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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION AT LOS ANGELES

UNITED STATES OF AMERICA ex rel.
Benjamin POEHLING

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., a
Delaware corporation; UNITED
HEALTHCARE SERVICES, INC., a
Minnesota corporation; UNITED
HEALTHCARE, INC., a Delaware
corporation; UNITEDHEALTHCARE
INSURANCE COMPANY, a Connecticut
corporation; UHIC HOLDINGS, INC., a
Delaware corporation; OVATIONS, INC., a
Delaware corporation; OPTUMINSIGHT,
INC., formerly known as INGENIX, INC., a
Delaware corporation; OPTUM, INC., a
Delaware corporation; AMERICHoice OF
NEW JERSEY, INC., a New Jersey
corporation; ARIZONA PHYSICIANS IPA,

Case No. 2:16-cv-08697 MWF (SS)

**CORRECTED SECOND
AMENDED COMPLAINT OF
PLAINTIFF-RELATOR
BENJAMIN POEHLING FOR
VIOLATIONS OF FALSE
CLAIMS ACT, 31 U.S.C. §§ 3729
ET SEQ.**

Constantine Cannon LLP

1 INC., an Arizona corporation; CARE
 2 IMPROVEMENT PLUS OF MARYLAND,
 3 INC., a Maryland corporation; CARE
 4 IMPROVEMENT PLUS OF TEXAS
 5 INSURANCE COMPANY, a Texas
 6 insurance company; CARE
 7 IMPROVEMENT PLUS SOUTH
 8 CENTRAL INSURANCE CO., an Arkansas
 9 insurance company; CARE
 10 IMPROVEMENT PLUS WISCONSIN
 11 INSURANCE COMPANY, a Wisconsin
 12 insurance company; CATAMARAN
 13 INSURANCE OF OHIO, INC., an Ohio
 14 corporation; CITRUS HEALTH CARE,
 15 INC., a Florida corporation; HEALTH PLAN
 16 OF NEVADA, INC., a Nevada corporation;
 17 MEDICA HEALTHCARE PLANS, INC., a
 18 Florida corporation; OXFORD HEALTH
 19 PLANS (CT), INC., a Connecticut
 20 corporation; OXFORD HEALTH PLANS
 21 (NJ), INC., also known as Oxford Health
 22 Plans of New Jersey, Inc., a New Jersey
 23 corporation; OXFORD HEALTH PLANS
 24 (NY), INC., a New York corporation;
 25 PACIFICARE LIFE AND HEALTH
 26 INSURANCE COMPANY, an Indiana
 27 insurance company; PACIFICARE OF
 28 ARIZONA, INC., an Arizona corporation;
 PACIFICARE OF COLORADO, INC., a
 Colorado corporation; PACIFICARE OF
 NEVADA, INC., also known as
 PacifiCare/UHC of Nevada, a Nevada
 corporation; PHYSICIANS HEALTH
 CHOICE OF TEXAS, LLC, a Texas limited
 liability company; PREFERRED CARE
 PARTNERS, INC., a Florida corporation;
 ROCKY MOUNTAIN HEALTH
 MAINTENANCE ORGANIZATION, INC.,
 a Colorado company; SIERRA HEALTH
 AND LIFE INSURANCE COMPANY,
 INC., a Nevada corporation; SYMPHONIX
 HEALTH INSURANCE, INC., an Illinois
 insurance company; UHC OF
 CALIFORNIA, INC., formerly known as
 PacifiCare of California, Inc. and PacifiCare
 of California/Secure Horizons, a California
 corporation; UNISON HEALTH PLAN OF
 TENNESSEE, INC., a Tennessee
 corporation; UNITED HEALTH CARE INS.
 CO. AND UNITED NEW YORK, a New
 York insurance company;
 UNITEDHEALTHCARE BENEFITS OF
 TEXAS, INC., formerly known as PacifiCare
 of Texas, Inc., a Texas corporation;
 UNITEDHEALTHCARE COMMUNITY
 PLAN OF OHIO, INC., formerly known as

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1 Unison Health Plan of Ohio, Inc., an Ohio
 2 corporation; UNITEDHEALTHCARE
 3 COMMUNITY PLAN OF TEXAS, L.L.C.,
 4 formerly known as Evercare of Texas, LLC, a
 5 Texas limited liability company;
 6 UNITEDHEALTHCARE COMMUNITY
 7 PLAN, INC., also known as Great Lakes
 8 Health Plan, Inc. and UnitedHealthcare of the
 9 Great Lakes Health Plan, Inc. a Michigan
 10 corporation; UNITEDHEALTHCARE
 11 INSURANCE COMPANY OF NEW YORK,
 12 also known as United Healthcare Insurance
 13 Company of New York, a New York
 14 insurance company;
 15 UNITEDHEALTHCARE INSURANCE
 16 COMPANY, also known as United
 17 Healthcare Insurance Company, a
 18 Connecticut insurance company;
 19 UNITEDHEALTHCARE OF ALABAMA,
 20 INC., an Alabama corporation;
 21 UNITEDHEALTHCARE OF ARIZONA,
 22 INC., an Arizona corporation;
 23 UNITEDHEALTHCARE OF ARKANSAS,
 24 INC., an Arkansas corporation;
 25 UNITEDHEALTHCARE OF FLORIDA,
 26 INC., also known as United Healthcare of
 27 Florida, Inc., a Florida corporation;
 28 UNITEDHEALTHCARE OF GEORGIA,
 INC., also known as United Healthcare of
 Georgia, Inc., a Georgia corporation;
 UNITEDHEALTHCARE OF NEW
 ENGLAND, INC., also known as United
 Health Plans of New England, Inc., a Rhode
 Island corporation; UNITEDHEALTHCARE
 OF NEW YORK, INC., also known as
 Americhoice of New York, Inc. and United
 Healthcare of New York, Inc., a New York
 corporation; UNITEDHEALTHCARE OF
 NORTH CAROLINA, INC., also known as
 United Healthcare of North Carolina, Inc., a
 North Carolina corporation;
 UNITEDHEALTHCARE OF OHIO, INC.,
 also known as United Healthcare of Ohio,
 Inc., an Ohio corporation;
 UNITEDHEALTHCARE OF OKLAHOMA,
 INC., formerly known as PacifiCare of
 Oklahoma, Inc., an Oklahoma corporation;
 UNITEDHEALTHCARE OF OREGON,
 INC., formerly known as PacifiCare of
 Oregon, Inc., an Oregon corporation;
 UNITEDHEALTHCARE OF
 PENNSYLVANIA, INC., formerly known as
 Unison Health Plan of Pennsylvania, Inc., a
 Pennsylvania corporation;
 UNITEDHEALTHCARE OF TENNESSEE,
 INC., also known as United Healthcare of

1 Tennessee, Inc., a Tennessee corporation;
 2 UNITEDHEALTHCARE OF THE
 3 MIDLANDS, INC., also known as United
 4 Healthcare of the Midlands, Inc., a Nebraska
 5 corporation; UNITEDHEALTHCARE OF
 6 THE MIDWEST, INC., also known as
 7 United Healthcare of the Midwest, Inc., a
 8 Missouri corporation;
 9 UNITEDHEALTHCARE OF UTAH, INC.,
 10 also known as United Healthcare of Utah,
 11 Inc., a Utah corporation;
 12 UNITEDHEALTHCARE OF
 13 WASHINGTON, INC., formerly known as
 14 PacifiCare of Washington, Inc., a
 15 Washington corporation;
 16 UNITEDHEALTHCARE OF WISCONSIN,
 17 INC., also known as United Healthcare of
 18 Wisconsin, Inc., a Wisconsin corporation;
 19 and, UNITEDHEALTHCARE PLAN OF
 20 THE RIVER VALLEY, INC., also known as
 21 United Healthcare Plan of the River Valley,
 22 Inc., an Illinois corporation.,

23 Defendants.

24 Pursuant to the March 15, 2017, Order on Corrected Notice of Election of the
 25 United States to Partially Intervene (Dkt. No. 93), and the July 19, 2017, notice by the
 26 Court (Dkt. No. 136), *qui tam* plaintiff Benjamin Poehling (“Relator”), through his
 27 attorneys, hereby submits this Corrected Second Amended Complaint, incorporating
 28 by reference the substantive False Claims Act allegations set forth in the Complaint in
 Intervention of the United States of America. Relator does not intend to pursue any
 claims other than those set forth in the Complaint in Intervention filed by the United
 States of America.

29 I. INTRODUCTION

30 1. This is an action to recover damages and civil penalties on behalf of the
 31 United States under the Federal False Claims Act, 31 U.S.C. §§ 3729–33 (the “FCA”),
 32 against UnitedHealth Group, Inc. and its affiliates and subsidiaries (“UHG,” “United,”
 33 or “Defendants”).

34 2. Defendants are now and have been, in some cases since at least 2006,
 35 engaged in a widespread scheme to knowingly submit, or cause to be submitted, false
 36 claims for payment to the United States by submitting false “risk adjustment”

1 information to the Centers for Medicare & Medicaid Services (“CMS”) in order to
2 improperly increase the amounts CMS pays them or their clients. Likewise,
3 Defendants have knowingly retained overpayments received from CMS as a result of
4 their false risk adjustment submissions.

5 3. The Medicare Advantage (“MA”) program is designed to apply to
6 Medicare a form of the “managed care” model commonly used by private health
7 insurance companies. Under the managed care model, an employer or other
8 organization seeking health care for its members—here the United States through the
9 Medicare Program—pays a managed care organization a fixed fee to provide health
10 services to its members. The payment is typically a per-member-per-month
11 (“PMPM”) rate, also known as a capitation rate. The managed care organization
12 receiving capitation payments (often a hospital, physician group, or other health
13 insurance company) is responsible for paying hospitals, physicians and all other
14 medical providers for health care services provided to the members of the plan. This
15 differs from traditional fee-for-service (“FFS”) models, where the organization pays
16 individual physicians, hospitals and other providers for each service they provide to
17 the organization’s members.

18 4. Through the MA program, Medicare allows private health insurers to set
19 up managed care plans to cover Medicare beneficiaries. Medicare pays a monthly
20 capitation rate for each beneficiary enrolled as a member of a MA plan. MA plans
21 must then use that money to pay hospitals, physicians and other health care providers
22 for the services the plan members receive and cover the plans’ administrative
23 expenses. Certain MA plans are also given money to pay for the plan members’
24 prescription drugs. Under both types of plans, CMS adjusts the capitation rate for
25 each beneficiary to reflect that beneficiary’s individual demographics (e.g., age and
26 gender), geographic location, and health status.

27 5. The adjustment for each member’s health status is one of the most
28 significant components of the capitation rate. Individuals with multiple and/or serious

1 health conditions account for more healthcare costs than healthy members.

2 Accordingly, CMS pays a substantially higher capitation rate for members who have
3 been recently treated for one or more serious, expensive diseases or conditions. These
4 increased payments are known as “risk adjustment” payments. On average, CMS
5 pays a MA plan close to \$3,000 per year for each condition that a member has that
6 requires a risk adjustment payment.

7 6. To receive these risk adjustment payments, MA plans submit claims to
8 CMS each year for each member for each qualifying disease or condition. When the
9 plan submits these claims, it must assert that the member received treatment in the
10 twelve-month period before the payment year for the diagnosed condition from a
11 qualified healthcare provider. MA organizations may only submit a diagnosis for risk
12 adjustment that: (1) stems from a face-to-face visit; (2) with a qualified healthcare
13 provider; (3) during the appropriate service period; and (4) is documented in a medical
14 record.

15 7. Defendants are engaged in systematic fraud in which they routinely:

16 a. “Upcode” risk adjustment claims by submitting claims for
17 diagnoses that the member does not have or for which the member was not
18 treated in the relevant year, or by claiming that a member was treated for a
19 more serious condition than the member actually has; and

20 b. Refuse to correct (and refuse to reimburse Medicare for)
21 previously submitted risk adjustment claims when defendants discover, or in the
22 exercise of reasonable care should discover, that those previously submitted
23 claims were false.

24 8. United (through its subsidiary Ingenix) is engaged in systematic fraud by
25 assisting and causing MA organizations to submit fraudulent risk adjustment claims,
26 and failing to correct (and reimburse Medicare) for previously submitted false claims.

27 9. Through this fraudulent scheme, defendants have defrauded the United
28 States of hundreds of millions—and likely billions—of dollars.

10. Defendants’ conduct alleged herein violates the federal False Claims Act. The federal False Claims Act (the “FCA”) was originally enacted during the Civil War. Congress substantially amended the Act in 1986—and, again, in 2009 and 2010—to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

11. The FCA prohibits, *inter alia*: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government; and (d) conspiring to violate any of these three sections of the FCA. 31 U.S.C. §§3729(a)(1)(A)-(C), and (G). Any person who violates the FCA is liable for a civil penalty of up to \$21,916 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. §3729(a)(1).

12. For purposes of the FCA, a person “knows” a claim is false if that person: “(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.” 31 U.S.C. §3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. *Id.*

1 Unless otherwise indicated, whenever the words “know,” “learn,” “discover” or similar
2 words indicating knowledge are used in this Complaint, they mean knowledge as
3 defined in the FCA.

4 13. Each claim for risk adjustment payments that defendants have submitted
5 or caused to be submitted to CMS, where the patient was not treated, by a qualified
6 provider, for that condition in the year in question, and/or the treatment and condition
7 are not properly documented in the medical record is a false and/or fraudulent claim
8 within the meaning of the FCA, so long as defendant knew that the claim was false
9 when it was submitted, or the defendant later discovered its falsity and refused to
10 correct the claim.

11 14. The FCA allows any person having information about an FCA violation
12 to bring an action on behalf of the United States, and to share in any recovery. The
13 FCA requires that the Complaint be filed under seal for a minimum of 60 days
14 (without service on the defendant during that time) to allow the government time to
15 conduct its own investigation and to determine whether to join the suit.

16 15. Based on the foregoing laws, *qui tam* plaintiff Benjamin Poehling seeks,
17 through this action, to recover damages and civil penalties arising from the false or
18 fraudulent records, statements and/or claims that the Defendants made or caused to be
19 made in connection with false and/or fraudulent claims for Medicare Advantage and
20 Medicare Part D risk adjustment payments.

21 **II. PARTIES**

22 **A. Plaintiffs**

23 16. Plaintiff-Relator Benjamin Poehling is an individual who, during the
24 relevant time period, was a resident of New Jersey until 2004, and subsequently a
25 resident of Minnesota. Poehling was hired by a division of UHG in 2002, having
26 previously performed consulting work for UHG while he was employed by Arthur
27 Andersen. At UHG and its divisions and subsidiaries, Relator held a variety of
28 positions, and had responsibilities including, without limitation, coordinating risk

1 adjustment services, described in depth below. Relator's employment with UHG
2 ended in December 2012.

3 17. The United States, on whose behalf Relator brings this suit, is the real
4 party in interest. The United States has ongoing contracts with defendants through
5 CMS, in accordance with defendants' participation in the Medicare and Medicaid
6 programs.

7 **B. Defendants**

8 18. Defendant UnitedHealth Group Inc. is a Delaware corporation
9 headquartered in Minnetonka, Minnesota. UnitedHealth Group, Inc. is the parent
10 corporation for a large number of businesses in two basic market areas. First,
11 UnitedHealthGroup, Inc. and its subsidiaries sell health insurance benefits including
12 Medicare Advantage plans. Second, UnitedHealthGroup, Inc. and its subsidiaries
13 provide various health care services to consumers and the health care industry,
14 including its own affiliated health benefits companies. For purposes of this
15 Complaint, "UHG" and "United" refers to and includes UnitedHealth Group, Inc.,
16 those entities identified below, all subsidiaries and affiliates that do business with the
17 United States, and all UHG entities holding Medicare Advantage contracts with CMS
18 during the relevant time period.

19 19. Defendant United HealthCare Services, Inc. is a Minnesota corporation
20 headquartered in Minnetonka, Minnesota, and is a direct subsidiary of UnitedHealth
21 Group, Inc.

22 20. Defendant UnitedHealthcare, Inc., is a Delaware corporation
23 headquartered in Minnetonka, Minnesota, and is a direct subsidiary of United
24 HealthCare Services, Inc.

25 21. Defendant UHIC Holdings, Inc., is a Delaware corporation, and is a
26 direct subsidiary of defendant United HealthCare Services, Inc. and an indirect
27 subsidiary of defendant UHG.
28

22. Defendant Ovation, Inc. is a Delaware corporation headquartered in Minnetonka, Minnesota, and is a direct subsidiary of United HealthCare Services, Inc.

23. Defendants Optum, Inc. and OptumInsight, Inc. are Delaware corporations headquartered in Eden Prairie, Minnesota, and are a direct subsidiaries of United HealthCare Services, Inc. Upon information and belief, OptumInsight, Inc. was formerly named Ingenix, Inc. and/or did business as Ingenix.

24. UHG operates Medicare Advantage plans in all fifty states and the District of Columbia. These managed healthcare insurance products, including UHG's Part C and D plan insurance products, are offered by it through various entities that are direct and indirect subsidiaries of UnitedHealth Group, Inc. These entities, defendants in this action, are listed on Attachment A to this complaint, which is incorporated herein by reference.

C. Defendants' Corporate Organization

25. United's health benefits business, UnitedHealthcare, sells health insurance benefits in both public and private markets. United's managed care division for the private sector is UnitedHealthcare Employer & Individual ("UHEI"). United's managed care divisions for the public sector—Medicare and Medicaid—are UHMR and UHCS. Together, UHMR and UHCS form United's Public & Senior Markets Group ("PSMG"). Within the health services business, now known as Optum, the principal divisions are or have been Ingenix, renamed OptumInsight, which provides data services and consulting; OptumHealth, which provides a variety of specialty and ancillary services (such as dental and chiropractic benefits as well as acquiring provider groups); and Prescription Solutions, now named OptumRx, a pharmacy benefits manager. UHG reports revenue in four segments: (a) UnitedHealthcare (UHEI, UHMR, and UHCS); (b) OptumHealth; (c) OptumInsight (formerly Ingenix); and (d) OptumRx (formerly Prescription Solutions).

