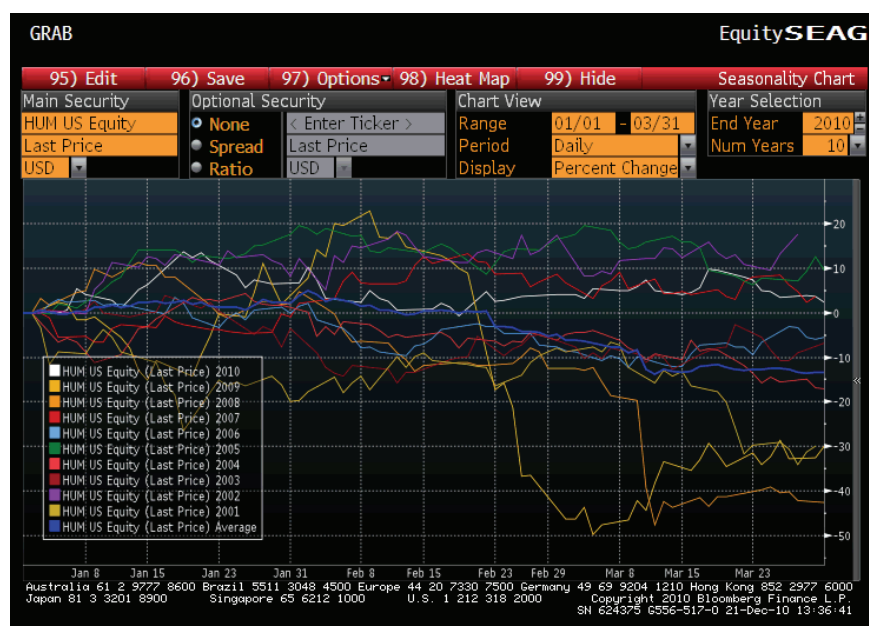
Another problem with extrapolating the data to the full contract is that it implies the problems are widespread, but that could mean it is also widespread enough to exist in traditional Medicare coding results. As we have stated, we believe the 2004 and 2006 audits have mostly revealed poor record keeping on the part of physicians and not clear overpayments relative to what should be paid. However, we agree there may still be some overpayments and that extrapolating the data from the samples to a broader pool of beneficiaries may have some merit. However, it may be more appropriate to extrapolate the data from all audits to all of Medicare rather than just a specific audit to a Medicare contract since the same problems that probably exist at the contract level may also exist in traditional Medicare. Since this would lower the level of risk scores in traditional Medicare at the same rate that it would lower the risk score of all the plans, it would mean that the payments to plans would stay similar on average, since the value of the overall risk score in traditional Medicare would rise to reflect the same traditional Medicare claim costs and the lower risk score average. We believe this is a continuing problem with the audit data being extrapolated to the contract level and not including some fix for the same issues existing in traditional Medicare. In the case of faulty claims, it would perhaps create a problem for Medicare in proving that physicians submitted faulty

RADV Audits - Contender or Pretender?

claims. But this is the same problem that extrapolating the sample data to a Medicare Advantage plan has in penalizing a plan for the assumption of errors being replicated in other non-audited physician's medical records. We believe CMS does not intend to harm seniors in Medicare Advantage with significant rate reductions, but we also believe that CMS wants to correct coding errors and overpayments to plans that result from the coding errors.

While we urge some caution in the near term, we believe fear of these audit results may have already caused the shares in the group to slide lower than they should. We note that historically, Medicare focused plans have underperformed frequently in the first quarter of the year as a result of fears of the following year rates that are finalized on the first Monday of April each year. As an example, see Exhibit 2, we have provided a 10 year, first quarter stock chart for Humana. The chart details the relative performance of the share price compared to January 1 of that year. We believe some of that typical first quarter underperformance may have been felt already in the fourth quarter of 2010 due to concerns about the RADV audits.

Exhibit 2. Humana Historical Stock Chart for Q1 in Each of the Last 10 Years



Source: Bloomberg

What is a RADV audit?

Risk Adjustment Data Validation (RADV) audits and the ensuing discussion of the results have been ongoing for years. We believe the most recent round of audits were for dates of service in 2006 for payment year 2007. We expect more audits to be conducted in 2011 for the 2007 or possibly 2008 date of service years (we believe it would be too soon to audit plan years after those years based on the requirement the senior was not in hospice care during the 12 months after the audit year and since the payment year is after the service year). The purpose of these audits is to make sure that provider documentation supports the rates being paid to health plans, which are risk adjusted based on the average risk score of a plan's beneficiaries so that health plans are paid more if their average beneficiary is less healthy. According to the rules for determining risk scores, seniors are assigned various scores for their various indications including demographic data (age, gender, county, disability status, Medicaid status) and diagnosis related information (summarized by about 70 Hierarchical Condition Categories (HCC), which are in turn defined by 189 condition categories, 804 diagnostic groups, and over 15,000 ICD-9 codes (International Classification of Diseases)). The purpose of the audit is to justify the HCC component of the risk adjustment score. To do this, plans have about 12 weeks to locate and obtain the one best medical record (from either an inpatient hospital chart, outpatient hospital chart, physician clinic chart, or clinically trained non-physician chart (e.g. podiatrist)) for each HCC for each beneficiary selected by CMS to be audited. We believe the typical audit would be focused on about 200 beneficiaries with perhaps several hundred HCCs. The medical record must contain all the information to support all the ICD-9 codes that are required to support the HCC. Some appeal processes have been established in 2010 that would allow some audit results to be overturned. In addition, there are now

provisions that allow health plans to obtain physician attestations to be submitted with the medical records to improve them for missing signatures, etc.

In a pilot study that was done in 2004 that targeted suspected HCC codes, the most common issues were invalid medical records, incorrect code assignments (diagnosis different than what is supported by the medical record), incorrect specificity (the record identified a code at the fourth or fifth digit and that was not specified in the submitted diagnosis, and no medical record submitted. In the 2004 pilot audit, 92 of the 261 HCC codes (or 35%) in the sample were found to have discrepancies. 60% of the 92 were due to coding discrepancies where the record supported a different HCC, 19% were discrepant due to missing records, 12% had specificity discrepancies, 4% had an additional record submitted that did not support the HCC, and 5% had incomplete or invalid medical records for which the reviewer could not determine a diagnosis. In 89 of the 92 discrepant HCCs, the submitted HCC resulted in higher payments. Some of the most common problems seemed to be:

- 1) omitted chronic conditions (for example, the physician may have been aware of a patient's diabetes, but the medical record submitted did not support this condition);
- 2) confirmed diagnosis was missing because the documentation was from a lab report;
- 3) the physician coded a level of specificity that was not supported by the medical record (for example ICD-9 250.7 which is diabetes with peripheral circulatory disorders, but the medical record only supported ICD-9 250.00 which is diabetes mellitus type 2 without mention of complication);
- 4) truncated codes (250.7 versus 250.70); and
- 5) An acute condition was coded but it should have been a "history of" condition.

In order to substantiate an HCC, each medical record submitted must contain the basis for each chronic condition during the audit year to be used in the risk adjustment calculation. This is where we assume a problem could occur easily. For example, if a patient has diabetes and a chronic heart condition, if both are not listed on a chart in the 2006 year, we believe the audit would find the missing HCCs to be discrepant. Therefore, the health plan is not supposed to be paid for the unsupported HCC, or any interaction adjustment that may be warranted which captures both of these chronic conditions. While the health plan and CMS may have recorded from prior years that the senior has both conditions, or the submitted claim may assume it (since these are chronic conditions), and the plan should be paid for them every year since it is taking higher risk insuring that senior, the physician may not have noted the basis for both conditions on the submitted medical record from the 2006 year. Therefore, when that senior's record is audited, we believe the audit would find the chronic HCCs discrepant and the plan would be found to have been overpaid. Since plans do not have the full charts it would be improbable that a health plan would know if every physician logged every diagnosis properly without an audit. Interestingly, we have found letters to CMS from the American Medical Association that have argued against health plans requesting this data unless there is an active CMS audit since this drives up costs for physicians. CMS seems unsympathetic to this issue since health plans have assumed the need to submit accurate records when they enter into a Medicare Advantage contract. But we see higher program costs for little returned value, if all physicians must submit all charts to all Medicare Advantage plans to protect against chronic condition code omission problems.

The following chart, Exhibit 2., shows an example of the effects of HCC Coding, for this example, we have used the following: A 70-year old female who lives on her own (not institutionalized) and who was originally entitled to Medicaid. Chronic conditions include diabetes with complications and CHF. As can be seen, the effect of the HCC's on payments to health plans raises the rate paid substantially.

Exhibit 3. Example of Risk Adjustment on Medicare Premiums

Example of Risk Adjustment Score on PMPM Payment		
Total County Rate:		\$650.00
County Rescaling Factor	1.04 x	
Rescaled County Rate:		\$676.00
Beneficiary Risk Score:		
70 Year Old Female	0.368	
Medicaid Female, Aged	0.179	
HCC 15 - Diabetes w/Peripheral Circulatory Manifestation	0.508	
HCC 80 - Congestive Heart Failure	0.410	
Disease Interaction Factor	0.154	
Total Beneficiary Risk Adjustment Score:	1.619 x	
Total Risk Adjusted Payment:		\$1,094.44

Source: Wells Fargo Securities, LLC

RADV Audits - Contender or Pretender?

Diagnostic codes have long been used to determine inpatient reimbursement, but outpatient reimbursement works differently. In the outpatient physician office setting, only one CPT (Current Procedural Terminology) code and the related ICD-9 codes are needed to be paid. Therefore, in these settings the entire diagnosis for the patient may not need to include the chronic conditions ICD-9 codes for the physician to be paid. However, the Medicare Advantage plan would need the complete information to be paid a full capitated rate for the risk of insuring the individual. We believe this disconnect sets up a potential cause for physicians to maintain incomplete information since they may not need the information to get paid themselves. For example, a senior with two chronic conditions, diabetes and congestive heart failure (CHF), may not seek treatment for both or either of these at the same time or both within the same year, but may instead see a physician about a sore back. The health plan would not be paid for the higher amount of risk it is taking for insuring that senior, if the physician (who only needed to be paid for treating the sore back) did not also note the chronic conditions on the medical chart, and perhaps that was the only time that senior visited a medical provider that year. Therefore, there is a risk of a health plan being overpaid for insuring a senior with chronic conditions that it can't document in the one medical record for the year. We believe this could be enough of a discrepancy for CMS to argue a plan was overpaid in an audit. It is possible CMS could allow attestations to prove these chronic conditions and could ultimately allow them since the diabetes and CHF are chronic and the plan probably should have been paid for the risk associated with these conditions, even if it is not in the chart for the current year.

According to a study from UnitedHealth's actuarial firm Reden & Anders, which was published in Managed Care Magazine in January 2008, in the year after chronic conditions were diagnosed many were omitted from future year's charts by physicians. In the second year after being identified, coding for Coronary Artery Disease fell to just 17%, Congestive Heart Failure fell to 18%, Chronic Obstructive Pulmonary Disease fell to 16%, Cardiovascular Disease fell to 16%, and Diabetes fell to 12% all from 100% in the prior year when the condition was diagnosed. The rates fell further in the third year. If the physician's claim, CMS, or the health plan retained these chronic diagnoses from one year to the next and CMS then paid a health plan for them in a later year, it would likely be considered overpaid in an audit of the later year. If the Reden & Anders data holds then over 80% of the time plans would be considered overpaid in the second year for these chronic conditions. However, if the physician had correctly recorded the data supporting these conditions, the health plan would rightly be getting paid for the extra risk.