26. United—through its UHMR and UHCS subsidiaries—is the largest provider of health insurance coverage for Medicare beneficiaries pursuant to MA

1 contracts with CMS. United operates MA plans in all fifty states and the District of
 2 Columbia as set forth in Paragraph 24. These MA plans and United's Part D plans
 3 covered millions of enrolled MA beneficiaries. In 2013 and 2014, United had
 4 approximately 3 million beneficiaries in its Part C plans and approximately 8 million
 5 in its Part D plans. In 2014, United's revenues from Parts C and D of the Medicare
 6 Program were approximately \$46 billion.

7 27. United's Ingenix division offers data and consulting services to United
 8 companies as well as other insurance companies, hospitals, physicians, and others.
 9 Ingenix's revenues were \$1.8 billion in 2009 and \$2.3 billion in 2010, by 2014
 10 Ingenix revenue has grown to over \$5.2 billion. (Ingenix was renamed as
 11 OptumInsight in 2011, but is referred to herein as Ingenix unless otherwise noted.)
 12 Historically, risk adjustment services were provided to UHMR through a team located
 13 within the UHMR business unit. In 2007, United moved its risk adjustment services
 14 group, or Clinical Assessment Solutions ("CAS"), to Ingenix. (CAS has changed
 15 titles several times. It has also operated as Advanced Clinical Solutions ("ACS"),
 16 Clinical Performance Solutions ("CPS"), and, currently, Clinical Performance &
 17 Compliance ("CPC").)

18 28. Ingenix provided chart review services to United entities and other
 19 parties, including but not limited to HealthNet. In addition, Ingenix submitted risk
 20 adjustment data to Medicare and shared the responsibility with other United entities
 21 for reporting invalid diagnoses to Medicare and returning overpayments to Medicare.

22 29. Between October 2006 and March 2017, Medicare Part C beneficiaries
 23 enrolled in UHG plans resided in the Central District of California for approximately
 24 24,302,000 "person-months." Each person-month equates to one month of a Part C
 25 beneficiary's enrollment in a United health plan.

III. JURISDICTION AND VENUE

30. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

31. This Court has personal jurisdiction over the Defendants, pursuant to 31 U.S.C. § 3732(a), as one or more Defendants can be found in, reside in, transact business in, and have committed acts related to the allegations in this Complaint in the Central District of California.

32. Venue is proper, pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)–(c), as the Defendants can be found in, reside in, and/or transact business in the Central District of California, and because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within this judicial district.

IV. LEGAL BACKGROUND

A. Medicare

33. Medicare is a federally-funded health care program primarily serving people age 65 or older. Initially created in Title XVIII of the Social Security Act of 1965, Medicare now has four Parts, A through D. The two original components of Medicare are Part A, which covers inpatient hospital costs and related services, and Part B, which covers outpatient health care costs, such as physicians' fees.

34. Traditionally, Medicare operates on a fee-for-service basis, meaning that Medicare directly pays hospitals, physicians and other health care providers for each service they provide to a Medicare beneficiary. Medicare beneficiaries are generally required to pay some portion of many of these services in the form of copayments, deductibles, coinsurance, or other set fees (collectively known as the members' "out of pocket" expenses).

35. In 1997, Congress created Medicare Part C, which provides similar benefits to Medicare members, but does so based on a managed care model, rather than the traditional fee-for-service model. Under Part C, rather than pay providers

1 directly, Medicare pays private managed care plans (later named “Medicare
2 Advantage” or “MA” plans) a capitation rate (per member per month) and those plans
3 are responsible for paying providers for the services they provide to members of that
4 specific MA plan.

5 36. MA plans must provide Medicare beneficiaries benefits at least
6 equivalent to those they would have received under the traditional Medicare Parts A
7 and B. Depending on the structure of the plan, MA plans may also provide additional
8 benefits beyond what traditional Medicare would have covered, such as dental care, or
9 cover some or all of their members’ out of pocket expenses associated with basic
10 Medicare Parts A and B services.

11 37. In 2003, Congress passed the Medicare Prescription Drug, Improvement,
12 and Modernization Act, creating Medicare Part D which provides prescription drug
13 coverage. Although a limited number of Medicare Part D plans are operated under a
14 cost-reimbursement contract, the plans are generally financed under a managed care
15 model. These managed care model plans are provided under both Part D prescription
16 drug plans, which offer only prescription drug coverage, and Part C plans, which
17 integrate the prescription drug coverage with the traditional Part C health care
18 coverage.

19 38. This Complaint refers, collectively, to Medicare Advantage plans with
20 and without Part D coverage, and stand-alone managed care Medicare Part D Plans as
21 “Medicare Advantage Plans” or “MA Plans.”

22 **B. Calculation of MA Plan Capitation Rates**

23 39. The capitation rates Medicare pays to MA plans are determined based on
24 a process involving consideration of past and expected future medical expenses, the
25 location of the plan’s actual and expected members, the health status and
26 demographics of those members and whether the plan will include any additional
27 benefits. That process is summarized in Medicare regulations as follows:
28

In short, under the bidding methodology each plan's bid for coverage of Part A and Part B benefits (i.e., its revenue requirements for offering original Medicare benefits) is compared to the plan benchmark (i.e., the upper limit of CMS' payment, developed from the county capitation rates in the local plan's service area or from the MA regional benchmarks for regional plans). The purpose of the bid-benchmark comparison is to determine whether the plan must offer supplemental benefits or must charge a basic beneficiary premium for A/B benefits.

Medicare Managed Care Manual ("MMCM"), ch. 8, § 60.

40. In other words, it is a three-step process involving: (a) development of the MA plan's bid rate; (b) review of the CMS benchmark rate; and (c) comparison of those two rates to develop the base capitation rate and determine whether any adjustments in the plan benefits or member premiums are required.

41. First, the MA plan develops a bid rate. This rate is the amount that the MA plan expects it will be required to pay to provide Medicare Parts A and B benefits to a hypothetical average member of the plan. This estimate must be based on either the MA plan's prior experience covering Medicare members, or an actuarially validated data analysis of expected costs. To represent an "average" plan member, the bid rate must make adjustments to standardize the effect of expected geographic diversity (because some areas are more expensive than others) and the relative health status (i.e., the number and nature of chronic conditions) of the members whose claims experience provided the basis for the bid. The bid rate also includes an amount that the MA plan expects to spend on administrative costs, and a profit margin.

42. The mechanism for standardizing the bid for individuals' demographic factors and health status is known as the "risk score." It is an artificial score that CMS assigns to every beneficiary. CMS starts with a score of zero, and then adds points for

1 the beneficiary's demographic condition (such as age and gender) and individual
2 disease states (such as diabetes or congestive heart failure). The average risk score is
3 one, with most Medicare beneficiaries having scores under three. The risk score
4 model is designed so that a population with an average risk score of two would be
5 expected to use twice as much health care (in dollars) as a population with a score of
6 one. The bid rate the MA plans develop must reflect the amount they will require to
7 provide services to a hypothetical population with a risk score of one.

8 43. Second, the MA plan must review the Medicare benchmark rate provided
9 by CMS. This rate is the amount that the Medicare program would spend to provide
10 Parts A and B benefits to an average member in the geographic area covered by the
11 MA plan's bid. The benchmark rate also includes several other adjustments, including
12 until recently a bonus payment to incentivize health insurance companies to enter the
13 MA market.

14 44. Third, the bid rate and the benchmark rate are compared to determine
15 whether the MA plan must charge its members a premium, or, instead, if it must offer
16 them enhanced benefits. If the bid rate is greater than the benchmark rate, Medicare
17 will only pay the MA plan the benchmark rate per member per month. That
18 benchmark rate becomes the base capitation rate that CMS pays the MA plan for a
19 member with a 1.0 risk score (described below). The MA plan must then charge the
20 beneficiaries who join its plan a monthly premium in order to make up the shortfall
21 between the bid rate and the base capitation rate. *See* MMCM, ch. 8, § 60.1.

22 45. If, on the other hand, the bid rate is less than the benchmark rate, then the
23 bid rate becomes the base capitation rate. The difference between the benchmark rate
24 and the bid rate is then split between the MA plan and the Medicare program. The
25 first 25% of the difference is retained by the Medicare program as plan savings. The
26 remaining 75% is returned to the MA plan, which must use the rebate to either provide
27 enhanced benefits to its plan members or to cover the members' out of pocket
28 expenses. In the end, then, in such situations, the base capitation rate equals the bid

1 rate, plus the MA plan receives 75% of the difference between the bid rate and the
2 benchmark rate.

3 46. Medicare does not, however, pay the plans the base capitation rate.
4 Instead, when payments are actually made, the base capitation rate is adjusted, for
5 each member, to reflect his or her actual age, gender, location, and, most important,
6 health status.

7 47. MA plans must rebid their rates every year.

8 **C. Calculation of Part D Plan Capitation Rates**

9 48. The process of calculating the capitation rates for the Part D portion of
10 MA plans is very similar to the process used for the base portion of the MA rate.
11 Annually, the plan develops and submits a bid rate based on the plan's estimate of the
12 monthly revenue requirements it will require to provide qualified prescription drug
13 coverage for an average, eligible individual. 42 C.F.R. § 423.265(c). As for the base
14 MA rate, a Medicare prescription drug coverage plan's average monthly bid rate is
15 adjusted to take into account the geographic differences in pricing and the relative
16 health status of the members on whom the bid calculation was based.

17 49. The risk score calculations for the Medicare Part D portion of the plans
18 mirror the calculation for the basic MA rate, determined by each beneficiary's
19 demographic information and health status. Each plan's bid must reflect the revenue
20 the plan will require to provide services to a population of "average" members, i.e.,
21 those with a risk score equal to one.

22 **D. Risk Adjustment Depends on Accurate, Substantiated Health**
23 **Condition Codes**

24 50. As described above, CMS pays MA plans at a capitation rate that reflects,
25 among other things, each member's health status. The process of adjusting the
26 capitation rate to reflect a member's disease states is known as risk adjustment. Risk
27 adjustment is intended to improve the accuracy of the payments CMS makes to these
28 plans. To this end, CMS pays a higher future premium for enrollees whom the MA

1 plan represents have been treated for certain diseases and conditions in the current
 2 year, based on the expectation that those enrollees will require treatment and/or
 3 management for the conditions in the following year. *See 2008 Risk Adjustment*
 4 *Training for Medicare Advantage Organizations Participant Guide* (“*Participant*
 5 *Guide*”), at 6.4.1 (for purposes of this Complaint, “treatment” is defined as treatment
 6 and management within the meaning of the *Participant Guide*).

7 51. Conversely, CMS pays a lower premium for enrollees who, although they
 8 may have certain typically expensive conditions, did not require care, treatment or
 9 management for those conditions in the current year. For these patients, the risk
 10 adjustment methodology assumes that because their condition did not require
 11 treatment in the current year, it has improved or otherwise changed so that it is not
 12 expected to require treatment in the following year.

13 52. As a practical matter, the CMS risk adjustment model evaluates enrollee
 14 health (and establishes risk adjustment payment rates) using diagnosis classifications
 15 set forth in the International Classification of Diseases, 9th Edition, Clinical
 16 Modification (“ICD-9-CM”) system. The ICD-9 system assigns each diagnosis a
 17 specific code. Under the MA model, these individual diagnosis codes are then
 18 organized into groups, called Hierarchical Condition Categories (“HCCs”). MMCM,
 19 ch. 8, § 50. (All HCC numbers and titles referenced in this complaint are in keeping
 20 with the CMS V12 model used between 2004 and 2013. In 2014, CMS began using
 21 the V22 model, which changed several of the HCC numbers and titles.) Every HCC
 22 consists of several ICD-9-CM diagnosis codes that are clinically related and are
 23 expected to require a similar level of resources to treat. *Id.* For example, there are
 24 five HCCs for patients with diabetes: HCC 15 (diabetes with renal or vascular
 25 manifestation); HCC 16 (Diabetes with Neurologic or Other Specified Manifestation);
 26 HCC 17 (Diabetes with Acute Complications); HCC 18 (Diabetes with
 27 Ophthalmologic or Unspecified Manifestation); and HCC 19 (Diabetes without
 28 Complication). Generally speaking, patients grouped in HCC 15 have the most

1 serious manifestations associated to their diabetes, and are expected to cost the most to
 2 treat. Patients in HCC 19 have the least cost-intensive type of diabetes, and therefore
 3 the CMS risk adjustment system provides a smaller enhanced payment for these
 4 patients.

5 53. CMS has used the same model for the Part D portion of risk adjustment.
 6 However, because certain diagnoses will be expected to increase liability for
 7 prescription drugs covered under Part D, but not hospital costs and physician fees
 8 covered under Part C, and vice versa, a distinct list of Hierarchical Condition
 9 Categories (“RxHCCs”) with corresponding diagnosis codes was created for
 10 Medicare’s Part D risk adjustment. See Participant Guide at 8.2.5.2. For example,
 11 RxHCC 75 represents Attention Deficit Disorder, a condition predicted to increase
 12 drug spending. However, because Attention Deficit Disorder is unlikely to result in
 13 hospitalization, RxHCC 75 has no corresponding HCC. On the other hand, HCC 77,
 14 Respirator Dependence/ Trachostomy Status, a condition category predictive of
 15 Medicare Part C medical costs, but not necessarily predictive of Part D drug expenses,
 16 has no RxHCC equivalent.

17 54. Although the HCC and RxHCC systems are not identical, they do have
 18 significant overlap. Certain HCCs have equivalent RxHCCs, meaning that the
 19 condition categories consist of identical ICD-9-CM diagnosis codes. For example,
 20 HCC 5 (Opportunistic Infections) is equivalent to RxHCC 2 (Opportunistic
 21 Infections), and HCC 37 (Bone/Joint/Muscle Infections/Necrosis) is the equivalent of
 22 RxHCC 39 (Bone/Joint/Muscle Infections/Necrosis). Even where they are not
 23 identical, most HCCs overlap with one or more RxHCCs. For example, of the thirty-
 24 seven diagnosis codes that fall within HCC 45 (Disorders of Immunity), twenty-seven
 25 fall within RxHCC 52 (Disorders of Immunity), seven fall within RxHCC 51 (Severe
 26 Hematological Disorders), and three do not fall within any RxHCCs. Thus, the
 27 majority of ICD-9-CM diagnosis codes that capture an HCC will also capture an
 28 RxHCC.

1 55. An individual ICD-9-CM code included in the HCC system for a
 2 particular member corresponds on average to nearly \$3,000 in extra revenue for the
 3 plan over the course of the following year for that member. So, for example, if a MA
 4 plan like United with 2.1 million members submitted just one incremental HCC-based
 5 diagnosis code per member to CMS, it would result in approximately \$6.3 billion in
 6 additional capitation payments from CMS.

7 56. Because submitting incorrect diagnosis codes increases risk adjustment
 8 payments, CMS requires MA plans to follow strict guidelines when submitting codes.
 9 *See, e.g., 2008 Risk Adjustment Training for Medicare Advantage Organizations*
 10 *Participant Guide*.

11 57. CMS requires that the patient must have been treated for the relevant
 12 diagnoses during a face-to-face encounter with an eligible provider, such as a
 13 physician, physician extender, or hospital, during the year in question.

14 58. Only services provided by an eligible provider type may be included.
 15 CMS expressly prohibits MA plans from submitting “risk adjustment diagnoses based
 16 on any diagnostic radiology services” or laboratory services. *Participant Guide*, at
 17 3.2.2, 4-3. The reason CMS prohibits MA plans from submitting codes based on
 18 radiology charts, for example, is that “[d]iagnostic radiologists typically *do not*
 19 *document confirmed diagnoses*. Confirmed diagnoses come from referring physician
 20 or physician extenders.” *Id.*, at 4-3 (emphasis added). Because radiologists generally
 21 list on their charts the diagnoses a doctor wants them to look for, not which diagnoses
 22 the patient actually has, CMS excludes radiology services as a valid provider type
 23 (i.e., source of risk adjustment data).

24 59. The treating provider must document the facts supporting the coded
 25 diagnosis in the patient’s medical record and sign and date the record. At a minimum,
 26 the plan must record five elements for submission to CMS:

- 27 a. the member’s Health Insurance Claim (“HIC”) number;
- 28 b. the ICD-9-CM diagnosis code;

- c. the “service from” date;
- d. the “service through” date; and
- e. the provider type.

60. MA plans are responsible for the content of risk adjustment data submissions to CMS, regardless of whether they submit the data themselves or through an intermediary. *Participant Guide*, at 3-13. Before submitting data to CMS, MA plans are required to filter the data “to ensure that they submit data from only appropriate data sources.” *Participant Guide*, at 4-11. For example, filters should include checking that physician data comes from face-to-face encounters with patients and ensuring that data does not come from non-covered providers, such as diagnostic radiology services.

61. MA plans that filter risk adjustment claims by CPT codes must also filter the data to ensure that only diagnoses treated through approved procedure types are included. *Id.* at 4-11. MA organizations typically classify professional (*e.g.*, physician) procedures using Current Procedural Terminology (“CPT”) codes and institutional procedures using revenue codes. These codes show whether the type of service in question was a face-to-face procedure such as a physical examination, or a non-qualifying remote procedure, such as a laboratory test or radiology exam.

62. MA plans are required to correct the risk adjustment data they submit to CMS. When the MA plan learns that information in a risk adjustment claim (*i.e.*, HIC number, diagnosis code, service dates, and provider type) contains an error, it must submit a “delete record” to CMS for that claim.

63. CMS also requires that diagnosis codes used as the basis for a risk adjustment claim be substantiated through documentation in a medical record. Upon request by CMS, MA plans must provide documentation to support each diagnosis and substantiate that the provider followed proper coding guidelines. *Id.* at 6-5; 5-52.

64. In general, CMS sets risk scores based on risk adjustment data submitted for services provided during the year preceding the payment year. 42 C.F.R. §§

1 422.310(g), 423.329(b)(3). The annual deadline for submitting risk adjustment data to
 2 CMS is in early September. *Id.* The data submitted by the September deadline
 3 determines members' preliminary risk scores for the following year.

4 65. Despite the September deadline, CMS accepts submissions of risk
 5 adjustment data for a period after the end of service year and, through a reconciliation
 6 process, adjusts its payments to the MA plan retroactively to account for codes
 7 submitted after the September deadline. MA plans are allowed to submit risk
 8 adjustment data until after the end of the payment year. After the payment year ends,
 9 CMS recalculates the risk score for any members for whom the MA plan made a
 10 retroactive submission.