Other errors besides chronic conditions can exist from incomplete information, coding errors, or information that is not authenticated by the provider. These errors could be caused by poorly trained, overworked, or low quality billing workers, difficult to read physician handwriting, or incomplete information recorded by the physician, overly complicated rules that do not capture the exact issue, fraud, or perhaps other issues. Health plans can try to enforce some improved record keeping, help physicians to be wary of common errors, and use fraud detection and prevention techniques, but they are unlikely to capture all the issues. Some examples of these errors follow:

- 1) Incomplete or wrong ICD-9 codes.
- 2) A patient was seen for several reasons, but the physician may have only noted the most important on the chart.
- 3) The physician may have used incomplete abbreviations (i.e. chart reflects "DM" for diabetes mellitus but not DM2 to show it is type 2 diabetes), or causal links not clearly indicated (i.e. chart reflects "DM, Nephropathy" but not diabetic nephropathy or nephropathy due to diabetes).
- 4) Information that was found in a lab or x-ray that was performed after a visit, but the chart was never updated with the information (the lab/x-ray itself is not used for confirming the HCC only the physician's medical chart) or the additional codes were not submitted and therefore the HCC can not be confirmed.
- 5) The patient's date of birth is not on the chart or the physician did not sign it.
- 6) Uncommon codes are not on the physicians' typical coding sheets so they fail to note them or look them up (i.e. V49.75 below knee amputation status)
- 7) Patients not seen within the 12 months.

How big could the RADV fines be?

We believe the December 21, 2010 HHS "request for comment", provides a framework for evaluating the potential risk to health insurers earnings from the RADV audits. In attempting to formalize a strategy and plan for the effective implementation of the results of the VADB audits, HHS is looking to find an appropriate method to calculate an estimate of payment errors. It is examining the selection of enrollees, extrapolation method for the sample data, and the calculation of a payment error recovery amount. The criteria applied by CMS in selecting the insurers' MA enrollees to be sampled and its method of extrapolating the data will be used

to determine the payment error estimate and the payment recovery amount for each MA contract selected for an audit. We believe that this recent request for comment by CMS has only heightened the anticipation of the impact of the RADV audits on plan revenues. In a response to comments from an earlier round of RADV rules that HHS proposed, HHS stated they “recognize that there may be potential merit in further refining the error rate calculation.” This statement was made in response to comments from the MA industry that stated the RADV rules could be viewed as making de facto payment adjustments to MA plans based on coding discrepancies, without an adjustment to original Medicare. We believe this is part of what HHS is attempting to improve and vet in the current “request for comment”.

According to the most recent “request for comment”, CMS will select up to 201 enrollees for medical record review from an insurer’s MA contract that has been selected for an audit. These enrollees will be ranked from lowest to highest based on their community risk score. They will then be sub-divided into three groups based on the total number of eligible enrollees, with one group having the third of the enrollees with the highest risk scores, another group with the third of the enrollees with the lowest risk scores, and the final group with the final third of the enrollees in the middle. CMS will select a third of the total number of records being sampled (in this case, 67 enrollees) from each group. The risk scores for each sampled enrollee will be compared to the RADV audit review of the HCCs and the “corrected” risk scores. The RADV risk scores will then be used to calculate the “corrected” payment that should have been received for the enrollee. These amounts will be compared with the actual payments received to calculate if the net amount was an overpayment or an underpayment to the insurer. A payment error will be calculated for each sampled enrollee based on the number of months the person was enrolled in the MA selected contract during the payment year. Depending on the actual size of the contract in terms of number of enrollees, a weight will be calculated for each enrollee that was sampled which would be used to extrapolate the calculated over/under payment amount per enrollee in the contract plan. These will be summed across all enrollees in the sample to determine an estimated payment error for the MA contract. The payment recovery (fine) will be the lower boundary of the 99% confidence interval around the payment error estimate. This will be determined by subtracting the standard error at a 99% confidence level (the standard error multiplied by 2.575) from the total weighted enrollee payment error for the three enrollee group samples. Based on numerous sample calculations we performed on what we believed were potentially possible data sets, we believe the 99% confidence level reduces the size of the potential fines substantially.

The criteria for enrollees who are eligible for the RADV audit states that they must be an enrollee in January of the payment year, continuously enrolled in the same MA contract for all 12 months of the data collection year, must be non-end stage renal disease status during or prior to the payment year, non-hospice between January of the data collection year and January of the payment year (and had less than 12 months of hospice during the payment year), in Medicare Part B coverage for all 12 months during the data collection period, and had at least one risk adjustment diagnosis submitted during the data collection period that led to at least one CMS-HCC assignment.

The following charts, Exhibits 4, 5, and 6, show how three scenarios would work under the extrapolation methodology outlined by the “request for comment” for each of the main publicly traded companies offering Medicare Advantage products. The key assumption is the overall error rate. We selected 6%, 10% and 14% for our scenarios based on our guess at a worst-likely case (14%) and the rate at which the standard errors started negating most of the material impact (6%), and the midpoint (10%). Our 14% worst-likely case is based on the audit results from 2004 that had a higher error rate, but that targeted suspected HCCs and that did not have an active appeal process and that was the plans first experience in selecting records to be audited. We improved that rate to reflect a much lower missing record rate (since physician attestations are now allowed) and a somewhat improved coding error rate since the 2006 audits should have been a random sample to be extrapolated and should not have targeted suspected error codes. The audit results impact on EPS drops substantially as can be seen in the three scenarios when the error rate drops below about 6% for nearly all companies. This is primarily because of the use of a standard error at 99% confidence in the calculation extrapolation. We have not assumed any reserves for these audits; however, we are aware that some companies may have already reserved partially for these audits. We have also assumed one HCC per senior, but we tiered the error rate to reflect likely higher concentrations of HCCs in the higher risk score tiers. We did not adjust for seniors that may have no HCCs. While there are many other assumptions in this model, the most significant assumption is the error rate.

RADV Audits - Contender or Pretender?

Exhibit 4. HCC Coding Errors EPS Impact – 6% Overall Error Rate

Scenario Example Assumptions: Overall error rate 6% Error rate in 1st third 9% Error rate in 2nd third 6% Error rate in 3rd third 3% Median Value of discrepant HCC (10 most common disc. HCCs only) \$2,650										
	Actual Largest Medicare Contract in 2007 (members)	# of Medicare Advantage Contracts in 2007	Actual Total Medicare Advantage in 2010 (members)	Scenario Example Potential Payment Error (\$ in millions)	Scenario Calculated Estimate of Standard Error (\$ in millions)	Scenario Calculated Standard Error at 99% Confidence Interval Multiplier of 2.575 (\$ in millions)	Scenario Payment Recovery Sought (\$ in millions)	Scenario Estimate of Contract Fine Risk to EPS from Largest Contract Audit (\$ per share)	Scenario Estimate of Annual Restatement Risk to EPS from all MA members (\$ per share)	
Aetna	50,762	31	436,061	\$9.24	\$2.79	\$7.18	\$2.06	\$0.00	\$0.03	
CIGNA	31,439	1	145,655	\$5.72	\$1.73	\$4.45	\$1.27	\$0.00	\$0.01	
Coventry	282,824	15	224,359	\$51.49	\$15.54	\$40.03	\$11.46	\$0.05	\$0.04	
Health Net	105,135	8	279,511	\$19.14	\$5.78	\$14.88	\$4.26	\$0.03	\$0.07	
Health Spring	50,465	5	198,324	\$9.19	\$2.77	\$7.14	\$2.04	\$0.02	\$0.09	
Humana	607,985	29	1,763,195	\$110.68	\$33.42	\$86.05	\$24.64	\$0.09	\$0.27	
Triple-S	18,278	2	54,418	\$3.33	\$1.00	\$2.59	\$0.74	\$0.02	\$0.06	
UnitedHealth	342,775	88	2,091,928	\$62.40	\$18.84	\$48.51	\$13.89	\$0.01	\$0.05	
WellCare	72,118	9	116,074	\$13.13	\$3.96	\$10.21	\$2.92	\$0.04	\$0.07	
WellPoint	124,214	22	488,577	\$22.61	\$6.83	\$17.58	\$5.03	\$0.01	\$0.03	

Source: Wells Fargo Securities, LLC

Note: Total Medicare Advantage 2010 Membership as of December CMS data file

Exhibit 5. HCC Coding Errors EPS Impact – 10% Overall Error Rate

Scenario Example Assumptions: Overall error rate 10% Error rate in 1st third 15% Error rate in 2nd third 10% Error rate in 3rd third 5% Median Value of discrepant HCC (10 most common disc. HCCs only) \$2,650										
	Actual Largest Medicare Contract in 2007 (members)	# of Medicare Advantage Contracts in 2007	Actual Total Medicare Advantage in 2010 (members)	Scenario Example Potential Payment Error (\$ in millions)	Scenario Calculated Estimate of Standard Error (\$ in millions)	Scenario Calculated Standard Error at 99% Confidence Interval Multiplier of 2.575 (\$ in millions)	Scenario Payment Recovery Sought (\$ in millions)	Scenario Estimate of Contract Fine Risk to EPS from Largest Contract Audit (\$ per share)	Scenario Estimate of Annual Restatement Risk to EPS from all MA members (\$ per share)	
Aetna	50,762	31	436,061	\$15.17	\$3.59	\$9.23	\$5.94	\$0.01	\$0.08	
CIGNA	31,439	1	145,655	\$9.40	\$2.22	\$5.72	\$3.68	\$0.01	\$0.04	
Coventry	282,824	15	224,359	\$84.54	\$19.98	\$51.44	\$33.10	\$0.14	\$0.11	
Health Net	105,135	8	279,511	\$31.43	\$7.43	\$19.12	\$12.30	\$0.08	\$0.20	
Health Spring	50,465	5	198,324	\$15.08	\$3.56	\$9.18	\$5.91	\$0.07	\$0.26	
Humana	607,985	29	1,763,195	\$181.73	\$42.94	\$110.58	\$71.15	\$0.27	\$0.77	
Triple-S	18,278	2	54,418	\$5.46	\$1.29	\$3.22	\$2.14	\$0.06	\$0.17	
UnitedHealth	342,775	88	2,091,928	\$102.46	\$24.21	\$62.34	\$40.11	\$0.02	\$0.14	
WellCare	72,118	9	116,074	\$21.56	\$5.09	\$13.12	\$8.44	\$0.13	\$0.21	
WellPoint	124,214	22	488,577	\$37.13	\$8.77	\$22.59	\$14.54	\$0.02	\$0.09	

Source: Wells Fargo Securities, LLC

Note: Total Medicare Advantage 2010 Membership as of December CMS data file

Exhibit 6. HCC Coding Errors EPS Impact – 14% Overall Error Rate

Scenario Example Assumptions: Overall error rate 14% Error rate in 1st third 21% Error rate in 2nd third 14% Error rate in 3rd third 7% Median Value of discrepant HCC (10 most common disc. HCCs only) \$2,650										
	Actual Largest Medicare Contract in 2007 (members)	# of Medicare Advantage Contracts in 2007	Actual Total Medicare Advantage in 2010 (members)	Scenario Example Potential Payment Error (\$ in millions)	Scenario Calculated Estimate of Standard Error (\$ in millions)	Scenario Calculated Standard Error at 99% Confidence Interval Multiplier of 2.575 (\$ in millions)	Scenario Payment Recovery Sought (\$ in millions)	Scenario Estimate of Contract Fine Risk to EPS from Largest Contract Audit (\$ per share)	Scenario Estimate of Annual Restatement Risk to EPS from all MA members (\$ per share)	
Aetna	50,762	31	436,061	\$21.45	\$4.18	\$10.77	\$10.68	\$0.02	\$0.14	
CIGNA	31,439	1	145,655	\$13.29	\$2.59	\$6.67	\$6.61	\$0.02	\$0.08	
Coventry	282,824	15	224,359	\$119.52	\$23.31	\$60.03	\$59.49	\$0.25	\$0.20	
Health Net	105,135	8	279,511	\$44.43	\$8.67	\$22.31	\$22.11	\$0.14	\$0.36	
Health Spring	50,465	5	198,324	\$21.33	\$4.16	\$10.71	\$10.61	\$0.12	\$0.47	
Humana	607,985	29	1,763,195	\$256.93	\$50.11	\$129.05	\$127.88	\$0.48	\$1.38	
Triple-S	18,278	2	54,418	\$7.72	\$1.51	\$3.88	\$3.84	\$0.10	\$0.31	
UnitedHealth	342,775	88	2,091,928	\$144.85	\$28.25	\$72.75	\$72.10	\$0.04	\$0.25	
WellCare	72,118	9	116,074	\$30.48	\$5.94	\$15.31	\$15.17	\$0.23	\$0.37	
WellPoint	124,214	22	488,577	\$52.49	\$10.24	\$26.36	\$26.13	\$0.04	\$0.17	