11 66. Thus, for example, the capitation rates for 2010 are based on the MA
 12 plans' members' health status (diagnosis codes) from 2009. The initial submission
 13 deadline for the 2009 diagnosis codes was September 4, 2009, and the final
 14 submission deadline was January 31, 2011. Thus, CMS calculated members' initial
 15 risk factors for 2010 based on the September 4, 2009 data, but MA plans were allowed
 16 to continue to submit 2009 diagnoses until January 31, 2011. After that date, for
 17 every member with a newly-submitted diagnosis, CMS recalculated the risk score and
 18 reconciled the member's payments in 2010 with the amount it would have paid at the
 19 new score.

20 67. To test the validity of MA plan risk adjustment data, CMS conducts Risk
 21 Adjustment Data Validation ("RADV") audits after the MA plan's final deadline for
 22 submitting risk adjustment data for the payment year. During such audits, CMS
 23 "validates" some of the MA plan's HCC scores by reviewing the medical records that
 24 the plan contends support the claimed diagnosis codes. *Id.* at 7-1. To facilitate the
 25 RADV audits, MA plans are required to submit to CMS medical records and
 26 coversheets for each sampled enrollee, including the "one best medical record"
 27 supporting each HCC. *Id.* at 7-9.

68. Historically, CMS has not extrapolated RADV audit results to the plan as a whole. (CMS has recently proposed moving toward extrapolation of RADV results.) Instead, CMS has merely sought repayment for those risk adjustment claims found to be false during the RADV audit. Because RADV audits generally used relatively small samples—a few hundred risk adjustment claims—the potential risk to MA plans, should they be found to have submitted false risk adjustment claims, has been relatively small. Without meaningful financial penalties, MA organizations have generally seen little incentive to conform to CMS’s risk adjustment rules. The fraudulent practices described in this Complaint are a product of the belief, common among MA organizations, that the law could be violated without meaningful consequence.

E. CMS Requires MA Plans To Certify the Validity of Their Bid Rates and Risk Adjustment Data To Prevent Fraud

69. In recognition of the fact that the integrity of the capitation rates depends on the integrity of the actuarial information used by the MA plans in developing their bid rates, and to otherwise guard against fraud, CMS requires MA organizations to submit three separate attestations, each signed by the CEO or CFO (or their authorized, direct subordinate). These attestations are a condition that the MA plans must meet to be eligible to receive any capitation payments from CMS.

70. The first attestation, which the MA organization submits on a monthly basis, requires the MA organization to “attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization.”

71. The second attestation, which is submitted annually, requires the MA organization to attest that the risk adjustment data it submits annually to CMS is “accurate, complete, and truthful.” The attestation acknowledges that risk adjustment information “directly affects the calculation of CMS payments . . . and that

misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.” The regulations also provide that if the claims data are generated by a “related entity, contractor, or subcontractor of an MA organization,” that entity must similarly certify the “accuracy, completeness, and truthfulness of the data.” 42 C.F.R. §422.504(l)(2).

72. The third attestation is the MA organization’s certification “that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposal bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposal bid submission.”

73. MA organizations must also submit bid submission attestations, certifying “that the information in its bid submission and assumptions related to projected reinsurance and low income cost sharing subsidies is accurate, complete, and truthful and fully conforms to the [bid submission regulations].”

F. The False Claims Act Contains a Duty to Correct Known Errors

74. The False Claims Act contains an independent requirement to correct errors that will cause, or have caused, a government overpayment. The Act attaches liability to anyone who knowingly makes, uses, or causes to be made or used, a false statement or record material to an obligation to pay or transmit money to the government, or who knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money to the government. 31 U.S.C. § 3729(a)(1)(G).

75. Accordingly, MA plans not only have a duty not to submit incorrect data to CMS, but also, for data they have already submitted, must delete the records from CMS’s database using a “delete code.”

V. UNITEDHEALTH GROUP

76. United is the largest provider of MA plans nationwide, covering benefits under Medicare Parts C and D in all fifty states and in most U.S. territories. United had 6.8 million individuals enrolled in its MA plans (Part C and Part D) at the end of 2010. The MA plans are operated by UHMR and UHCS and offered to Medicare beneficiaries under such brand names as, for example, SecureHorizons, AmeriChoice, Evercare, AARP MedicareRx and UnitedHealth Rx.

77. United has expanded rapidly since its founding in 1977. The company's growth in recent years has been driven by acquisitions, nowhere more so than in its Medicare business. These acquisitions included the 2004 purchase of Oxford Health Plans, the 2005 acquisition of PacifiCare Health Systems, and the 2007 acquisition of Sierra Health Services, Inc.

78. Recently, United has also been expanding vertically by acquiring provider groups who care for many of the patients in United's MA plans. Foremost among these purchases was the 2011 purchase of WellMed, a large physician-owned practice management company located primarily in Texas.

79. United has organized its businesses into two primary segments: health plans and health services, as described above. See ¶¶25-28. Within the health services segment, Ingenix provides risk adjustment services (and other services) to United's MA plans and also sells those same services commercially to other MA plans.

80. Ingenix submits or previously submitted diagnosis codes for risk adjustment to CMS on behalf of UHMR and UHCS as well as on behalf of commercial clients including, for example, Health Net, Arcadian, Tufts, and Medica. United relocated its risk adjustment team from UHMR to Ingenix to enable these commercial deals, as well as to allow UHMR and UHCS to charge their risk adjustment costs with markups to CMS on their annual bids. This risk adjustment team was based in Orange County, California.

81. At every level, United is driven by a corporate culture that demands and rewards financial success from its employees. The risk adjustment practices described in this Complaint are attributable in large part to these demands and rewards. As to demands, United evaluated many of its employees, including Relator, until recently on their success at “maximizing revenue” by increasing risk scores. United gave Relator as well as clinical staff specific goals for increasing risk scores. Relator’s March 30, 2008 review, for example, evaluated him against United’s “business goal” of increasing risk scores by 3%. There were no similar performance goals for the overall accuracy of risk adjustment submissions. Nor was there any accountability assigned for reducing the number of false claims submitted to CMS.

82. For rewards, United tied its performance incentives directly to risk score increases. These incentives have been at the center of United’s risk adjustment practices. Relator, for example, received a \$15,000 bonus in 2010 for his work to meet UHMR’s target of \$100 million in additional internal operating income (“IOI”) from risk adjustment payments. His bonus, however, paled in comparison to the incentives offered to those higher up in the company. Optum CEO (and former CEO of UHMR) Larry Renfro received a compensation package in 2010 that included a potential bonus, called a “cash incentive award,” which tied his earnings to revenue, IOI, and provider satisfaction. Increasing risk scores met all three objectives. Mr. Renfro’s 2010 cash incentive award was \$900,000—150% of his bonus target. In 2011, Mr. Renfro received a \$1.4 million cash incentive award, which was made in consideration of his “successful execution of a major multi-track Medicare remediation initiative,” of which increasing United’s risk score was a substantial component.

83. During Mr. Renfro’s term as UHMR’s CEO, UHMR set revenue and IOI targets based on risk adjustment and entered into agreements with providers that offered financial rewards for increasing risk scores. As discussed below, many of the policies and practices United used to achieve these goals were fraudulent. Despite

1 misgivings expressed by various United personnel, however, United took no action to
2 stop its misconduct. Lack of independence contributed to the problem. For example,
3 PSMG's Chief Compliance Officer, David Orbuch, reported not to the Board of
4 Directors, but to Mr. Renfro.

5 84. United aligned the incentives of its entities, staff, and vendors to increase
6 risk scores. Ingenix had an incentive to increase the number of risk adjustment claims
7 (based on incremental/newly-found diagnosis codes) it submitted to CMS for payment
8 under the terms of its Service Level Agreement with UHMR. The Agreement
9 provided for base payments plus a significant "incentive fee" tied to risk score
10 increases. Exhibit 1, incorporated herein.

11 85. In 2009, United changed to a more fixed-fee arrangement with Ingenix.
12 Ingenix, however, continues to receive incentive fees based on risk score increases
13 from at least one of its commercial clients, Health Net.

14 86. In addition, the managers responsible for Ingenix's Orange County based
15 risk adjustment program (now called CPC), including Jeff Dumcum, Paul Bihm, and
16 Stephanie Will, had employment agreements with United that included financial
17 incentives based on increased risk scores. Furthermore, United gave incentives to its
18 healthcare providers and vendors. As described below, for example, United
19 (PacifiCare at the time) entered into an agreement with WellMed, such that
20 WellMed's data subsidiary, DataRap, would provide risk adjustment services for a
21 subset of United's MA plan in Dallas, Texas. The agreement paid WellMed a fee
22 based almost entirely on the increase in United's risk score year over year.

23 87. United's senior management push relentlessly to increase United's
24 revenue from risk adjustment. Tellingly, UHMR has assigned risk adjustment to its
25 Finance Department, not one of its clinical departments. (Relator was assigned to his
26 job despite having no clinical background.) In 2010 and 2011, UHMR has
27 implemented projects referred to as "remediation plans", "focus area projects," or
28 "affordability agendas" to increase IOI.

1 88. The remediation plan for 2010 called for \$800 million in additional IOI,
2 \$100 million of which was to come from increased risk adjustment revenue. In 2011,
3 the additional IOI target from risk adjustment rose to approximately \$125 million.

4 89. While speaking at the Citi 2011 Global Healthcare Investor conference
5 on March 2, 2011, UHMR's CEO, Tom Paul, commented that United's 2010
6 affordability agenda allowed United to not raise premiums or cut benefits, while still
7 achieving business objectives. He went on to say the affordability agenda will
8 continue in 2011 and beyond. These remediation plans are merely United's latest
9 effort to exploit risk adjustment's large revenue potential. As described below, United
10 has engaged in a course of conduct since at least 2006 to maximize its risk adjustment
11 payments from CMS. For much of the past decade, United's attitude may be
12 summarized by an email from former UHMR CFO Jerry Knutson to Ingenix's Jeff
13 Dumcum, then based in Orange County, California:

14 Wanted to get together with you and discuss what we can do
15 in the short term and long term to really go after the
16 potential risk scoring you have consistently indicated is out
17 there. . . . You mentioned vasculatory disease opportunities,
18 screening opportunities, etc with huge \$ opportunities. Lets
19 turn on the gas!

20 Exhibit 2, incorporated herein.

21 **VI. DEFENDANTS' FRAUD AGAINST THE UNITED STATES**

22 **A. United Knowingly Submits, and Causes To Be Submitted, False Risk** 23 **Adjustment Claims and Fails to Correct Previously-Submitted False** 24 **Risk Adjustment Claims**

25 **1. United Upcodes Risk Adjustment Claims**

26 90. As outlined below, since at least 2006, Defendants have engaged in a
27 deliberate scheme to defraud the United States by submitting tens or hundreds of
28 thousands of false claims for risk adjustment payments. Defendants submitted these
false claims even though they knew that the patients upon whom the claims were

1 based did not have the claimed diagnoses, had not been treated for those diagnoses in
2 that year, or were otherwise ineligible for risk adjustment payments under CMS rules.

3 91. Defendants routinely “upcoded” the risk adjustment claims they
4 submitted to Medicare, claiming that a patient had been treated, in the relevant time
5 period for: (a) a diagnosis that the patient did not have; (b) a more severe diagnosis
6 than the one the patient had; and/or (c) a diagnosis that the patient may have
7 previously been treated for, but which was not treated in the relevant year.

8 92. Defendants engaged in the upcoding both directly, by creating documents
9 to use to submit the risk adjustment claims themselves, or indirectly by paying,
10 encouraging or otherwise convincing physicians, hospitals or others to submit
11 upcoded data to Defendants, which upcoded data Defendants then used to submit risk
12 adjustment claims.

13 93. Defendants also refused to correct previously submitted risk adjustment
14 claims even though the Defendants knew, or should have known, that those claims
15 were false. Defendants were on notice that certain individual risk adjustment claims
16 or certain classes of claims were potentially or likely false, but nonetheless submitted
17 them without attempting to ensure their accuracy.

18 94. In this manner, Defendants have fraudulently caused CMS to pay tens or
19 hundreds of thousands of false claims for risk adjustment payments worth at least
20 hundreds of millions of dollars.

21 95. UHG engages in an aggressive and extensive effort to find a justification
22 or pretext to submit risk adjustment claims for additional diagnoses—regardless of
23 whether the patient had or was actually treated for the diagnosis in the relevant period
24 by a qualifying provider. United’s program has some components that are broad-
25 based, and others that target specific high value HCCs. As an overall goal, UHG
26 attempts to reach each of its members at least once every two years through one of its
27 programs designed to find additional risk adjustment claims.

1 96. United runs multiple programs designed to identify additional HCCs for
 2 submission to CMS to increase its risk scores, including: (a) reviewing medical charts,
 3 (b) paying physicians bonuses for submitting paperwork to support claims for
 4 additional diagnosis codes, (c) sending physicians forms identifying conditions that
 5 United suspects the patient has, and (d) initiatives designed to get patients to visit their
 6 doctors each year for the purpose of being “treated” for high value diagnoses.

7 97. These programs are designed with one primary goal – to increase UHG’s
 8 Medicare risk adjustment reimbursement. Accuracy of the claims is, at best, a
 9 secondary concern.

10 98. United has used its programs to promote increased coding of numerous
 11 HCCs that United knows are regularly submitted by providers when those providers
 12 should have submitted a less severe HCC code or no code at all. Notwithstanding this
 13 knowledge, United not only refuses, beyond a limited audit sample, to confirm the
 14 accuracy of these codes when submitted, but actually pushes chart reviewers,
 15 physicians, and others to code for these problematic HCCs more often. United calls
 16 them “undercoded” HCCs.

17 99. Some examples of such HCCs that United knows are over-coded, but still
 18 encourages reviewers and providers to increase coding for include, but are not limited
 19 to, HCC 7 (Metastatic Cancer and Acute Leukemia), HCC 8 (Lung, Upper Digestive
 20 Tract, and Other Severe Cancers), HCC 9 (Lymphatic, Head and Neck, Brain, and
 21 Other Major Cancers), HCC 10 (Breast, Prostate, Colorectal and Other Cancers and
 22 Tumors), HCC 15 (Diabetes with Renal or Peripheral Circulatory Manifestation),
 23 HCC 16 (Diabetes with Neurological or Other Specified Manifestation), HCC 18
 24 (Diabetes with Ophthalmologic or Unspecified Manifestation), HCC 19 (Diabetes
 25 without Complication), HCC 21 (Protein-Calorie Malnutrition), HCC 51
 26 (Drug/Alcohol Psychosis), HCC 52 (Drug/Alcohol Dependence), HCC 55 (Major
 27 Depressive, Bipolar, and Paranoid Disorders), HCC 69 (Spinal Cord
 28 Disorders/Injuries), HCC 71 (Polyneuropathy), HCC 80 (Congestive Heart Failure),

HCC 82 (Unstable Angina and Other Acute Ischemic Heart Disease), HCC 92 (Specified Heart Arrhythmias), HCC 96 (Ischemic or Unspecified Stroke), HCC 105 (Vascular Disease), HCC 108 (Chronic Obstructive Pulmonary Disease), HCC 108 (Chronic Obstructive Pulmonary Disease), HCC 112 (Pneumococcal Pneumonia, Empyema, Lung Abscess), HCC 131 (Renal Failure), HCC 132 (Nephritis), and HCC 155 (Vertebral Fractures w/o Spinal Cord Injury).

100. United trains and otherwise encourages its chart reviewers to identify diagnoses that do not qualify for risk adjustment claims. Chart reviewers are encouraged to look beyond members' provider-reported diagnoses and identify diagnoses from supplementary data in the medical records. United submits these additional diagnoses without seeking any confirmation from the appropriate providers.

101. For example, in January 2009, a representative of the University Physician's Network ("UPN") emailed United's executives to inform them that, because of Ingenix's illegal practices, UPN was terminating its plan to assist United with the collection of diagnosis information. The email explained that Ingenix's chart review methods result in the submission of diagnoses that were not certified by, and may not be supported by the treating physician. The UPN representative reported that Ingenix's staff attempted to assure him that the practice was legal, but that research and consultation with others confirmed that Medicare regulations do not permit a "non-treating [provider]...submitting data for the purpose of increasing the compensation to United from Medicare."

a. Chart Review

102. As described above, the vast majority of the information United uses as the basis for its risk adjustment claims comes initially from physicians, hospital or other providers in the form of claims data or other submissions. These sources are secondary to the primary records those providers hold—namely the patients' medical records, also known as charts.

1 103. As is common with secondary sources, the claims data and other
2 information United receives from providers is known to have some (and at times
3 many) errors—even when providers make good faith efforts to submit only accurate
4 information.

5 104. For example, in some cases, the claims data does not include all of the
6 diagnosis codes that it should. Providers often fail to document all diagnoses that
7 were treated, because, historically, complete reporting of all treated diagnosis codes
8 was generally not essential for reimbursement.

9 105. In other cases, the claims data erroneously indicates a patient was treated
10 for a certain diagnosis. Sometimes this happens because of mere clerical error, but
11 often it is the result of limitations in claims processing computer systems or a
12 misunderstanding by coding personnel of the proper coding rules. For example,
13 coders sometimes indicate that a patient was treated for a certain diagnosis, where, in
14 fact, the patient only had a history of past treatment for the diagnosis, or the patient
15 was tested to see if they had that diagnosis.

16 106. Moreover, there are routinely situations where the coding personnel
17 correctly identify the patient as having been treated for a certain diagnosis, but make a
18 mistake as to how severe the patient's illness is. Thus, the coders may either overstate
19 or understate the severity of the diagnosis.

20 107. United's chart review program is designed to directly review the original
21 documents—the patient medical records held by the providers—to correct these
22 known problems.

23 108. Because United has a duty to submit accurate data, and it knows that the
24 claims data contains substantial errors, it has a dual responsibility when conducting
25 these reviews: it should verify that already-submitted codes are accurate and
26 documented while it looks for codes that should have been, but were not, submitted to
27 CMS. However, as detailed below, United fails to meet his obligation to identify and
28 correct previously submitted, but erroneous risk adjustment claims.