Source: Wells Fargo Securities, LLC

Note: Total Medicare Advantage 2010 Membership as of December CMS data file

A second topic to discuss, regarding the size of potential fines, is the revelation of a False Claims Act settlement which appeared linked in a trade newsletter to comments by an industry consultant that a large fine might result to a publicly traded managed care plan from RADV audits. We are not aware of any settlements pending with any of the publicly traded managed care plans, but most have disclosed in their 10Ks and 10Qs that there is some risk of a material adverse result from the RADV audits for over a year now. The above analysis reveals that many plans could have a material issue from the audits. However, we believe it is also instructive to look

at the settlement that brought out the discussion. We believe that settlement was another reason the group has been under some pressure. However, we believe this case is not indicative of the relative magnitude of a fine that would potentially face the insurers for the “typical” RADV audit since this case involved alleged fraud and physician ownership. The settlement was between Dr. Walter Janke, his wife, Lalita Janke, and Vero Beach, Fla.-based Medical Resources LLC, who have agreed with the Justice Department to pay \$22.6 million to resolve claims that they inflated Medicare diagnosis codes. This settlement was announced November 24, 2010, and we believe the group has been trading “softly” since this announcement.

The Jankes were the owners of America’s Health Choice Medical Plans Inc. (AHC), a Medicare Advantage plan. The Jankes also own Medical Resources, which was AHC’s primary care provider. The agreement resolves a lawsuit brought by the United States in the U.S. District Court for the Southern District of Florida that alleged that the Jankes and Medical Resources violated the False Claims Act by causing AHC to falsely increase the severity of beneficiary diagnoses to obtain higher Medicare payments. This alleged fraud occurred because the plan was paid more for coding done by the plan’s owners who were also the physicians. This would not be the same case for publicly traded health plans since the physicians that are doing the coding would not directly benefit from inflating the diagnoses (although they could benefit from inflating claims, which health plans attempt to minimize with fraud prevention and detection).

This case has been linked to the RADV audits, and we believe, based on a reading of the complaint, that a RADV audit was conducted on AHC by CMS. However, we note that this was a somewhat distinct audit since it was based on 2005 plan year data for 2006 plan year payments, which is the period between the 2004 pilot audits and the more recent 2006 audits that were more widespread with the publicly traded health insurers. In this case, the audit was of 193 beneficiaries and it revealed that of 550 assigned HCCs, 61% (or 335) could not be substantiated. We note this is nearly double the percentage of unsubstantiated claims found in the 2004 RADV pilot audits which targeted suspected diagnosis codes. A reading of the complaint against the Jankes reveals that CMS had in 2005, because of “long-standing quality of care concerns”, notified AHC that their Medicare Advantage contract would be terminated. This was before the audit, but the plan was allowed to stay open while the owners searched for a buyer. In determining the size of the potential problem, CMS found that AHC was paid \$3,015 for each beneficiary as a result of the unsubstantiated HCCs. This multiplied by the 9,456 beneficiaries resulted in an assumed overpayment of \$28.5 million. CMS found that AHC’s risk scores were 33% higher than other Florida Medicare Advantage plans and 27% higher than Medicare Advantage plans nationally. CMS also found that AHC beneficiaries had 65% more HCCs than other Florida Medicare Advantage plans and 45% more than all other Medicare Advantage plans per member. One additional aspect of the problem at AHC was that its systems, which were developed by their son, did not have the capability of deleting diagnosis codes known to be false. Furthermore, after independent reviews (at least one conducted by a potential buyer) found the codes used to reimburse AHC were not supported by the medical records, the Jankes did not report that to CMS or correct the data according to the complaint. The complaint alleges that retroactive “data sweeps” commissioned by the Jankes resulted in them filing for more HCC codes to correct the past errors of omission, however, they allegedly did not correct the “numerous errors” found of extra codes.

The original complaint against the Jankes was filed on February 10, 2009, and it included the information about the CMS audit. This suggests to us that audits of the 2006 year that uncovered alleged fraud, may have already been pursued and the current RADV conversation is more about the documentation errors that resulted in overpayments than about suspected fraud that caused overpayments. We believe the significant fine relative to the size of the Jankes plan has caused investors to fear similarly sized problems could exist in the publicly traded health plans. However, we note that the key difference is that in this settled case the physicians were also the owners of the health plans, which makes them direct beneficiaries of the alleged coding fraud. It would be harder for physicians that contract with the publicly traded health plans to realize similar profits from such a scheme; therefore, it is not likely that this sort of alleged fraud would exist. Therefore, while we believe the case has made investors more wary, it is not particularly representative of what is likely to happen with the publicly traded health insurers in our view.

How Can Health Plans Prevent the Problem From Affecting Future Earnings?

We believe plans can attempt to train physicians, use systems and procedures to code more accurately, use better logic and diligence in selecting records to be submitted for audit requests, and eventually to reserve and price for audit settlements that could find more physician errors in the future. We also believe some of the consulting firms that provide “revenue enhancement” type services will be more carefully monitored to make sure they are not getting paid for putting plans more at risk in RADV audits. But the amount of the reaction may depend on the amount of pressure from CMS to seek penalties for the audit results.