1 109. Ingenix conducts chart reviews on behalf of UHMR, UHCS, and
2 commercial clients. In the retrospective chart review process, Ingenix identifies
3 provider charts to review and arranges for the charts to be collected. It uses both
4 internal coders and also contracts with external vendors to review and code the charts.

5 110. These vendors review charts using a blind review. In a blind review, the
6 reviewer codes every condition he or she identifies from the chart without knowing
7 what codes the provider identified from the chart previously. Thus, the reviewer
8 works from the raw chart material and reaches independent conclusions.

9 111. Ingenix conducts chart reviews provider-by-provider. For each provider,
10 members are selected for review, with a priority placed on members who have not
11 been reviewed in the past year and members whom United believes may have a risk
12 adjusting condition that has not been reported to CMS. Following every provider
13 review, the reviewer submits the diagnosis codes it found to Ingenix.

14 112. Ingenix defrauds CMS by acting on chart review data in two very
15 different ways: it acts on the missed codes by submitting risk adjustment claims to
16 CMS, but takes no action on the incorrect codes.

17 113. When it receives the data from the reviewer, listing the diagnosis codes
18 found during the review, Ingenix inputs the list into IRADS, its risk adjustment
19 database (discussed in greater detail below). IRADS' design adds the reviewer's
20 codes to the codes already in the system (i.e., the provider's codes) like pouring
21 additional water into a bucket.

22 114. For codes the reviewer coded but the provider did not code, IRADS will
23 add a new entry. If this is a newly discovered diagnosis code for that patient—
24 meaning no other provider had also reported treating the patient for that diagnosis
25 during that time period—Ingenix will then submit a new risk adjustment claim to
26 CMS.

27 115. Ingenix could easily perform a comparable comparison to look for over-
28 coded diagnosis codes. Using either the data available from the chart reviewers or

1 readily available additional information, Ingenix could determine whether a diagnosis
2 code contained in IRADS was absent from the patient's medical record for that given
3 provider. Ingenix, however, refuses to take any steps (other than an extremely limited
4 program described below) to determine whether the chart review data has identified
5 over-coded claims.

6 116. For situations where an existing code (e.g., one a provider had submitted
7 with its claims data) was not validated by the reviewed provider's medical records by
8 the reviewers, IRADS does nothing. No effort is made to find other support for the
9 diagnosis code or to delete from the IRADS system any claims that suggested the
10 reviewed provider had treated the patient for the non-validated diagnosis.

11 117. United has also found high error rates in diagnoses identified by a former
12 external chart review vendor, Outcomes, Inc., but, beyond a limited audit sample,
13 United has not reviewed the vendor's work in order to determine the extent of CMS's
14 overpayment for the vendor's erroneous diagnoses.

15 118. Chart reviews have been lucrative for United. For 2006 dates of service,
16 the first year of fully phased-in risk adjustment, United's return on investment
17 ("ROI") from chart reviews was 15 to 1. Exhibit 3, page 12, incorporated herein.
18 United spends approximately \$30 for each chart it reviews but receives an average of
19 \$450 per chart in additional CMS payments for the new codes it submitted. *Id.*

20 119. Relator believes that even if United properly conducted chart review—
21 "looking both ways" for both helpful and harmful errors—United would still earn
22 substantially more in newly found codes than it lost by correcting erroneous codes.
23 However, United has steadfastly refused to take anything more than token steps to
24 "look both ways."

25 120. Unsurprisingly, UHMR and Ingenix have emphasized performing as
26 many chart reviews as possible. UHMR reviewed approximately 600,000 charts in
27 2006 and approximately 600,000 in 2007. *See* Exhibit 3. On information and belief,
28 Ingenix reviewed between 600,000 and 800,000 charts in 2008. In 2009, Ingenix

1 reviewed approximately 800,000 charts. Exhibit 4, pages 8 and 22, incorporated
2 herein. United's only limitation in the number of charts it can review is its providers'
3 dislike of the disruptions the reviews cause to their practices.

4 121. In 2010, United's senior executives set a target for United's risk
5 adjustment programs to generate an additional \$100 million in internal operating
6 income ("IOI") above and beyond what was originally targeted. For 2011, United's
7 incremental IOI target for risk adjustment is \$125 million. Chart reviews are an
8 important part of United's strategy for realizing this additional IOI. United's senior
9 executives are fully aware that the company "looks one way" during chart reviews.
10 See ¶¶172-178.

11 **b. Patient Assessment Forms**

12 122. In addition to the chart review program, which involves broad review of
13 the provider medical records, United has several initiatives which are targeted to a
14 specific subset of patients or providers. As with the chart review program, these other
15 initiatives are designed to "look" just one way—seeking only to add incremental
16 codes and ignoring evidence that previously submitted risk adjustment claims may be
17 false.

18 123. United's Patient Assessment Forms ("PAF") program targets suspected
19 undercoded conditions, such as certain chronic conditions that a provider or group has
20 coded less frequently than their prevalence rates would indicate. For these conditions,
21 such as diabetes and chronic kidney disease ("CKD"), Ingenix mines patient data for
22 episodes in which a patient with a chronic condition has not been treated for a
23 diagnosis during the payment year.

24 124. The PAF program also identifies target patients by looking for situations
25 where a patient filled a prescription for a drug that suggests the patient has a given
26 diagnosis, or engages in a behavior (*e.g.*, smoking) that suggests a risk adjustment
27 eligible diagnosis may be present.
28

1 125. Ingenix prepares a form for these target patients and sends the form to
 2 their doctor, so he or she can “treat” the patient for that condition. For example, if a
 3 provider diagnosed a member with diabetes in 2008 and 2009 but not 2010, Ingenix
 4 would send the provider a PAF and ask the provider to check the member for diabetes.

5 126. Ingenix pays providers a fee to encourage them to consult PAFs when
 6 treating their patients.

7 127. The program may have certain clinical benefit if and to the extent it helps
 8 ensure that members with chronic diseases receive treatment for their conditions.
 9 However, that clinical concerns are not driving this program is demonstrated by which
 10 patients are targeted. For example, PAFs are only distributed to providers for
 11 members for whom United, or one of its risk adjustment clients such as Health Net,
 12 receives risk adjustment payments from CMS. If United were using the PAFs to
 13 improve clinical outcomes, they would include all their members, including their non-
 14 Medicare members, in the PAF program. Furthermore, as with the chart review
 15 program, the PAF program focuses solely on conditions that tend to be under-coded—
 16 and thus for which improved coding accuracy stands to increase revenue. Ingenix
 17 chooses the conditions it targets through PAFs based on revenue impact, not clinical
 18 impact, and ignores conditions that are frequently overcoded.

19 128. For example, United knows that cancer and stroke are often improperly
 20 coded years after the patient stopped receiving treatment. United could use the PAF
 21 program to highlight these potentially overcoded conditions to providers. For
 22 example, if a member has been coded with an acute episodic stroke for three
 23 continuous years, United can easily notify the provider that two of the three codes are
 24 probably incorrect. The member most likely had a stroke in the first year (*i.e.*, not
 25 each year) and the condition should now be coded as “history of stroke.” United
 26 could alert the provider as to its suspicion, ask the provider to assess their coding and
 27 documentation for accuracy, and submit a medical chart supporting the diagnosis.
 28 United does not include this information in its PAF reviews, however, because the

1 provider's poor coding habits actually increase United's reimbursement from CMS.
2 Therefore, though patients and providers might benefit from knowing this
3 information, United chooses not to use it because it would decrease United's revenue
4 from CMS.

5 129. Initially, Ingenix received completed PAFs from providers and submitted
6 the diagnoses listed on the PAF without reviewing the medical record. More recently,
7 Ingenix has required that the medical record accompany the completed PAF—
8 purportedly so that diagnoses claimed on the PAF could be "validated." Instead,
9 United actually reviews these medical records for incremental diagnoses that the
10 provider may have missed. In this way, the PAF program has become a one-way
11 chart review designed to only find incremental codes to submit to CMS for
12 reimbursement.

13 130. United not only skews the PAF program to focus solely on undercoded
14 diagnoses, it prevents providers from taking the initiative on their own to focus on
15 overcoded conditions. Ingenix maintains an online provider portal, called Insite, that
16 "percent of premium" capitated providers use to manage risk adjustment activities for
17 their members.

18 131. Insite contains numerous reports geared towards helping providers
19 assess, diagnose and code incremental conditions. One such report, for example, is
20 the Central Suspect Report ("CSI"). Similar to PAFs, this report lists conditions that
21 United suspects the member may have, but are not coded currently. Another report is
22 the Declining RAF report. This report ranks members with risk scores that have
23 declined period over period, a fact that highlights to providers that they may have
24 missed one or more conditions in their coding. Some Insite reports go so far as to
25 calculate the estimated financial impact of coding a particular condition. This allows
26 the provider to estimate the incremental reimbursement the provider would receive
27 from United by coding the specific condition. Similar to United's other risk
28

1 adjustment programs, Insite is designed to identify incremental diagnosis codes that
2 United may submit to CMS for payment.

3 132. To Relator's knowledge, however, Insite contains no function for
4 providers to notify United of overcoded conditions.

5 133. Relator brought the discrepancy between overcoded and undercoded
6 conditions to the attention of senior UHMR and Ingenix management. Management
7 dismissed his concerns, however, arguing there were "better ways" to address
8 overcoded conditions, such as chart validation, discussed below. Both UHMR and
9 Ingenix knew, however, that the chart validation program was incredibly limited, and
10 that the company had no plans to provide resources to address the problem of
11 overcoded conditions through that program.

12 134. Instead, the PAF program is deliberately limited to seeking under-coded
13 diagnosis codes so that United can avoid discovering over-coded diagnoses that it
14 knows exist.

15 c. Clinical Operations Initiatives

16 135. Clinical Operations Initiatives ("COI") is a program designed in part to
17 "improve" the coding of conditions that United believes are frequently "undercoded."
18 One such COI focuses on diabetes coding. As described above, the HCC model
19 assigns multiple HCCs to conditions, such as diabetes, that have variations in severity
20 and cost. For instance, a patient with well-controlled diabetes is likely to incur lower
21 medical expenses than a patient with uncontrolled diabetes and complications. CMS
22 therefore assigns a lower-paying HCC to well-controlled diabetes and a higher-paying
23 HCC to uncontrolled diabetes. The goal of the COI program is to increase the severity
24 of the diagnosis codes assigned to patients with one of these target HCCs.

25 136. Originally, the COI program sought to improve diabetes coding by
26 monitoring providers with high percentages of HCC 19 codes. HCC 19 is a code for
27 diabetes without complications. The risk score associated with HCC 19 is much
28 lower than the risk score for HCC 15, which is the code for diabetes with renal

1 complications. United suspected that some providers were coding HCC 19 when one
2 of the more severe diabetes codes (HCC 15–18) would be more appropriate.

3 137. Under the COI program, United pays providers approximately \$100 for
4 each diabetes patient they assess for diabetes complications, submit a supporting
5 diagnosis via a claim, and submit a medical record with matching documentation. In
6 addition, it pays \$200 for each doctor that receives training on the COI program and
7 diagnosis coding. Recently, the COI program has expanded to other conditions that
8 United suspects are frequently undercoded, such as chronic kidney disease (“CKD”),
9 and chronic pulmonary disease (“COPD”).

10 138. Like the PAF program, however, United does not pay doctors to improve
11 coding for conditions that are frequently overcoded. Again, United knows that cancer
12 and stroke are generally overcoded. But because improving their accuracy would
13 decrease revenue, United does not include these conditions in COI. Instead, COI is
14 limited to conditions United believes are the most frequently undercoded, such as
15 diabetes, CKD, and COPD, and represent large opportunities for increased
16 reimbursement from CMS.

17 139. In addition, United looks one way with the medical records it receives
18 from doctors under the COI program. Thus, when United receives a chart, it does not
19 check whether the other diagnoses listed in the chart (such as those submitted through
20 claims) are correct.

21 140. Even worse, Relator has information and believes that United does not
22 delete its previous diagnosis when the provider submits a medical record that
23 diagnoses the member with a *less* severe condition (such as diabetes) than before. For
24 example, United may send the doctor a list of diabetic members to assess. One or
25 more members may be coded with HCC 15 (diabetes with complications). If the
26 doctor submits a claim and medical records for that member diagnosing the member
27 with HCC 19 (diabetes without complications), United does not submit a delete code
28 to CMS for HCC 15. United simply assumes, without justification, that another

1 doctor was responsible for the HCC 15 code. Similar to its chart reviews, therefore,
 2 United affirmatively solicits diagnoses from its providers but ignores them when they
 3 cast doubt on the validity of a higher-paying diagnosis.

4 **d. Other Initiatives to Increase Risk Adjustment Payments**

5 141. Ingenix runs several additional programs to increase risk adjustment
 6 payments, including:

7 142. **Provider Attestations:** Medical charts must be signed, credentialed and
 8 dated to be used to validate a diagnosis. When Ingenix performs chart reviews, it
 9 identifies charts that are missing one of these elements, preventing United from
 10 submitting the incremental diagnoses found in those charts to CMS for payment. To
 11 get around this obstacle, when Ingenix identifies a chart that is (1) missing an
 12 administrative element and (2) contains an incremental diagnosis that would increase
 13 United's reimbursement from CMS, Ingenix sends an attestation form to the provider
 14 to confirm the administrative elements. If it receives the attestation from the provider,
 15 Ingenix submits the incremental codes in the charts to CMS for risk adjustment
 16 payment. If it does not receive the attestation, however, Ingenix does not delete any
 17 codes that the provider previously submitted for that member, even though Ingenix
 18 knows the member's chart is invalid. Moreover, when Ingenix identifies a chart that
 19 is missing an administrative element but does *not* contain an incremental diagnosis,
 20 Ingenix does not send an attestation form to the provider, though it knows United may
 21 have submitted diagnoses to CMS based on the invalid chart.

22 143. **Members without Visits:** To encourage members to visit their doctors at
 23 least once each year, Ingenix works with providers to schedule annual checkups. In
 24 some cases, this program can have clinical benefits, if the physician actually treats the
 25 patient, substantively, for the condition in question. However, in other situations, the
 26 visit is medically unnecessary if the patient is merely brought in so that the physician
 27 can "code the diagnosis" United has flagged for risk adjustment purposes.

1 144. **Hospital Data Capture:** Under this program, Ingenix elicits “data
2 dumps” from hospitals to ensure it has received all of their diagnosis codes. Hospitals
3 often enter more diagnoses for a patient than are transmitted to United. The Hospital
4 Data Capture program is designed to retrieve the incremental codes that United did
5 not receive so that United can submit those codes to CMS for payment.

6 145. **Provider Coding Training:** United trains providers on how to code
7 “properly.” United often directs training to providers with low risk scores or with a
8 financial incentive to increase risk scores, such as percent of premium capitated
9 providers. Historically, however, it did not proactively offer training to providers who
10 performed poorly in validation audits, because they routinely over-coded diagnoses.
11 Only recently has United begun offering any such training. The reason, again, is that
12 United’s priority is increasing code submissions.

13 146. United employs each of the above programs to increase its risk
14 adjustment payments from CMS. In 2010 and 2011, United’s management directed
15 UHMR to increase its internal operating income from risk adjustment by \$100 million
16 and \$125 million, respectively, above and beyond what was already planned. UHMR
17 worked to achieve the targets by increasing its risk adjustment scores by capturing
18 past conditions (PAF), decreasing the percentage of members without visits,
19 increasing the number of providers that use Insite, and performing more chart reviews.

20 147. The company monitored the progress of each program closely. The
21 pressure to earn \$100 million in additional risk adjustment income, however, gave
22 UHMR no incentive to identify, block, and delete incorrect codes. In fact, the
23 company viewed the possibility that it would have to start reviewing charts for
24 incorrect codes as a negative. In a January 2010 “Coding Accuracy Progress Report,”
25 UHMR warned, “Potential changes to general coding accuracy strategy, including
26 chart audits, could impact 2010 results.” Exhibit 5, incorporated herein. In other
27 words, looking both ways in chart reviews to identify both incremental and incorrect
28 codes would jeopardize its ability to achieve the \$100 million target.

2. **United Fails To Correct (and Reimburse Medicare for) False Risk Adjustment Claims**

148. United knows that much of the claims data and other information that it receives from physicians and other providers is unreliable. For this reason, United engages in extensive and expensive initiatives to review and correct that claims data, outlined in the prior section. Unfortunately—for the United States—United deliberately chooses to look only one way in its remedial efforts.

149. United designs its chart review and other corrective initiatives to seek out only errors that, if corrected, will lead to increased risk adjustment payments. With the exception of certain small programs—designed to provide the appearance of fairness—United deliberately designs these programs to avoid discovering that United’s previously submitted risk adjustment claims are false (and thus that United should submit a “delete” code).

150. Although many of these programs could easily be used to look for both incremental and delete codes, United has deliberately structured them to look only for incremental codes. To provide cover for its scheme, United has a few limited initiatives designed to look for delete codes. However, these initiatives designed to find false claims are far smaller than their counterparts, and are subject to far stricter data validation rules.

151. Notwithstanding its efforts to avoid learning that previously-submitted claims are false, United nonetheless often generates information that gives it reason to question the accuracy of diagnosis codes it has already submitted to CMS. United, however, intentionally (and myopically) does not compare the information to the diagnoses it has already submitted to CMS. Instead, United simply submits the incremental diagnoses it finds to CMS, purposely ignoring all evidence or suggestions of invalid diagnoses that it submitted improperly in the past.

152. Perhaps the best evidence of both United’s knowledge that the underlying claims data requires verification, and United’s fraudulent refusal to correct false

1 claims, is the disparity between its efforts to find “incremental” (new) codes and
2 “delete” (previously submitted, but false) codes. United attempts to review a medical
3 record for every member once every two years to try to find incremental codes, but
4 only has a nascent, limited project to identify delete codes. For 2009 dates of service,
5 United reviewed approximately 1.4 million charts to try to find incremental codes, but
6 only reviewed approximately 3,000 to 5,000 charts to try to find delete codes (and
7 even then, only a limited portion of each chart was reviewed).

8 153. United has half-heartedly created a small chart validation program that is
9 little more than a fig leaf designed to obscure its misconduct, and has been dragging
10 its feet for years in completing a very limited pilot program designed to develop a
11 system to look both ways.

12 154. Under the chart validation program, Ingenix selects providers who have
13 coded certain HCCs at levels significantly above the condition’s national prevalence
14 rate. Ingenix audits the providers’ charts for those codes to determine if the codes
15 were properly documented and substantiated.

16 155. United, however, imposes four restrictions to limit the number of
17 validation audits it performs. First, the provider who submitted the code must be a
18 Level I provider, defined as a provider with a financial incentive contract with United,
19 such as a capitation or gainshare agreement. This limitation excludes both large
20 provider groups without coding incentives (Level II) and small provider groups (Level
21 III). Second, the provider must have at least 500 United Medicare members. Third,
22 for an HCC to qualify as “suspect,” the provider must have coded it at over 300% of
23 Ingenix’s national prevalence rate. Fourth, United reviews a small number of
24 members (initially only 30) per provider and HCC, often a tiny sample size relative to
25 the number of codes the provider submitted.

26 156. Ingenix’s approach to chart validation is therefore highly focused and
27 excludes a vast majority of United’s providers and risk adjustment data. None of the
28 limits on chart validation exist for chart reviews. For example, whereas chart

1 validation contains safeguards to ensure diagnoses are not improperly deleted, United
2 submits diagnoses from outside vendors' chart reviews without validating them in any
3 way. The reason for the limits on chart validation is that chart validation is an
4 expense that has no revenue potential.

5 157. Ingenix's chart validation program reviewed 4,000 charts in 2010 for the
6 2008 and 2009 service years. By comparison, Ingenix's chart review program
7 reviewed approximately 1.4 million charts for the 2008 and 2009 service years. See
8 Exhibit 4 (2009 chart reviews).

9 158. Despite their limited scope, Ingenix monitors the results of its validation
10 audits closely. It compiles data on the validation percentages of each HCC, as well as
11 the validation percentages for each provider group. Often, Ingenix identifies specific
12 HCCs and specific provider groups with low validation (*i.e.*, high error) percentages.
13 In May 2009, for instance, Ingenix's Dr. Maninder Khalsa identified five problem
14 HCCs (with 15 to 30% error rates): HCC 10 (breast, prostate, colorectal cancers);
15 HCC 96 (stroke); HCC 15 (diabetes with renal/circulatory complications); HCC 105
16 (vascular disease); and HCC 92 (arrhythmias).

17 159. Similarly, an Ingenix validation audit of 2008 codes from Hemet
18 Community Medical Group reviewed 30 HCC 67 (quadriplegia) codes and validated
19 only two. Though this was an extreme result, Ingenix identified dozens of other
20 provider groups with low validation totals in specific HCCs.

21 160. Previously, United did little to nothing with the data it found during chart
22 validation. Though it submitted delete codes for diagnoses that it could not
23 substantiate, until recently Ingenix did not expand its search when it identified a
24 problem area. Recently it has enacted a policy calling for an expanded review of any
25 HCC that validates 80% or less of the time.

26 161. Nor has Ingenix targeted known over-coded conditions, such as cancer or
27 strokes, for additional scrutiny. (By contrast, in 2009 Ingenix planned a "High Value
28

1 Suspects” initiative to target potentially under-coded, high-revenue members and
2 providers.)

3 162. In 2010, United developed a pilot program that would look for both
4 incremental and unsupported diagnoses during chart reviews. Though aspects of the
5 pilot program have recently been adopted, United continues to stack the deck in favor
6 of submitting incremental codes. The pilot, as well as United’s subsequent program,
7 contain several limitations that do not exist in ordinary chart reviews.

8 163. First, the pilot was limited to members with only one provider so that
9 United does not delete a diagnosis that some other provider’s chart might validate.
10 This restriction does not apply to chart reviews—during chart reviews, whenever
11 United identifies a chart that calls another provider’s diagnosis into question, it
12 ignores the chart. United’s limited program to look both ways subsequent to the pilot
13 continues to only review charts from members with just one provider.

14 164. Second, United limited the number of charts the pilot program reviewed
15 so that it had time to validate all of them before CMS’s January 31, 2011 deadline for
16 submitting diagnoses from 2009 dates of service. In contrast, United does not limit its
17 efforts to find *incremental* codes before the January 31 deadline to build in time to
18 ensure the codes are valid. On the contrary—United runs special programs up to the
19 deadline to find as many incremental diagnoses as possible. United does not pause to
20 check whether it will have enough time to validate these incremental diagnoses,
21 because it simply does not validate the diagnoses it submits.

22 165. United’s refusal to correct errors in its risk adjustment claims is so
23 extreme that it submits risk adjustment claims to CMS for diagnoses taken from
24 claims that it itself refuses to pay as being fraudulent and/or abusive.

25 166. Through its fraud and abuse department, regular claims processing
26 efforts, and some of the other initiatives discussed in greater detail above, United
27 routinely learns that the claims data that was used as the basis for certain risk
28 adjustment claims is erroneous. Nonetheless, United routinely submits risk

1 adjustment claims—or fails to correct previously submitted claims—in purported
2 reliance on that false data.

3 167. Like most insurance companies, United contains a Fraud and Abuse
4 Prevention Unit (“F&A”) in Ingenix that is responsible for identifying and resolving
5 fraudulent claims. F&A mines claims data for anomalies that suggest a fraudulent
6 claim. For example, F&A looks for claims for drugs that were not truly administered
7 to patients, such as patients who supposedly received cancer drugs despite not having
8 a cancer diagnosis. If and when F&A identifies a claim that it considers sufficiently
9 false to be fraudulent, it takes action against the provider who submitted the claim,
10 either by denying the claim or demanding reimbursement.

11 168. Ingenix, however, refuses to use this information to correct its risk
12 adjustment database or claims submissions. Ingenix’s F&A unit does not report the
13 fraudulent claim to Ingenix’s Clinical Assessment Solutions (“CAS”) group; thus the
14 CAS group cannot block submission of the claim’s diagnosis codes to CMS or delete
15 HCCs it already submitted due to the claim.

16 169. Ingenix knows that CAS is submitting fraudulent codes to CMS because
17 it cannot interact with F&A, but has chosen not to fix the problem. Beginning as late
18 as 2009, Ingenix explored improving the coordination between CAS and F&A as a
19 way to increase coding accuracy. Dr. Maninder Khalsa of CAS stated in May 2009
20 that “[w]e have reached out to the INGENIX Fraud and Abuse Prevention Unit in an
21 effort to coordinate our areas of expertise and collaborate where possible.” During
22 that time and subsequently, Relator recommended to Ingenix that it must coordinate
23 CAS and F&A to prevent the submission of fraudulent codes. He voiced these same
24 concerns to his superior at UHMR, Scott Theisen. Ingenix, however, has refused to
25 fix the problem.

26 170. United’s submission of fraudulent codes reflects its broader failure to
27 coordinate its claims processing system with IRADS (the system it uses to process and
28 submit risk adjustment claims), as discussed below. Specifically, when a claim is

1 denied, United deliberately refuses to check whether the denial affects the validity of
2 risk adjustment claims, i.e., whether it compels United to delete any diagnosis codes.

3 171. There are similar problems with other programs and initiatives at United.
4 As described above, in other situations, United learns through chart review initiatives
5 or other programs that certain claims data or other sources of diagnosis codes used in
6 risk adjustment claims are false. United deliberately refuses to delete those false
7 diagnosis codes from its risk adjustment claims systems, and refuses to correct
8 previously submitted risk adjustment claims that were based on those false diagnosis
9 codes.

10 **3. United Continues To Develop New Programs To Seek New**
11 **Claims To Submit, While Slow-Walking Its Limited Efforts to**
12 **Correct Overcoded Claims**

13 172. Relator has spoken with senior United executives about, and has other
14 personal knowledge that those executives are aware of, the fraudulent risk adjustment
15 practices discussed in this Complaint, including United's chart review practices and
16 other risk adjustment initiatives. On this basis, Relator knows that at least the
17 following United executives know about some or all of the problems discussed herein,
18 and have participated in the scheme to continue submitting fraudulent claims and to
19 refuse to correct previously submitted false claims: Stephen Hemsley, UHG Chief
20 Executive Officer; Gail Boudreaux, UHG Executive Vice President and CEO of
21 United Healthcare; Larry Renfro, Optum CEO; Tom Paul, UHMR Chief Executive
22 Officer; Cindy Polich, UHMR President; Lee Valenta, Ingenix's former Chief
23 Operating Officer (and current President of Ingenix's Life Sciences Division); Jack
24 Larsen, former CFO of PSMG (and current CEO of UHCS); Scott Theisen, UHMR
25 Senior Vice President of Finance; Jeff Dumcum, Senior Vice President of Ingenix;
26 and David Orbuch, PSMG Chief Compliance Officer.

27 173. Although numerous United officials have acknowledged to Relator that
28 the company should be "looking both ways" when it tests the validity of its risk
adjustment data sources, United continues to focus almost exclusively on adding

1 incremental codes. Although United has created a very limited “pilot project” to test
 2 the possibility of “looking both ways” during chart reviews, that program gets limited
 3 resources and serves primarily as a fig leaf to mask the one-sided nature of United’s
 4 efforts.

5 174. Though the pilot is only experimental, United invokes it as justification
 6 for continuing its fraudulent chart reviews. In an email on September 9, 2010, UHMR
 7 President Cindy Polich, who worked at United’s Orange County, California office,
 8 emailed Relator that she and UHMR Chief Executive Officer Tom Paul had discussed
 9 whether to increase chart reviews despite knowing the reviews disregarded incorrect
 10 codes, and “had resolved the issue of concern by agreeing to develop and implement a
 11 pilot.” Exhibit 6, incorporated herein. Polich told Relator that she and Paul “both
 12 agreed that this issue should not stand in the way of moving forward with additional
 13 chart audits.” *Id.* In May 2011, UHMR CFO Scott Theisen decided that UHMR
 14 should limit the number of chart reviews and PAFs it performed in 2012 to the
 15 number it performed in 2011, due to his “compliance concerns.” At or around the
 16 same time, Theisen told Relator and senior executives at Ingenix that he had discussed
 17 the chart review problem, as well as the IRADS problems discussed below, with UHG
 18 CEO Stephen Hemsley and UHG Executive Vice President Gail Boudreaux.

19 175. Moreover, United continues to invest significant resources toward
 20 finding incremental diagnoses while at the same time devoting significantly fewer
 21 resources to the pilot or to fixing IRADS. For example, United developed
 22 “playbooks” containing ideas for increasing its risk scores. These playbooks are
 23 garnering top-level attention at the company while the myriad problems with United’s
 24 risk adjustment programs and processes go unresolved.

25 176. United conceals the one-way nature of its risk adjustment programs from
 26 CMS and even its investors. For example, United’s remediation plan for 2010 that
 27 sought to increase IOI by \$800 million allocated \$100 million to “Project 7.” Project
 28 7 was United’s codeword for initiatives to increase risk adjustment payments. The

1 company used a codeword (as opposed to “growth,” “enrollment,” or “claims”)
 2 because it did not want CMS or other investigatory government agencies to know it
 3 had a campaign to claim an additional \$100 million through risk score increases.

4 177. Similarly, during its fourth-quarter earnings call on January 21, 2011,
 5 Tom Paul, CEO of UHMR, told investors that UHMR “on a year-over-year basis” was
 6 seeing “improvements” in its risk adjustment “accuracy rates.” This statement was
 7 misleading, for while UHMR had found and submitted a substantial number of
 8 incremental codes, it has no evidence that its submissions were more accurate (i.e., the
 9 error rate of the data it submits has decreased). This fact is well known at United.

10 178. At Relator’s urging, United has changed the text of the letters it sends to
 11 providers about chart reviews to remove the word “accuracy.” The letters now say
 12 that United reviews charts to ensure it submits “complete diagnosis information” to
 13 CMS, not complete and accurate information.

14 **4. United Encourages Providers To Upcode, and Submits False** 15 **Risk Adjustment Claims Based on That Upcoding**

16 179. United encourages and provides incentives to its provider groups and risk
 17 adjustment vendors to upcode their claims data, and then uses that upcoded data to
 18 submit false and/or fraudulent risk adjustment claims to Medicare. Moreover, even
 19 when it is faced with evidence that a provider or provider group is routinely upcoding
 20 its diagnosis information, United does little or nothing to either correct the provider’s
 21 coding practices, or give that provider’s claims information special scrutiny before
 22 using it as the basis for the submission of a risk adjustment claim to Medicare.

23 180. United routinely provides physicians, hospitals and other providers
 24 information on diagnoses that United wants them to code more frequently. Often this
 25 information is presented as educational material designed to increase coding accuracy.
 26 Significantly, though, this information routinely focuses only on diagnoses that, if
 27 coded, would lead to increased reimbursement for United. In fact, United often pairs
 28

1 this coding “advice” with information on how much money United (and, often, the
2 providers themselves) stands to make if the diagnoses is coded more often.

3 181. From the inception of CMS’s risk adjustment system, UHMR and
4 Ingenix have known that many of their capitated providers are fraudulently submitting
5 false and incorrect risk adjustment diagnoses. United’s policy and practice, however,
6 has been to continue accepting diagnoses from its capitated providers even when it
7 knows the data from those providers is unreliable. Only in rare instances does United
8 audit its providers, and in those instances it merely deletes whatever bad diagnoses it
9 finds without conducting a top-to-bottom review, correcting the capitated provider’s
10 methods or terminating its relationship with the provider. Thus, UHMR and Ingenix
11 knowingly submit, or cause the submission of, false risk adjustment claims to CMS.

12 182. On information and belief, UHMR’s capitated providers are knowingly
13 submitting incorrect and/or unsubstantiated codes to Ingenix, for transmission to
14 CMS. For example, Princeton IPA of San Antonio, a capitated provider within
15 WellMed, had a risk score of 1.383 in January 2010 among its 34,163 members (by
16 January 2011, Princeton’s risk score was 1.504 among 34,902 members). Exhibit 7,
17 incorporated herein. Such a risk score suggested that WellMed’s members were
18 substantially sicker than average (CMS sets the risk score for an average Medicare
19 beneficiary at 1). UHMR knows that WellMed’s unusually high risk score is in large
20 part attributable to fraud. For example, Relator learned in the fall of 2010, following
21 an audit conducted by Ingenix, that WellMed (Princeton IPA of San Antonio)
22 routinely submits improper diagnoses.

23 **5. United Knows that its Risk Adjustment Claims Submission**
24 **System Is Flawed, and Routinely Submits False Claims, But**
25 **Has Failed to Fix that System or To Find and Fix Past False**
26 **Claims**

27 **a. Background**

28 183. United knows of several significant problems with the way that its
Ingenix Risk Adjustment Data System (“IRADS”) processes claims data and submits

1 risk adjustment claims to CMS. These errors always, or almost always, cause the
2 submission of false and/or upcoded claims. Almost never do these errors cause
3 United to fail to submit a valid claim.

4 184. Notwithstanding this knowledge, United has failed to fix the IRADS
5 system, or to fix the previously submitted false claims caused by these flaws in the
6 programming and logic of the IRADS system.

7 185. The risk adjustment information United submits to CMS originates
8 primarily from provider encounter and claims data. Providers submit encounters and
9 claims information to United through one of several automated systems, such as the
10 Professional Encounter System (“PES”), COSMOS, NICE, Pulse, Facets, and others.

11 186. United collects data from these systems and sends the data to Ingenix for
12 incorporation into IRADS. IRADS applies multiple logic filters to the data to identify
13 which diagnosis codes are eligible for submission to CMS, and which are not.

14 187. For example, when UHMR receives a claim from a provider containing
15 an ICD-9-CM diagnosis code for diabetes, IRADS should screen that claim to ensure
16 that all the required data elements are present, pursuant to CMS rules. If IRADS finds
17 the Provider ID on the claim corresponds to a primary care physician, and a CPT code
18 for a physical examination, it should then submit the code for risk adjustment. This is
19 because the information on the claim corresponds to a face-to-face encounter between
20 a physician and the patient. However, if the claim’s Provider ID corresponds to a
21 laboratory technician and the CPT code is for blood work, IRADS should filter out
22 that claim because it is clear the diagnosis code is based on a lab test, not a face-to-
23 face encounter with an appropriate provider type.

24 188. From these eligible codes, IRADS creates the data file that Ingenix
25 submits to CMS’s risk adjustment processing system (“RAPS”). Claims and
26 encounter data processed through IRADS account for approximately 95% of the
27 diagnoses United submits to CMS.
28

b. United Knows that the Filtering Logic Built Into IRADS is Deeply Flawed and Consistently Errs in Favor of Overcoding Risk Adjustment Claims

189. The serious problems that United has identified with IRADS include, but are not limited to:

- a. use of “exclusion logic” to bias IRADS filters so that when in doubt they err on the side of including a diagnosis code and submitting a claim;
- b. use of flawed logic concerning identification of provider specialties, leading to the inclusion of services provided by ineligible provider types;
- c. failing to correct the IRADS data, and failing to correct previously submitted claims, when a provider informs United that a previously submitted claim was invalid or incorrect;
- d. failing to properly separate information on individual service lines where one claim includes more than one separate procedure;
- e. resubmitting previously deleted diagnoses to CMS;
- f. submitting diagnoses from an institutional claim where the patient did not receive a face-to-face service; and
- g. failing to update IRADS’ filtering logic to include the most current CPT codes.

190. These problems are interrelated and often work in conjunction to cause erroneous submissions.

191. Relator has discussed the problems with IRADS with many of United’s senior executives. In this way, Relator knows the company is aware of the problems. Although United knows about the issues with IRADS, it has allowed Ingenix to continue submitting risk adjustment data to CMS, and has not disclosed the problems to CMS. United continues to submit diagnosis codes it knows are ineligible for risk adjustment. Likewise, United has not deleted codes that IRADS improperly submitted and has limited its investigation into the extent of the errors.

1 192. Relator has information to believe that the problems with IRADS may
 2 also be found in its legacy risk adjustment processing systems, and thus date from the
 3 very beginning of the risk adjustment system in 2004. United has intentionally not
 4 reviewed whether its legacy systems contained an error it has identified in IRADS
 5 (“Issue 1,” discussed *infra*) and thus whether it needs to delete any improperly-
 6 submitted codes, for example. United also has not reviewed whether its legacy
 7 systems contained any of the other errors it has identified in IRADS.