RADV Audits - Contender or Pretender?

This is where we believe the government has a problem in deciding what to do with the audit data. For us, it seems the problem starts with the physician. It is not necessarily the health plans' fault if physician records are incomplete. If the health plan knew of the problem with the medical records and that the risk scores assigned by CMS were wrong, they would have corrected the data and if needed, bid differently for the contract. Obviously, if the health plan has purposely inflated claim codes (perhaps, even fraudulently), then we would expect the government to show no sympathy and treat them like in the case of AHC described above. But ICD-9 coding is a complicated process and we believe there are frequent errors. Some of which are made in the original Medicare program as well. This leaves the traditional Medicare benchmarks and risk scores, that Medicare Advantage plan payments are based on, perhaps as incorrect as the rates being paid to the Medicare Advantage plans. Therefore, it seems selecting the Medicare Advantage plans as the only target of the data extrapolation as a half answer that penalizes the health plans, without resolving the greater problem in traditional Medicare. As an example of the complexity of getting physicians to do the right thing in coding (especially in the cases where the physicians may not be paid for it and it may raise physician practice costs to find the right codes), we have included below the text from a Humana newsletter website for physicians, Exhibit 7. It identifies the 10 most common problems that were identified by Humana, apparently from a RADV audit. In addition, we have included, Exhibit 1, the risk score impact per HCC code of these 10 most common problems identified by Humana.

Exhibit 7. Humana's 10 Most Common HCC Coding Errors

The Centers for Medicare & Medicaid Services (CMS) conducts medical record reviews each year to validate the accuracy of risk adjustment data and payments made to Medicare Advantage Organizations (MAOs). Risk adjustment data validation (RADV) ensures that appropriate payments have been made to MAOs. Humana participated in the 2007 national sample.

While collecting and reviewing the medical records for the RADV07 National Sample, Humana identified the most problematic Hierarchical Condition Category (HCC) codes. These HCCs were most likely to have validation problems and/or lack support in the associated medical record. The problematic HCCs and the common errors associated with them are listed below.

1. HCC105 - Vascular Disease

When documenting vascular diseases, physicians should be as specific as possible and document any pertinent signs or symptoms (pain; cramping or fatigue in the legs, buttocks or feet; cold feet, etc.) and/or radiological findings (X-rays, ultrasound/Doppler studies, angiography, etc.) which may further support the condition. This will allow the coder to determine the specific HCC within the vascular disease category, which includes peripheral vascular disease (PVD) (443.9), peripheral artery disease (PAD) (443.9), intermittent claudication (443.9), abdominal aortic aneurysm (AAA) (441.4) and deep vein thrombosis (DVT) (453.40). Also, physicians must document as legibly as possible; PVD may be mistaken for PUD (peptic ulcer disease), leading to incorrect coding as well as future clinical issues.

2. HCC16 - Diabetes w/Neurological Manifestations

Physicians must specifically document complications of diabetes mellitus (e.g. nephropathy, neuropathy, angiopathy, etc.) as "diabetic" or "due to diabetes" in order for these disease processes to be coded appropriately. Without this documentation, no cause-and-effect relationship can be assumed. The diabetes must be properly linked to the manifestation using terms such as "with," "due to" and "secondary to." For example, the medical record must state "diabetes with neuropathy" or "diabetic neuropathy."

3. HCC71 - Polyneuropathy

In order for this HCC to be validated, the medical record must specify a diagnosis of polyneuropathy. If the documentation simply says "neuropathy" without reference to a specific type, the appropriate code is neuropathy, unspecified (355.9). This also is true of other types of neuropathy, such as peripheral neuropathy (356.9) and peripheral autonomic neuropathy (337.9).

4. HCC82 - Unstable Angina/Acute Ischemic

Unstable angina is most often a sign of an impending myocardial infarction and requires emergency treatment and/or hospitalization. Therefore, it is not often used in an office setting. More likely, the stable angina (angina that is relieved with rest and/or medication) (413.9) or Prinzmetal's (variant) angina (413.1) is more appropriate. To avoid this error, the physician needs to be very specific when documenting angina.

5. HCC92 - Specified Heart Arrhythmias

If the physician does not specify the type of heart arrhythmia (e.g., atrial fibrillation, atrial flutter, sick sinus syndrome, severe or persistent sinus bradycardia, etc.) then it should be coded as cardiac (heart) dysrhythmia, unspecified (427.9).

6. HCC10 - Breast, Prostate, other Cancers (154 codes in this HCC)**7. HCC9 - Lymphatic, Head and Neck, other Cancers****(410 codes in this HCC)**

Both of these code series are for cancers that are current conditions. If the patient has a history of cancer, but there is no current evidence of an existing malignancy and no current treatment, the cancer should not be coded as a current condition. When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment directed to that site, and there is no evidence of any existing primary malignancy -- a code from personal history of malignant neoplasm (V10) should be used to indicate the former site of the malignancy. If the patient is still under active or current treatment for malignancy of primary site (i.e., radiation or chemotherapy), retain the code for malignancy of primary site.

8. HCC96 - Ischemic or Unspecified Stroke

This HCC should not be coded from a physician's office or progress note unless the documentation specifically states that the cerebral vascular accident (CVA) or stroke occurred during the office visit. An acute stroke is typically only coded during the initial episode of hospital care. In an office setting, it is more likely that the patient is presenting for follow-up post-CVA. A "history of" or "late effect" HCC for CVA should be used (V12.54 history of CVA with no residual deficits). It also is important to document any deficits from the CVA. As a reminder, when coding, terms such as "weakness" is not the same as "hemiparesis." (Late effects of CVA with specific deficits is classifiable to use codes in category 430-437 and 438.9 to identify deficit.)