8 **c. Improper Use of Exclusion Logic**

9 193. The most pervasive problem with IRADS is that it was built to use
 10 “exclusion logic” to filter diagnosis codes. As a result, the system essentially takes
 11 the position of “when in doubt, submit a claim.”

12 194. Generally speaking, exclusion logic compares objects in a database
 13 against a defined “exclusion list” and marks the matches (if any) for exclusion. For
 14 example, exclusion logic in an airport security system might compare travelers’ names
 15 against a list of the FBI’s Ten Most Wanted and flag any matches for security
 16 officials.

17 195. In IRADS, the exclusion logic filters out claims data if one or more of the
 18 data elements exactly matches a list of codes to exclude. For physician claims, the
 19 exclusion lists include, without limitation: (a) CPT codes; and (b) the provider’s
 20 specialty type. For institutional claims, the lists include, without limitation: (a) the
 21 bill type; (b) the revenue code; and (c) discharge status.

22 196. Thus, for example, IRADS’ exclusion list for CPT codes includes the
 23 codes for ineligible procedures such as laboratory work and diagnostic radiology. If a
 24 CPT code for the diagnosis matches a CPT code on the exclusion list, IRADS
 25 excludes the diagnosis from the data United submits to CMS for risk adjustment.

26 197. IRADS’ exclusion logic, however, contains a basic and devastating
 27 error—it only catches information that *matches* information on its exclusion lists
 28

1 exactly. Information that is invalid but not on the exclusion list passes through the
2 filter.

3 198. Incredibly, this means that even if a key data element is left blank, or
4 filled with a completely erroneous value, IRADS assumes that is a valid value because
5 the blank or erroneous value does not appear on the list of codes to exclude. Thus
6 IRADS will use that claim data when submitting risk adjustment claims.

7 199. This error causes Ingenix to claim payment for HCCs taken from claims
8 data that are obviously ineligible for risk adjustment. For example, IRADS may catch
9 and filter a diagnosis with CPT code 74150 (a radiology code). However, it will not
10 catch a diagnosis with a CPT code field that is blank, erroneous (*e.g.*, 74x50), or even
11 reads “this diagnosis is not eligible for risk adjustment.” So long as the field does not
12 match the CPT codes on the exclusion list, the IRADS filter will not catch the bogus
13 entry and the invalid diagnosis code will pass through to CMS.

14 200. The exclusion logic error is emblematic of United’s design for IRADS
15 and its approach to risk adjustment in general—if United has any doubt about whether
16 a diagnosis is eligible for risk adjustment, it submits it for payment.

17 **d. Flawed Provider Specialty Logic**

18 201. United designed its claims systems and IRADS in such a way that it
19 improperly submits claims to CMS for diagnoses made by ineligible provider types.

20 202. First, because of an error in the way IRADS processes provider billing
21 identification numbers (“billing IDs”), IRADS fails to screen many diagnoses by
22 provider type. As described above, CMS forbids MA plans from submitting
23 diagnoses based on documents from ineligible providers such as registered nurses
24 (“RN”) or radiologists. Thus, CMS requires MA plans to screen the diagnosis codes
25 they submit by provider type.

26 203. The claims and encounter forms that United enters into IRADS each
27 contain a billing provider identification number (“billing ID”). UHMR typically
28

1 assigns billing IDs on a billing/contract basis, such that large, multi-specialty provider
2 groups contracted with UHMR often have a single billing ID.

3 204. IRADS takes a shortcut in how it screens for provider types—it assumes
4 that if a billing ID ever submits a claim or encounter with an eligible provider type,
5 then the billing ID’s future claims and encounter forms will also have eligible
6 provider types. When IRADS receives a claim with an eligible provider type, it adds
7 the billing ID from that claim to its list of billing IDs associated with eligible provider
8 types. Once the billing ID has been added to that list, IRADS treats all claims
9 submitted by that billing ID as valid, regardless of the actual provider specialty of the
10 provider who provided the service in question.

11 205. For example, if a newly-credentialed medical center submits five claims
12 to United for a radiologist, IRADS will identify the provider specialty as
13 “radiologist,” an ineligible provider type, and block the diagnoses from going to CMS.

14 206. However, the first time the medical center submits a code from an
15 *eligible* provider (*e.g.*, internist), IRADS treats the billing ID as conclusive evidence
16 that the medical center’s future diagnoses will likewise be made by eligible providers.
17 From that point forward, IRADS stops filtering the medical center’s claims by
18 provider type altogether, allowing all subsequent diagnoses from the medical center’s
19 radiologists to be submitted to CMS for risk adjustment (assuming they pass the other
20 filters).

21 207. Second, United designed its claims systems to default all unknown
22 provider types to CMS physician specialty code 99, “unknown physician specialty.”
23 Generally speaking, health care providers use a different taxonomy for provider
24 specialties than CMS. CMS requires providers to submit a valid provider type with
25 each claim, so providers must map their taxonomy to CMS’s. CMS recognizes
26 approximately 66 physician specialty codes. Thus, a provider submitting a claim for a
27 diagnosis made by an acute care nurse practitioner must map its code for the nurse
28 practitioner, code 363LA2100X, to the appropriate CMS physician specialty code,

code 50. United's claims systems are designed so that many provider specialty codes default to physician code 99. For some of United's claims systems, codes default when they fail to map to an eligible CMS physician specialty type. In another system, the Provider Encounter System, all provider specialties map to code 99. Thus, IRADS cannot filter many claims for ineligible provider specialties. United's use of code 99 as a default is improper, because to use it United has to know the provider is a *physician*. It cannot use the code whenever it knows nothing about the provider who submitted the claim.

e. Failure to Remove Diagnosis Codes Associated With Claims "Voided" by the Provider

208. When one of United's institutional providers voids a claim that was the source of a risk adjustment claim submitted to CMS, United processes the void instruction (*i.e.*, reverses the claim and recoups any claim payment) but does not delete the diagnosis code from its IRADS database or submit a delete code to CMS to reverse the risk adjustment claim. CMS therefore pays United an additional amount for diagnoses taken from cancelled claims.

209. United's general process for submitting diagnoses for risk adjustment starts with the claims and encounter data it receives from providers. Providers submit these claims and encounter data to United, which extracts data from them and enters the data into IRADS.

210. The "void and replace" occurs because IRADS only collects a limited portion of the data in the claims system. For example, United receives most claims from hospitals and other institutional providers on Form UB-04. Exhibit 8, incorporated herein. Form UB-04 includes a field for the type of bill the claim represents (Item 4). The bill type is a three-digit code. The last digit of the code indicates whether the institution submitted the bill to void or replace a prior Form UB-04.

211. IRADS, however, is unable to process the bill type's void/replace instruction. Thus when United receives instructions from a provider to void out a prior claim, and then replace it with a new claim, IRADS essentially treats this as three valid claims: (a) the original claim; (b) the "void" instruction, which looks like the original claim but for the data element that identifies it as a voiding claim; and (c) the new claim. Thus, if no filter applies, IRADS submits to CMS *both* the diagnosis from the original claim *and* the diagnosis from the replacement claim.

212. IRADS submits false data because of this error. For example, a fee-for-service provider who submits a claim ("claim #2") on Form UB-04 (diagnosis: vascular disease) to replace a claim ("claim #1") on Form UB-04 (diagnosis: congestive heart failure ("CHF")) will receive payment from United based on claim #2 only. United, however, submits both the vascular disease diagnosis (HCC 105) and the CHF diagnosis (HCC 80) to CMS for risk adjustment. By doing so, United represents that its member was treated for both conditions in the present year, when in fact the member was only treated for one. United claims payment from CMS for both conditions.

f. Failure to Separately Filter Procedure Codes When Multiple Services Are Included on a Single Claim

213. IRADS also fails to distinguish which diagnosis codes are associated with which procedures in situations where one claim form contains separate line items for two or more different procedures. Instead, IRADS assumes that all diagnosis codes on a claim are associated with each of the procedure codes. Thus, if either of the procedure codes is valid for risk adjustment purposes, IRADS uses all of the diagnosis codes for risk adjustment.

214. Both professional (*i.e.*, physician) and institutional (*i.e.*, hospital) claims forms have multiple lines in which the provider can list the multiple procedures that may have been performed for a member. At least some of United's claims systems,

1 such as NICE (legacy PacifiCare) are capable of processing individual service lines.
 2 IRADS, however, is not programmed to treat each line separately.

3 215. For example, a claim may contain two service lines: (1) an office visit
 4 with a doctor who diagnosed cancer; and (2) a laboratory procedure performed by a
 5 technician to determine if the member has diabetes. The claim contains two diagnoses
 6 (cancer and diabetes) drawn separately from the two service lines. IRADS, however,
 7 *conflates* the service lines into a single data point. When checking for CPT codes,
 8 therefore, IRADS identifies the eligible CPT code (the office visit) and attributes it to
 9 both the cancer and diabetes diagnoses, even though the doctor had only diagnosed
 10 cancer. The CPT code for the laboratory procedure is effectively ignored.
 11 Consequently, IRADS submits both diagnoses to CMS, falsely representing that the
 12 doctor had diagnosed and treated the patient for two conditions, when in fact the
 13 doctor had only diagnosed one.

14 216. The service lines that IRADS is incapable of processing appear in
 15 United's claims forms. For example, Health Insurance Claims Form 1500 ("Form
 16 1500"), the industry's standard claims form for professional health services, contains a
 17 field (Item 33) for the provider ID as well as a field (Item 21) for diagnosis codes.
 18 Exhibit 9, incorporated herein. Form 1500 also includes six "service lines" (each line
 19 consists of Items 24A–J) indicating, *inter alia*, the dates of service, the procedures
 20 performed (*i.e.*, CPT codes), the "diagnosis pointer," and the rendering provider
 21 identification number. The diagnosis pointer (Item 24E) relates one of the diagnoses
 22 in Item 21 to each of the service lines in Item 24 in order to document which health
 23 condition each service treated.

24 217. IRADS is unable to process critical information in Form 1500's service
 25 lines (Item 24) that determines the claim's risk adjustment eligibility. In addition to
 26 its inability to process CPT codes correctly, IRADS uses the field for *billing* provider
 27 number (Item 33) to determine whether an eligible provider type submitted the claim.
 28 In doing so, IRADS ignores Item 24J, which lists the *rendering* provider identification

1 number for each service line. (The provider accumulator error is associated with this
 2 false correlation. See ¶¶201-207.) For example, in the prior example of a claim with
 3 two diagnoses (cancer and diabetes) from two service lines, Form 1500 lists the cancer
 4 and diabetes diagnoses in Item 21 and the doctor and the laboratory technician as
 5 rendering providers in Item 24J(1)–(2). Because IRADS relies on the billing provider
 6 (Item 33) and ignores the rendering provider (Item 24J), it does not filter the diabetes
 7 diagnosis, even though it is supported only by a lab request.

8 218. When United stands to have to *delete* HCCs because of an invalid CPT
 9 code, however, it finds itself quite capable of processing service lines individually.
 10 For example, in August 2009 Ingenix learned that it had submitted 257,515 diagnoses
 11 to CMS that were associated with a CPT code that was inconsistent with a face-to-face
 12 encounter with a qualifying provider. Because the CPT code was invalid, United
 13 knew it likely had to delete the diagnosis codes. In discussing the potential loss of
 14 257,515 diagnoses, however, Ingenix’s Angelo Fiorucci wrote Ingenix’s Paul Bihm
 15 and Randall Myers that “I believe that we will be able to reduce the 257,515 because
 16 we have to validate that every claim line was coded as an ‘Invalid CPT Code.’” Two
 17 things are clear from this response. First, United knows that just because IRADS
 18 submitted a diagnosis code to CMS does not mean that the diagnosis code is linked to
 19 a valid CPT code on the claims form. Thus, United has reason to know that IRADS
 20 submits false claims to CMS. Second, United is willing and able to process claims
 21 forms by individual service lines—in other words, to correct the mistake caused by the
 22 logic error in IRADS—only when it would otherwise have to delete a diagnosis.

23 219. In April 2011, Ingenix Director of Encounter Operations, Rebecca
 24 Martin, confirmed to Relator that Ingenix had in fact reviewed individual service lines
 25 when it deleted diagnoses in 2009. Martin, who, upon information and belief, was
 26 based in Orange County, said she suspected Ingenix had done the same when it had
 27 deleted diagnoses in 2006 as well. Relator gave Martin the hypothetical of a claim
 28 containing diagnoses of diabetes from a laboratory CPT (ineligible), cancer from a

1 radiology CPT (ineligible), and CHF from an office visit CPT (eligible). As discussed
 2 previously, IRADS improperly submits all three diagnoses to CMS. In
 3 acknowledging that Ingenix acts differently when it has to delete diagnoses, Martin
 4 told Relator: “In your example, we would have put diabetes and cancer on the delete
 5 list and saved CHF.”

6 **g. Resubmission of Previously Deleted Diagnoses**

7 220. IRADS submits improper diagnoses to CMS because it is unable to
 8 associate a diagnosis Ingenix has deleted with a duplicate diagnosis in a resubmitted
 9 claim. When Ingenix decides to delete a diagnosis code listed in a claim, and the
 10 claim is later resubmitted by the provider, IRADS does not associate the newly-
 11 resubmitted claim with the deleted diagnosis. Therefore, Ingenix may determine that
 12 a diagnosis was improperly submitted to CMS, and yet resubmit the same code (if no
 13 filter applies) because IRADS is unable to associate the resubmitted claim with the
 14 deleted diagnosis.

15 **h. Submitting Institutional Claims for Non-Face-To-Face**
 16 **Services**

17 221. Perhaps most egregiously, United identified and disclosed to CMS a
 18 problem in IRADS that was causing it to submit false diagnoses, but has knowingly
 19 fixed the problem in only one out of two contexts.

20 222. The problem, which United refers to as “Issue 1,” affects diagnosis codes
 21 that corresponded to multiple procedure codes. As discussed above, MA plans must
 22 use procedure codes to filter diagnoses codes to ensure the diagnoses were made
 23 during a face-to-face encounter with an eligible provider. The procedure codes used
 24 in professional (*e.g.*, physician) claims are known as CPT codes; the procedure codes
 25 used in institutional (*e.g.*, hospital) claims are called revenue codes.

26 223. For Issue 1, IRADS was inexplicably programmed to skip CPT code
 27 filtering—and essentially assume that a diagnosis was made during a face-to-face
 28 encounter with an eligible provider—as long as the diagnosis code was associated

1 with two or more CPT codes. IRADS made this assumption regardless of what the
 2 CPT code values were. Thus, even when the diagnosis code was submitted with two
 3 invalid CPT codes, IRADS would assume one of those codes was valid and submit a
 4 risk adjustment claim based on that diagnosis code.

5 224. In 2008 and 2009, United investigated Issue 1 and confirmed it had
 6 caused United to submit invalid diagnoses to CMS. United notified CMS, fixed the
 7 CPT code filter, and submitted delete codes for the false diagnoses.

8 225. United, however, knowingly did not fix Issue 1 as it pertains to
 9 *institutional* claims. For institutional claims, IRADS continues to use the same
 10 erroneous logic such that an institutional claim with multiple non face-to-face revenue
 11 codes (the institutional equivalent to CPT codes) will pass IRADS' revenue code filter
 12 automatically. The result is that two wrongs often equal a right. A diagnosis with one
 13 bad revenue code is filtered out; a diagnosis with two bad revenue codes is submitted
 14 to CMS for payment.

15 **i. United Knowingly Fails to Filter Diagnoses With**
 16 **Current Procedure Codes**

17 226. To ensure that it screens diagnoses based on their procedure codes
 18 properly, United is required to review the procedure codes on its exclusion list
 19 annually. Procedure codes—CPT codes and revenue codes—are regularly modified
 20 or changed year-over-year, and MA plans often determine that they need to update
 21 their risk adjustment filters to reflect the changes. United, however, fails to perform
 22 annual procedure code reviews. The exclusion logic in IRADS is therefore out of date
 23 and results in United improperly submitting to CMS diagnoses with procedure codes
 24 that are no longer associated with a face-to-face encounter with an eligible provider.

25 **B. Ingenix Knowingly Submits, and Causes To Be Submitted, False**
 26 **Risk Adjustment Claims and Fails to Correct Previously-Submitted**
 27 **False Risk Adjustment Claims**

28 227. UHG's Ingenix subsidiary performs risk adjustment services for health
 plans other than United's. The health plans include, without limitation, defendants

1 Health Net, Arcadian, and Tufts. The services Ingenix provides these plans include
 2 both processing and submitting risk adjustment claims to CMS using the flawed
 3 IRADS system and performing chart reviews for incremental codes. Ingenix performs
 4 these services in the same manner as it does for United, as discussed *infra*. As such,
 5 Ingenix knowingly submits, causes to be submitted, and conspires with its commercial
 6 clients to submit false claims on behalf of its commercial clients. So too, those
 7 commercial clients submit, cause to be submitted, and conspire with Ingenix to submit
 8 false claims. Ingenix and its commercial clients also fail to correct (and reimburse
 9 Medicare for) previously submitted claims that they later learn, or should learn, are
 10 false.

11 228. Ingenix told at least some clients that it was developing a system to start
 12 “looking both ways”—*e.g.*, to look for both incremental and inaccurate diagnoses
 13 during chart reviews (a limited system was adopted in July 2011). Relator has
 14 information and believes that some of Ingenix’s commercial clients, having opt-out
 15 clauses in their contracts, have told Ingenix that they will cease using Ingenix to
 16 submit their risk adjustment data if Ingenix decides to start “looking both ways.”

17 229. Health Net, meanwhile, has told Ingenix that it would simply follow
 18 United’s lead, agreeing to having Ingenix review its charts for incremental and
 19 incorrect codes only if and when United implemented such reviews.

20 230. In a June 2011 meeting with senior UHMR executives, Jeff Dumcum
 21 said that Ingenix’s commercial clients had not asked it to look both ways during chart
 22 reviews, but that they “may change their opinion when CMS releases their RADV
 23 extrapolation methodology.” He noted that Health Net was the only commercial
 24 client currently willing to purchase “two way” chart reviews when United eventually
 25 implemented it. In March 2011, meanwhile, Dumcum told senior UHMR managers
 26 that he was unaware of any other large plan that looked both ways in its chart reviews.
 27 Ingenix understands from its interaction with smaller MA plans, meanwhile, that they
 28 have overwhelmingly chosen not to look both ways because, as self-perceived “small

1 fish,” they believe they stand a lesser chance of CMS singling them out for defrauding
2 the government.

3 231. In addition, Ingenix’s commercial risk adjustment clients have
4 independent reason to know that Ingenix ignores incorrect diagnoses when it performs
5 chart reviews: when Ingenix reports chart review results to its clients, it reports
6 thousands of additional diagnoses, but no delete codes. The Defendants know the risk
7 adjustment data they submitted to CMS was not 100% accurate and substantiated. By
8 not identifying a single diagnosis to delete or replace, Ingenix clearly demonstrates to
9 its clients that it disregards inaccurate and/or ineligible diagnoses.

10 **C. WellMed Knowingly Submits, and Causes To Be Submitted, False**
11 **Risk Adjustment Claims and Fails to Correct Previously-Submitted**
12 **False Risk Adjustment Claims**

13 232. WellMed, through its various affiliates and subsidiaries, is both a
14 provider group and a managed care plan. In those joint roles, WellMed has both
15 caused MA plans to submit false risk adjustment claims by providing those plans with
16 false and fraudulent diagnosis information in connection with claims for physician
17 services, and submitted false risk adjustment claims on its own in its capacity as a MA
18 health plan. WellMed also fails to correct (and reimburse Medicare for) previously
19 submitted claims that it later learns, or should learn, are false

20 233. Relator has information and believes that WellMed maintains policies
21 and practices designed to maximize its risk adjustment submissions without regard to
22 their accuracy or eligibility. WellMed allocates significant resources to increasing its
23 risk adjustment payments, submitting data to IRADS through its own processing
24 system, DataRap, which is designed to identify HCCs (and which UHMR previously
25 used directly for a portion of its Texas membership).

26 234. DataRap is WellMed’s system for identifying, processing, and submitting
27 diagnosis codes to CMS for payment. WellMed developed the system now called
28 DataRap around 2005 to allow its nurse practitioners to perform chart reviews. In
2008, WellMed expanded the system to include filtering and submitting diagnoses to

1 CMS. Like IRADS, however, DataRap contains serious flaws that have caused
2 WellMed and United to submit false claims to CMS. WellMed built DataRap using
3 exclusionary logic that fails to filter diagnoses that are missing necessary information,
4 such as CPT codes or provider specialty information. DataRap's list of CPT codes is
5 sparse and has not been updated since the system's development in 2008, which
6 causes it to submit diagnoses associated with CPT codes that are no longer eligible for
7 risk adjustment. It also cannot accommodate service line item processing and only
8 filters for laboratory and radiology CPT codes—not other CPT codes that indicate the
9 absence of a face-to-face encounter. Therefore, like IRADS, WellMed designed
10 DataRap to maximize the number of claims it could submit with disregard for whether
11 those claims were false.

12 235. In addition, WellMed previously conducted chart reviews on behalf of
13 UHMR to identify codes for submission to CMS. Unlike United, WellMed's chart
14 audits are prospective. The reviewer looks at present-year charts to check if the
15 doctor had failed to code a diagnosis made in the prior year. The reviewer does not,
16 however, look for invalid diagnoses in the chart. Furthermore, in July 2011, WellMed
17 IT employee Bryan Bain told Relator that WellMed's practice is not to delete
18 incorrect diagnoses from prior years. Thus, if a chart reviewer in 2011 found an
19 invalid diagnosis code in a 2010 chart, he or she could not delete that diagnosis
20 because the "delete file" that WellMed prepares for submission to CMS is designed to
21 include only present-year diagnoses.

22 236. When WellMed denies a claim on grounds of fraud, waste, and abuse, it
23 does not check whether it submitted diagnoses to CMS based on the denied claim. It
24 thus claims payment from CMS for diagnoses taken from claims it identified as
25 fraudulent.

26 237. The serious problems with DataRap, chart review, and fraud, waste, and
27 abuse have contributed to WellMed's artificially inflated risk scores.
28

1 238. WellMed’s risk adjustment practices gave it the highest projected risk
2 score among UHMR’s capitated providers with over 2,000 members in January 2010.

3 239. Instead of imposing a corrective action plan on WellMed or terminating
4 its contract, UHMR bought most of WellMed’s business in 2011. Thus, UHMR
5 continues to submit—and has refused to correct previously submitted—diagnoses to
6 CMS from WellMed, even though it knows many of those diagnoses are false, and has
7 increased its revenue from WellMed’s fraudulent coding by buying a stake in it.

8 240. Prior to its purchase by United, WellMed owned two health plans,
9 Physicians Health Choice (“PHC”) and Citrus Health Care, Inc. (“Citrus”). PHC
10 insures or insured approximately 40,000 Part C beneficiaries in Texas, Florida,
11 Arkansas, and New Mexico. Citrus insures or insured approximately 10,000 Part C
12 beneficiaries and 44,000 Medicaid beneficiaries in Florida. United acquired both
13 PHC and Citrus when it bought WellMed.

14 241. WellMed, through its health plans PHC and Citrus, defrauded CMS
15 through the plans’ risk adjustment practices.

16 242. Both PHC and Citrus use WellMed’s DataRap system to filter and submit
17 diagnoses to CMS. As described above, DataRap was designed to submit diagnoses
18 so long as WellMed lacked tangible evidence the diagnosis was false, i.e., it submits
19 diagnoses that it failed to confirm, but also could not disprove, to have come from a
20 qualifying face-to-face encounter. WellMed’s CFO, Joe Zimmerman, told Relator in
21 April 2011 that any problems found in WellMed’s charts would logically exist in
22 PHC’s and Citrus’s charts as well. He said “we use the same training, tools and
23 process with our own health plans as we do in San Antonio,” i.e., at Princeton IPA,
24 which submits WellMed’s risk adjustment data to CMS through DataRap. Therefore,
25 in addition to DataRap, PHC and Citrus share WellMed’s fraudulent chart review and
26 fraud, waste, and abuse processes.

27 243. In May 2011, Relator was assigned to review PHC’s and Citrus’s
28 submission systems as part of United’s ongoing efforts to absorb WellMed. UHMR

1 CFO Scott Theisen warned Relator to be careful because employees at WellMed
2 would be paranoid on account of the many compliance issues United was finding at its
3 new company.

4 **VII. COUNT I**

5 **Substantive Violations of the Federal False Claims Act**

6 **31 U.S.C. §§ 3729(a)(1)(A)–(C), (a)(1)(G)**

7 244. Relator realleges and incorporates by reference the allegations made in
8 Paragraphs 1 through 243 of this Complaint.

9 245. This is a claim for treble damages and forfeitures under the Federal False
10 Claims Act, 31 U.S.C. §§ 3279–33, as amended.

11 246. Through the acts described above, Defendants, their agents, employees,
12 and co-conspirators, knowingly presented, or caused to be presented, to the United
13 States false and fraudulent claims, and knowingly failed to disclose material facts, in
14 order to obtain payment or approval from the United States and its contractors,
15 grantees, and other recipients of its funds.

16 247. Through the acts described above, Defendants, their agents, employees,
17 and co-conspirators, knowingly made, used, and caused to be made and used false
18 records and statements, which also omitted material facts, in order to induce the
19 United States to approve and pay false and fraudulent claims.

20 248. Through the acts described above, Defendants, their agents, employees,
21 and co-conspirators, knowingly made, used, and caused to be made and used false
22 records and statements material to an obligation to pay and transmit money to the
23 United States, and knowingly concealed and improperly avoided and decreased an
24 obligation to pay and transmit money to the United States.

25 249. Through the acts described above, Defendants, their agents, employees
26 and other co-conspirators knowingly conspired to submit false claims to the United
27 States and to deceive the United States for the purpose of getting the United States to
28 pay or allow false or fraudulent claims.

1 250. The United States, unaware of the falsity of the records, statements, and
2 claims made and submitted by Defendants, its agents, employees, and co-conspirators,
3 and as a result thereof, paid money that it otherwise would not have paid.

4 251. By reason of the payment made by the United States, as a result of
5 Defendants' fraud, the United States has suffered hundreds of millions of dollars in
6 damages and continues to be damaged.

7 **VIII. PRAYER FOR RELIEF**

8 WHEREFORE, qui tam plaintiff Benjamin Poehling prays for judgment against
9 Defendants as follows:

- 10 1. That Defendants cease and desist from violating 31 U.S.C. §§ 3279–33;
11 2. That the Court enter judgment against Defendants in an amount equal to
12 three times the amount of damages the United States has sustained as a result of
13 Defendants' actions in violation of the Federal False Claims Act, as well as a civil
14 penalty in an amount as set forth in 31 U.S.C. § 3729(a) and 28 C.F.R. 85.3(a)(9) for
15 each violation of 31 U.S.C. § 3729;
16 3. That Relator be awarded the maximum amount allowed pursuant to 31
17 U.S.C. § 3730(d) of the Federal False Claims Act;
18 4. That Relator be awarded all costs of this action, including attorneys' fees
19 and expenses; and
20 5. That the United States and Relator receive all such other relief as the
21 Court deems just and proper.

22 ///

IX. JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands trial by jury.

DATED: July 21, 2017

CONSTANTINE CANNON LLP
PHILLIPS & COHEN LLP

By: /s/ Mary A. Inman
Mary A. Inman
Attorneys for *Qui Tam* Plaintiff Benjamin
Poehling

Constantine Cannon LLP

ATTACHMENT A

DEFENDANTS NAMED IN PARAGRAPH 24

1. AmeriChoice of New Jersey, Inc. is a New Jersey corporation, doing business as AmeriChoice Personal Care Plus and UnitedHealthcare Community Plan.
2. Arizona Physicians IPA, Inc. is an Arizona corporation, doing business as APIPA Personal Care Plus and UnitedHealthcare Community Plan.
3. Care Improvement Plus of Maryland, Inc. is or was a Maryland corporation, doing business as Care Improvement Plus.
4. Care Improvement Plus of Texas Insurance Company is a Texas insurance company, doing business as Care Improvement Plus.
5. Care Improvement Plus South Central Insurance Co., is an Arkansas insurance company, doing business as Care Improvement Plus and UnitedHealthcare.
6. Care Improvement Plus Wisconsin Insurance Company, is a Wisconsin insurance company, doing business as Care Improvement Plus and UnitedHealthcare.
7. Catamaran Insurance of Ohio, Inc., is an Ohio corporation.
8. Citrus Health Care, Inc., is or was a Florida corporation.
9. Health Plan of Nevada, Inc., is a Nevada corporation.
10. Medica HealthCare Plans, Inc. is a Florida corporation.
11. Oxford Health Plans (CT), Inc., is a Connecticut corporation, doing business as AARP MedicareComplete from SecureHorizons; Oxford Medicare Advantage; SecureHorizons; SecureHorizons by UnitedHealthCare; and, UnitedHealthcare.
12. Oxford Health Plans (NJ), Inc., also known as Oxford Health Plans of New Jersey, Inc., is a New Jersey corporation, doing business as AARP MedicareComplete from SecureHorizons; AARP MedicareComplete provided by SecureHorizons; Evercare; Evercare by UnitedHealthcare; Evercare Health Plans; Evercare Plan H; SecureHorizons; SecureHorizons by UnitedHealthCare; and, UnitedHealthcare.
13. Oxford Health Plans (NY), Inc., is a New York corporation, doing business as Oxford Medicare Advantage; SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
14. PacifiCare Life and Health Insurance Company is an Indiana insurance company, doing business as SecureHorizons Direct; and, SecureHorizons MedicareDirect.
15. PacifiCare of Arizona, Inc. is an Arizona corporation doing business as SecureHorizons Medicare Advantage Plan; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.

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- 1 16. PacifiCare of Colorado, Inc, is a Colorado corporation doing business as AARP
2 MedicareComplete from Secure Horizons; AARP MedicareComplete provided
3 by SecureHorizons; Secure Horizons Medicare Advantage Plan;
4 SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
- 5 17. PacifiCare of Nevada, Inc., also known as Pacificare/UHC of Nevada, is a
6 Nevada corporation doing business as AARP MedicareComplete provided by
7 SecureHorizons; Pacificare/UHC of Nevada; Secure Horizons Medicare
8 Advantage Plan; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
- 9 18. Physicians Health Choice of Texas, LLC, is a Texas limited liability company
10 doing business as Physicians Health Choice.
- 11 19. Preferred Care Partners, Inc. is a Florida corporation doing business as
12 UnitedHealthcare.
- 13 20. Rocky Mountain Health Maintenance Organization, Inc., is a Colorado
14 company.
- 15 21. Sierra Health and Life Insurance Company, Inc. is a Nevada corporation doing
16 business as Erickson Advantage and UnitedHealthcare.
- 17 22. Symphonix Health Insurance, Inc. is an Illinois insurance company doing
18 business as Symphonix Health
- 19 23. UHC of California, Inc., formerly known as PacifiCare of California, Inc. and
20 Pacificare of California/Secure Horizons, is a California corporation doing
21 business as SecureHorizons by UnitedHealthcare, Secure Horizons Medicare
22 Advantage Plan and UnitedHealthcare.
- 23 24. Unison Health Plan of Tennessee, Inc., is a Tennessee corporation doing
24 business as Unison Advantage and UnitedHealthcare Community Plan.
- 25 25. United Health Care Ins. Co. and United New York, is a New York insurance
26 company doing business as UnitedHealthcare.
- 27 26. UnitedHealthcare Benefits of Texas, Inc., formerly known as PacifiCare of
28 Texas, Inc., is a Texas corporation doing business as SecureHorizons Medicare
Advantage Plan; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.
- 27 27. UnitedHealthcare Community Plan of Ohio, Inc., formerly known as Unison
Health Plan of Ohio, Inc., is an Ohio corporation doing business as Unison
Advantage and UnitedHealthcare Community Plan.
- 28 28. UnitedHealthcare Community Plan of Texas, L.L.C., formerly known as
Evercare of Texas, LLC, is a Texas limited liability company doing business as
Evercare by UnitedHealthcare and Evercare Health Plans; and,
UnitedHealthcare.
- 29 29. UnitedHealthcare Community Plan, Inc., also known as Great Lakes Health
Plan, Inc. and UnitedHealthcare of the Great Lakes Health Plan, Inc. is a
Michigan corporation, doing business as Great Lakes Personal Care Plus and
UnitedHealthcare Community Plan.

30. UnitedHealthcare Insurance Company of New York, also known as United Healthcare Insurance Company of New York, is a New York insurance company doing business as SecureHorizons; SecureHorizons MedicareDirect; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
31. UnitedHealthcare Insurance Company, also known as United Healthcare Insurance Company, is a Connecticut insurance company doing business as AARP MedicareComplete from SecureHorizons; Erickson Advantage; Evercare by UnitedHealthcare; Evercare Health Plans; Evercare Senior Care Options; SecureHorizons; SecureHorizons by UnitedHealthcare; SecureHorizons MedicareDirect; United Health Group; UnitedHealthcare; and UnitedHealthcare Community Plan.
32. UnitedHealthcare of Alabama, Inc. is an Alabama corporation, also known as United Healthcare of Alabama, Inc., doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.
33. UnitedHealthcare of Arizona, Inc. is an Arizona corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
34. UnitedHealthcare of Arkansas, Inc. is an Arkansas corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
35. UnitedHealthcare of Florida, Inc., also known as United Healthcare of Florida, Inc. is a Florida corporation doing business as AmeriChoice; Evercare at Home; SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
36. UnitedHealthcare of Georgia, Inc., also known as United Healthcare of Georgia, Inc., is a Georgia corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; and UnitedHealthcare.
37. UnitedHealthcare of New England, Inc., also known as United Health Plans of New England, Inc., is a Rhode Island corporation doing business as AARP MedicareComplete provided by SecureHorizons; AARP MedicareComplete from SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
38. UnitedHealthcare of New York, Inc., also known as Americhoice of New York, Inc. and United Healthcare of New York, Inc. is a New York corporation doing business as AmeriChoice Personal Care Plus; SecureHorizons; SecureHorizons by UnitedHealthcare; UnitedHealthcare; and, UnitedHealthcare Community Plan
39. UnitedHealthcare of North Carolina, Inc., also known as United Healthcare of North Carolina, Inc. is a North Carolina corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare and UnitedHealthcare.
40. UnitedHealthcare of Ohio, Inc., also known as United Healthcare of Ohio, Inc., is an Ohio corporation doing business as SecureHorizons, SecureHorizons by UnitedHealthcare and UnitedHealthcare.

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41. UnitedHealthcare of Oklahoma, Inc., formerly known as PacifiCare of Oklahoma, Inc., is an Oklahoma corporation doing business as Secure Horizons Medicare Advantage Plan; SecureHorizons by UnitedHealthcare, and UnitedHealthcare.
42. UnitedHealthcare of Oregon, Inc., formerly known as PacifiCare of Oregon, Inc., is an Oregon corporation, doing business as AARP MedicareComplete from SecureHorizons; AARP MedicareComplete provided by SecureHorizons; SecureHorizons Medicare Advantage Plan; SecureHorizons by UnitedHealthCare; and, UnitedHealthcare.
43. UnitedHealthcare of Pennsylvania, Inc., formerly known as Unison Health Plan of Pennsylvania, Inc., is a Pennsylvania corporation doing business as Unison Advantage; UnitedHealthcare Community Plan; and UnitedHealthcare.
44. UnitedHealthcare of Tennessee, Inc., also known as United Healthcare of Tennessee, Inc., is a Tennessee corporation doing business as AARP MedicareComplete from SecureHorizons; AARP MedicareComplete provided by SecureHorizons; SecureHorizons; and SecureHorizons by UnitedHealthcare.
45. UnitedHealthcare of the Midlands, Inc., also known as United Healthcare of the Midlands, Inc., is a Nebraska corporation doing business as SecureHorizons by UnitedHealthcare and UnitedHealthcare.
46. UnitedHealthcare of the Midwest, Inc., also known as United Healthcare of the Midwest, Inc., is a Missouri corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
47. UnitedHealthcare of Utah, Inc., also known as United Healthcare of Utah, Inc., is a Utah corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
48. UnitedHealthcare of Washington, Inc., formerly known as PacifiCare of Washington, Inc., is a Washington corporation, doing business as AARP MedicareComplete from SecureHorizons; Secure Horizons Medicare Advantage Plan; SecureHorizons by UnitedHealthcare; and, UnitedHealthcare.
49. UnitedHealthcare of Wisconsin, Inc., also known as United Healthcare of Wisconsin, Inc. is a Wisconsin corporation doing business as SecureHorizons; SecureHorizons by UnitedHealthcare; UnitedHealthcare Community Plan; UnitedHealthcare Personal Care Plus; and, UnitedHealthcare.
50. UnitedHealthcare Plan of the River Valley, Inc., also known as United Healthcare Plan of the River Valley, Inc. is an Illinois corporation doing business as AmeriChoice Secure Plus Complete; SecureHorizons by UnitedHealthcare; UnitedHealthcare; and, UnitedHealthcare Community Plan.