9. HCC108 - COPD

There are several conditions, which fall within the COPD group; some of those conditions include: chronic bronchitis, emphysema, chronic obstructive asthma. If these conditions are listed in addition to COPD the codes are as follows: Chronic bronchitis (491.20), emphysema (491.20), chronic obstructive asthma (493.20). If COPD is not listed then the correct codes are as follows: Chronic bronchitis (491.9), emphysema (492.8). In order to ensure accuracy of coding these chronic respiratory conditions, the physician is encouraged to document as specifically as possible.

10. HCC31 - Intestinal Obstruction

This HCC is intended for acute intestinal obstruction, including acute and chronic peptic ulcer with perforation, paralytic ileus, intussusception, impaction of intestine, peritonitis, etc. These conditions more commonly are seen in an acute care setting. In an office setting, it is more likely that a code for history of intestinal obstruction is appropriate. V12.79 is used for unspecified history of intestinal obstruction is appropriate. V12.79 is used for unspecified history of intestinal obstruction; other codes in the group are available for specificity, such as V12.71 for history of peptic ulcer disease. The appropriate code will vary depending on provider documentation.

Improving the accuracy of documentation and coding may speed up claims processing and facilitate reimbursement.

Source: Humana's "Your Practice" Q3 2009 and Wells Fargo Securities, LLC

Required Disclosures

To view price charts for all companies rated in this document, please go to

<https://www.wellsfargo.com/research> or write to

7 Saint Paul Street, 1st Floor, R1230-011, Baltimore, MD 21202

ATTN: Research Publications

Additional Information Available Upon Request

I certify that:

- 1) All views expressed in this research report accurately reflect my personal views about any and all of the subject securities or issuers discussed; and
- 2) No part of my compensation was, is, or will be, directly or indirectly, related to the specific recommendations or views expressed by me in this research report.

- Wells Fargo Securities, LLC maintains a market in the common stock of Aetna Inc., AMERIGROUP Corp., CIGNA Corp., Coventry Health Care, Inc., Health Net, Inc., Humana Inc., UnitedHealth Group Inc., WellPoint, Inc.
- Wells Fargo Securities, LLC or its affiliates managed or co-managed a public offering of securities for Aetna Inc., CIGNA Corp., UnitedHealth Group Inc., WellPoint, Inc. within the past 12 months.
- Wells Fargo Securities, LLC or its affiliates intends to seek or expects to receive compensation for investment banking services in the next three months from Aetna Inc., AMERIGROUP Corp., CIGNA Corp., Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Triple-S Management Corp., UnitedHealth Group Inc.
- Wells Fargo Securities, LLC or its affiliates received compensation for investment banking services from Aetna Inc., CIGNA Corp., UnitedHealth Group Inc., WellPoint, Inc. in the past 12 months.
- Aetna Inc., CIGNA Corp., UnitedHealth Group Inc., WellPoint, Inc. currently is, or during the 12-month period preceding the date of distribution of the research report was, a client of Wells Fargo Securities, LLC. Wells Fargo Securities, LLC provided investment banking services to Aetna Inc., CIGNA Corp., UnitedHealth Group Inc., WellPoint, Inc.
- Aetna Inc., AMERIGROUP Corp., CIGNA Corp., Health Net, Inc., UnitedHealth Group Inc. currently is, or during the 12-month period preceding the date of distribution of the research report was, a client of Wells Fargo Securities, LLC. Wells Fargo Securities, LLC provided noninvestment banking securities-related services to Aetna Inc., AMERIGROUP Corp., CIGNA Corp., Health Net, Inc., UnitedHealth Group Inc.
- Humana Inc., WellPoint, Inc. currently is, or during the 12-month period preceding the date of distribution of the research report was, a client of Wells Fargo Securities, LLC. Wells Fargo Securities, LLC provided nonsecurities services to Humana Inc., WellPoint, Inc.
- Wells Fargo Securities, LLC received compensation for products or services other than investment banking services from Aetna Inc., AMERIGROUP Corp., CIGNA Corp., Health Net, Inc., UnitedHealth Group Inc., WellPoint, Inc. in the past 12 months.
- Wells Fargo Securities, LLC or its affiliates may have a significant financial interest in Aetna Inc., AMERIGROUP Corp., CIGNA Corp., Coventry Health Care, Inc., Health Net, Inc., Humana Inc., Triple-S Management Corp., UnitedHealth Group Inc., WellCare Health Plans, Inc., WellPoint, Inc.

AET: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above commercial pricing, further enrollment or mix changes due to the weak economy, and further regulatory pressure on premium rate increases.

AGP: Key risks include strained state budgets possibly causing Medicaid rate increases to be below medical cost trend, continued valuation pressure on the group from health care reform, and higher than anticipated medical costs from the increasing medical complexity of the enrollees that AMERIGROUP covers.

CI: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above pricing, further enrollment or mix changes due to the weak economy, further regulatory pressure on premium rate increases, and balance sheet risk related to the company's run-off reinsurance business and the related commercial real estate portfolio. The company also has risk due to the turmoil in South Korea.

CVH: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above pricing, further enrollment or mix changes due to the weak economy, further regulatory pressure on premium rate increases, and relatively weaker market positioning in its key markets of Pittsburgh, St. Louis, and Florida.

GTS: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above commercial pricing, regulatory pressure on rate increases, the upcoming IT system conversion, and its single market focus.

HNT: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above commercial pricing, further enrollment or mix changes due to the weak economy, further regulatory pressure on premium rate increases, and relatively weaker market positioning in the competitive California and West Coast market.

HUM: Key risks include rate pressure and other changes in Medicare Advantage, margin contraction and continued valuation pressure from health care reform, potential loss of its TRICARE program, and to a lesser extent margin pressure from medical cost growth above commercial pricing, and regulatory pressure on commercial MLRs and premium rate increases.

UNH: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above premium growth, further enrollment or mix changes due to the weak economy, Risk Adjustment Data Validation audit results, and further regulatory pressure on premium rate increases.

WCG: Key risks include WellCare's ability to manage the rate pressure in the Medicare business, Medicaid rates (particularly in Florida and Georgia) in relation to cost trend and required benefits, margin contraction from medical cost growth, the expected Georgia Medicaid rebid in 2011, and continued valuation multiple pressure from health care reform.

WLP: Key risks include margin contraction and continued valuation pressure from health care reform, margin pressure from medical cost growth above commercial pricing, further enrollment or mix changes due to the weak economy, further regulatory pressure on premium rate increases, and potential missteps in the pending IT systems conversions.

Wells Fargo Securities, LLC does not compensate its research analysts based on specific investment banking transactions. Wells Fargo Securities, LLC's research analysts receive compensation that is based upon and impacted by the overall profitability and revenue of the firm, which includes, but is not limited to investment banking revenue.

STOCK RATING

1=Outperform: The stock appears attractively valued, and we believe the stock's total return will exceed that of the market over the next 12 months. BUY

2=Market Perform: The stock appears appropriately valued, and we believe the stock's total return will be in line with the market over the next 12 months. HOLD

3=Underperform: The stock appears overvalued, and we believe the stock's total return will be below the market over the next 12 months. SELL

SECTOR RATING

O=Overweight: Industry expected to outperform the relevant broad market benchmark over the next 12 months.

M=Market Weight: Industry expected to perform in-line with the relevant broad market benchmark over the next 12 months.

U=Underweight: Industry expected to underperform the relevant broad market benchmark over the next 12 months.

VOLATILITY RATING

V = A stock is defined as volatile if the stock price has fluctuated by +/-20% or greater in at least 8 of the past 24 months or if the analyst expects significant volatility. All IPO stocks are automatically rated volatile within the first 24 months of trading.

As of: January 6, 2011

45% of companies covered by Wells Fargo Securities, LLC Equity Research are rated Outperform.

Wells Fargo Securities, LLC has provided investment banking services for 43% of its Equity Research Outperform-rated companies.

53% of companies covered by Wells Fargo Securities, LLC Equity Research are rated Market Perform.

Wells Fargo Securities, LLC has provided investment banking services for 45% of its Equity Research Market Perform-rated companies.

3% of companies covered by Wells Fargo Securities, LLC Equity Research are rated Underperform.

Wells Fargo Securities, LLC has provided investment banking services for 42% of its Equity Research Underperform-rated companies.

Important Information for Non-U.S. Recipients

EEA – The securities and related financial instruments described herein may not be eligible for sale in all jurisdictions or to certain categories of investors. For recipients in the EEA, this report is distributed by Wells Fargo Securities International Limited (“WFSIL”). WFSIL is a U.K. incorporated investment firm authorized and regulated by the Financial Services Authority. For the purposes of Section 21 of the UK Financial Services and Markets Act 2000 (“the Act”), the content of this report has been approved by WFSIL a regulated person under the Act. WFSIL does not deal with retail clients as defined in the Markets in Financial Instruments Directive 2007. The FSA rules made under the Financial Services and Markets Act 2000 for the protection of retail clients will therefore not apply, nor will the Financial Services Compensation Scheme be available. This report is not intended for, and should not be relied upon by, retail clients.

Australia – Wells Fargo Securities, LLC is exempt from the requirements to hold an Australian financial services license in respect of the financial services it provides to wholesale clients in Australia. Wells Fargo Securities, LLC is regulated under U.S. laws which differ from Australian laws. Any offer or documentation provided to Australian recipients by Wells Fargo Securities, LLC in the course of providing the financial services will be prepared in accordance with the laws of the United States and not Australian laws.

Hong Kong – This report is issued and distributed in Hong Kong by Wells Fargo Securities Asia Limited (“WFSAL”), a Hong Kong incorporated investment firm licensed and regulated by the Securities and Futures Commission to carry on types 1, 4, 6 and 9 regulated activities (as defined in the Securities and Futures Ordinance, “the SFO”). This report is not intended for, and should not be relied on by, any person other than professional investors (as defined in the SFO). Any securities and related financial instruments described herein are not intended for sale, nor will be sold, to any person other than professional investors (as defined in the SFO).

Japan – This report is distributed in Japan by Wells Fargo Securities (Japan) Co., Ltd, registered with the Kanto Local Finance Bureau to conduct broking and dealing of type 1 and type 2 financial instruments and agency or intermediary service for entry into investment advisory or discretionary investment contracts. This report is intended for distribution only to professional customers (Tokutei Touseika) and is not intended for, and should not be relied upon by, ordinary customers (Ippan Touseika). The rating stated on the document is not a credit rating assigned by a rating agency registered with the Financial Services Agency of Japan but a rating assigned by a group company of a registered rating agency. The rating agency groups call respectively Fitch Ratings, Moody's Investors Services Inc or Standard & Poor's Rating Services. Any decision to invest in securities or transaction should be made after reviewing policies and methodologies used for assigning credit ratings and assumptions, significance and limitations of credit rating stated on the web site of rating agencies.

About Wells Fargo Securities, LLC

Wells Fargo Securities, LLC is a U.S. broker-dealer registered with the U.S. Securities and Exchange Commission and a member of the New York Stock Exchange, the Financial Industry Regulatory Authority and the Securities Investor Protection Corp.

This report is for your information only and is not an offer to sell, or a solicitation of an offer to buy, the securities or instruments named or described in this report. Interested parties are advised to contact the entity with which they deal, or the entity that provided this report to them, if they desire further information. The information in this report has been obtained or derived from sources believed by Wells Fargo Securities, LLC, to be reliable, but Wells Fargo Securities, LLC, does not represent that this information is accurate or complete. Any opinions or estimates contained in this report represent the judgment of Wells Fargo Securities, LLC, at this time, and are subject to change without notice. For the purposes of the U.K. Financial Services Authority's rules, this report constitutes impartial investment research. Each of Wells Fargo Securities, LLC, and Wells Fargo Securities International Limited is a separate legal entity and distinct from affiliated banks. Copyright © 2011 Wells Fargo Securities, LLC.

SECURITIES: NOT FDIC-INSURED/NOT BANK-GUARANTEED/MAY LOSE VALUE