EXHIBIT 1

Advanced Clinical Solutions Group
Service Level Agreement
Clinical Quality & Risk Scoring Analytic Services

✓ 1. Services:

- a. Ingenix, through its Advanced Clinical Solutions Group ("ACS"), will provide Clinical Quality and Risk Scoring Analytic Services (the "Clinical Quality & Analytic Services", or "Services") to Ovations for Medicare Advantage members belonging to SecureHorizons and Evercare (including Medicaid) as follows:
 - i. Data mining and tool development
 - ii. Provider Engagement and education around diagnostic coding.
 - iii. Oversight of encounter collection, submission and reconciliation pursuant to CMS risk adjustment rules and requirements.
 - iv. Optimize the level of accuracy and completeness of diagnostic coding for a respective population by identifying opportunities to improve documentation and coding accuracy, facilitating improvement in accuracy by working directly with providers, Nurse Practitioners and Care Managers to improve documentation and coding practices, and finally executing the timely and accurate submission of claim coding information to CMS, thereby ensuring appropriate revenues are being paid by CMS for the underlying risk inherent within the member population
 - v. Provide clinical support programs to encourage early assessment and on-going treatment of chronic disease.
 - vi. Conduct internal validation testing of outlier providers and fully support the CMS validation requirements.
 - vii. Provide analysis on payments received from CMS
 - viii. Perform reasonable ad hoc reporting and analysis relating to Medicare Advantage revenue as required to support Ovations
- b. ACS must comply with all HIPAA requirements and CMS requirements on patient confidentiality
- c. ACS to be subject to Ovations compliance and delegated provider oversight programs
- d. Ingenix must comply with all applicable Fraud and Abuse regulations including the False Claims Act

2. Technology

- a. To the extent allowed by existing licensing arrangements, contracts and legal restrictions, Ovations will grant licensing rights allowing Ingenix to make the following systems commercially available:
 - i. iRADS – encounter submission system
 - ii. CERTS – Membership & Revenue Reconciliation system
- b. Ingenix to make systems commercially available to plans external to UHG with prior consent of Ovations, whose consent will not be unreasonably withheld.
- c. Ovations will transfer necessary technology and intellectual property to enable performance of the Services, commercialization of the Services, as

Advanced Clinical Solutions Group
Service Level Agreement
Clinical Quality & Risk Scoring Analytic Services

well as to enable Ingenix to make future enhancements to the ACS technology.

- d. Disputes related to above consent will be decided by the UHG CEO and CFO or their designee
- e. Ingenix to make systems commercially available to Providers at their own discretion as allowed by existing licensing arrangements.

3. Steering Committee

- a. Ingenix will form a "steering committee" to meet at least quarterly and discuss progress and issues
- b. Steering Committee to be comprised of:
 - i. Secure Horizons President (Sheila McMillan),
 - ii. Secure Horizons CFO (Joe Hafermann),
 - iii. Secure Horizons or Ovations Chief Medical Officer,
 - iv. Evercare President, CFO, or other executive (Jeff Maloney),
 - v. Head of Ingenix Clinical Analytics unit (Jeff Dumcum),
 - vi. Ingenix Business Solutions representative (Dave Ostler), and
 - vii. Ingenix Chief Operating Officer (Lee Valenta),and
 - viii. CSG President (Richard Anderson)
- c. Agenda at quarterly steering committee meeting to include:
 - i. Strategic direction
 - ii. Resourcing Issues
 - iii. Compliance with Service Level Agreement provisions
 - iv. Clinical Integration
 - v. Network development integration
 - vi. Preliminary upcoming year financial targets

4. Reporting

- a. Head of Ingenix Clinical Quality Unit and Secure Horizons CFO/Evercare CFO to meet monthly and discuss financial forecasts.
- b. Ingenix Clinical Quality Unit to provide monthly report specifying: *To whom?*
 - i. Summary of any compliance issues
 - ii. Current and Forecasted FTE's dedicated to the Clinical Quality Unit,
 - iii. Projected results to Ovations including:
 - 1. Estimation of Elimination of current year Lag payment
 - 2. Estimation of current year Final Settlement payment
 - 3. Estimation of prior year Final Settlement
 - iv. Other Financial and Operational Reports as reasonably requested.
- c. Ingenix will work jointly with Ovations in the period leading up to the annual bid process (early June) in developing forecasted revenue assumptions for the subsequent year to support Ovations bid planning process. Prior to April 15 of each year, Ingenix will provide to Ovations

Advanced Clinical Solutions Group
Service Level Agreement
Clinical Quality & Risk Scoring Analytic Services

its best estimates for revenue rate impacts from risk scoring, in a format acceptable to the Secure Horizons and Evercare CFOs.

- d. Ingenix will provide Oventions with prior notification (as soon as practical, but in no case less than 45 days), with its intent to take any of the following actions:
 - i. A reduction of force that is greater than 10% of the then current Clinical Quality Unit workforce. In such case, the parties will meet and agree to any necessary amendments to the Monthly Base Fee described in Section 5(a)i below.
 - ii. Termination of any of the top 5 most highly compensated employees of the Clinical Quality Unit.

5. Exclusivity

- a. For 2007, Ingenix will perform the Clinical Quality & Analytic Services exclusively for Oventions with the following exceptions:
 - i. Member and Revenue Reconciliation and Encounter submission software
 - ii. State Medicaid Programs with prior consent of Oventions, whose consent will not be unreasonably withheld, and
 - iii. UHG Affiliated entities.
- b. For 2008, Ingenix will perform the Clinical Quality & Analytic Services exclusively for Oventions with the following exceptions:
 - i. Member and Revenue Reconciliation and Encounter submission software
 - ii. State Medicaid Programs with prior consent of Evercare, whose consent will not be unreasonably withheld,
 - iii. UHG Affiliated entities
 - 68 iv. Regional Payers with prior consent of Oventions, whose consent will not be unreasonably withheld, and
 - v. Ingenix may sell Clinical Quality & Analytic Services to Providers at its own discretion.
- c. For 2009 and beyond , Ingenix will perform the Clinical Quality & Analytic Services exclusively for Oventions with the following exceptions:
 - i. Member and Revenue Reconciliation and Encounter submission software
 - ii. State Medicaid Programs with prior consent of Evercare, whose consent will not be unreasonably withheld,
 - iii. UHG Affiliated entities
 - iv. Regional Payers with prior consent of Oventions, whose consent will not be unreasonably withheld,
 - 69 v. National Payers with the prior consent of Oventions, whose consent will not be unreasonably withheld.
 - vi. Ingenix may sell Clinical Quality & Analytic Services to Providers at its own discretion.
- d. Disputes related to the above Exclusivity Consent Waivers will be decided by the UHG CEO and CFO or their designee.

Advanced Clinical Solutions Group
Service Level Agreement
Clinical Quality & Risk Scoring Analytic Services

6. Financial Relationship

a. Ingenix will be paid a Monthly Base Fee and an Incentive Fee as described below:

- i. The Base Fee will be \$3.00 PMPM beginning June 1, 2007 and ending December 31, 2007. The Base Fee will be \$2.25 PMPM beginning January 1, 2008 and ending December 31, 2008. PMPM is defined as the monthly average of Secure Horizons and Evercare Medicare Advantage members, excluding Evercare Institutional members, that are Continuously Enrolled for the rolling three prior months. Evercare Institutional Members Monthly Base Fee will be \$.25 PMPM.

1. Fees for years subsequent to 2008 will be negotiated in the normal course (prior to June 1, 2008 for 2009) and will take into consideration historical results of the Clinical Quality and analytical Services, Ingenix cost forecasts, and federal funding levels and medical trend for Medicare Advantage products.

- ii. The Incentive Fee will be calculated as follows:

*- Same as 2007
- Evercare only
- Just for 2007*

HCC Change	2.5% to 3.0%	3.0% to 3.5%	3.5% to 4.0%	4.0 to 4.5%	> 4.5%
Reimbursement Percentage	5.0%	5.5%	6.0%	6.5%	7.0%

?

Incentive Fees - 2008 and beyond

HCC Change	2.5% to 3.0%	3.0% to 3.5%	3.5% to 4.0%	4.0 to 4.5%	> 4.5%
Reimbursement Percentage	8.0%	10.0%	10.5%	11.0%	11.5%

- b. For purposes of calculating the 2007 Incentive Payment, Incremental Plan Revenues will represent the combined total of the Current Year (CY) Lag Elimination Payment to be paid by CMS during calendar 2007, the
 - ① Current Year (CY) Estimate of the 2007 Final Settlement (as determined and reported by Ovarions accounting, and reviewed by Ingenix), and the
 - ② Prior Year (PY) Final Settlement (for 2006) to be paid by CMS during calendar 2007.

*'07 Plan of Ing. used on 2005 = 200
'07 Plan of Ing. used on 2005 = 200
0% = 0% just based on 2005 = 200*

Advanced Clinical Solutions Group
Service Level Agreement
Clinical Quality & Risk Scoring Analytic Services

- c. For purposes of calculating the 2008 (and beyond) Incentive Payments, Incremental Plan Revenues will be calculated in accordance with Exhibit A attached hereto. ?
- d. During the November submission of the Annual Budget cycle, the Parties will agree on an estimated calendar year "Contingent Fee" to use in each UHG forecasting cycle. Monthly "accruals" will be recorded based on one-twelfth of this agreed estimate. The Parties will adjust the calendar year Contingent Fee estimates at each UHG forecasting cycle date. (presumably April 30, June 30, August 31, October 31) and adjust the Monthly accrual to obtain the goal of not having an over accrual or under accrual at December 31st of such calendar year.
- e. Calculation of the Incentive Fee will be trued up by April 15 of the succeeding year. The Secure Horizons CFO will verify results and payment calculation prior to payment.
- f. 2007 arrangements:
 - i. The Base Fee of \$3.00 PMPM will begin effective June 1st
An estimate of the Monthly Incentive Fee will be agreed between the two parties by June 8th and recorded for the remaining 7 months of 2007. Such estimate will be reviewed on August 31st and October 31st to determine if a change in the monthly accrual is necessary.
- g. Notwithstanding the preceding paragraphs, in the event that Ingenix proposes to offer Clinical Quality Services to an Ovations National Competitor and Ingenix has offered more favorable pricing terms to such National Competitor for the same type, scope and level of effort of Services, then Ingenix shall make such more favorable pricing terms available to Ovations on a go-forward basis for such services in the affected geographic market.

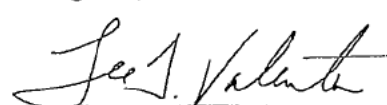
Agreed & Acknowledged:

Ovations, Inc



Jerry Knutson

Ingenix, Inc



Lee D. Valenta

Ingenix/Ovations Service Level Agreement

Exhibit A: Incentive Fee HCC RAF Change

Assumptions			Base Yr 2007	Year 1 2008	Year 2 2009	Year 3 2010
Summary Information						
Total Members	a	+50k/Yr	1,300,000	1,350,000	1,400,000	1,450,000
Continuously Enrolled	b	82%	n/a	1,066,000	1,107,000	1,148,000
New Members	c = a-b		n/a	284,000	293,000	302,000
RAF						
Age/Sex	d	0.005	0.470	0.475	0.480	0.485
Medicaid/Previously Disabled	e		0.020	0.020	0.020	0.020
HCC - Chronic Conditions	f	0.025	0.490	0.515	0.540	0.565
Total	g = sum(d:f)		0.980	1.010	1.040	1.070

*For Illustration Benchmark and Measurement period RAF scores are shown to be the same; however, they will be different values based on the defined populations.

Avg Rate (Avg PMPM/Total RAF)	h	\$	800	\$	832	\$	865	\$	900
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HCC RAF Change Only

Prospective RAF Change	i	0.025	0.025	0.025
Incremental Revenue	j = b*h*i*12	\$ 266,073,600	\$ 287,359,488	\$ 309,922,529
Percent Change	k = i/g	2.5%	2.4%	2.3%

Retrospective RAF Change

PY Final Payment	l	\$ 87,000,000	\$ 100,065,546	\$ 113,131,093
PY Total Revenue	m	\$13,151,000,000	\$15,126,000,000	\$17,101,000,000
% Change	n = l/m	0.7%	0.7%	0.7%

NewCo Incentive Calc

Total Change % for incentive schedule	o = k+n	3.1%	3.1%	3.0%
Total Incremental Revenue	p = j+l	\$ 353,073,600	\$ 387,425,034	\$ 423,053,622
Incentive %	q	10.000%		
Incentive	r = q*p	\$ 35,307,360		

Incentive Schedule - Continuously Enrolled Intersegment MA Members

Range	Incentive % of Incremental Revenue
<2.5%	0.0%
2.5% - 3.0%	8.0%
3.0% - 3.5%	10.0%
3.5% - 4.0%	10.5%
4.0% - 4.5%	11.0%
>4.5%	11.5%

Jeff Dumcum

Exhibit A Definitions

- a. Total MA Members = Total Members enrolled on July 1st of each year (include retro-active enrollment/disenrollment)
- b. Continuously Enrolled MA Members = Members enrolled 7/1 of the baseline year still enrolled 7/1 of the following year.
- c. New MA Members = Members enrolled post 7/1 of the baseline year
 *Membership numbers include all contracted MA Plans.
 Ovarions
 Includes: All Secure Horizons and Evercare Community MA Plans
 Excludes: Evercare Institutional Plans, Medicaid Only Plans and Prescription Drug Plans (PDP).
 Members switching Ovarions MA plans will be counted in the plan of record as of 7/1 of measurement year.
- d. Average Age/Sex RAF = Average of member level RAF scores calculated from CMS Age/Sex Tables
- e. Average Medicaid/Previously Disabled = Average of member level RAF scores calculated for Medicaid Add-on and Previously Disabled
- f. Average HCC RAF = Average of member level RAF scores calculated for reported HCC conditions
- g. Average Total RAF = d + e + f
- h. Average Rate = Average Total CMS Payment PMPM divided by Average Total RAF
- i. Prospective HCC RAF Change = Measurement Year HCC RAF minus Benchmark Year HCC RAF (2) - (1)
 (1) Benchmark Year HCC RAF - Average RAF from HCC factors for Continuously Enrolled MA Members (b.)
 Use the conditions reported for benchmark year at payment year factors (Remove impact CMS model adjustments to HCC scores)
 Assume all members in Community plans at Community risk scores and all Institutional Plans at Institutional Risk scores (Remove C to I impact)
 (2) Measurement Year HCC RAF - Average RAF from HCC factors for Continuously Enrolled MA Members (b.)
 Use the conditions reported for measurement year at payment year factors (Remove impact CMS model adjustments to HCC scores)
 Assume all members in Community plans at Community risk scores and all Institutional Plans at Institutional Risk scores (Remove C to I impact)
- j. Incremental Revenue = $b * h * i * 12$
- k. Prospective Percent Change = i / g
- l. Prior Year Final Payment = HCC Portion of Final Payment for Benchmark year received in the Payment Year for all community plans
 Excludes: Final payment impact from changes of status for enrollment, special status and demographic factors (ie C to I)
- m. Prior Year Total Revenue = Total revenue received from CMS (MMR files) for members effective the prior year.
- n. Retrospective Percent Change = l / m
- o. Total Change Percent for Incentive Schedule = $k + n$
- p. Total Incremental Revenue = $j + l$
- q. Reimbursement Percent = Applicable percent of incremental revenue per the Incentive Schedule.
- r. Incentive Payment = $q * p$

Benchmark/Baseline Year = Year prior to Incentive plan (For 2008 Incentive Plan the Benchmark/Baseline year is 2007)

Measurement/Payment Year = Year of the Incentive Plan and the expected year of CMS payment receipt.

Estimate of Intersegment ACS Revenue**2008 Payment Year****Per Provisions of Exhibit A****Values Based on Estimated Change From 2006 to 2007**

Summary Information		Base Yr 2007	Year 1 2008
Total Members	a		1,349,344
Continuously Enrolled	b		1,122,576
New Members	c = a-b		226,768
RAF			
Age/Sex	d	0.493	0.460
Medicaid/Previously Disabled	e	0.020	0.020
HCC - Chronic Conditions	f	0.430	0.458
Total	g = sum(d:f)	0.943	0.939

Avg Rate (Avg PMPM/Total RAF) h \$ 832

HCC RAF Change Only

Prospective RAF Change	i	0.034
Incremental Revenue	j = b*h*i*12	\$ 376,043,790
Percent Change	k = i/g	3.57%

Retrospective RAF Change

PY Final Payment	l	\$ 165,000,000
PY Total Revenue	m	\$ 13,100,000,000
% Change	n = l/m	1.26%

NewCo Incentive Calc

Total Change % for incentive	o = k+n	4.83%
Total Incremental Revenue	p = j+l	\$ 541,043,790
Incentive %	q	11.500%
Incentive	r = q*p	\$ 62,220,036

EXHIBIT 2

From: Knutson, Jerry J
Sent: Wednesday, November 07, 2007 11:52 AM
To: Dumcum, Jeff S
Cc: Valenta, Lee D; Hafermann, Joseph A; Poehling, Benjamin
Subject: Step on the Gas

Jeff:

Wanted to get together with you and discuss what we can do in the short term and long-term to really go after the potential risk scoring you have consistently indicated is out there. As we have discussed, I'd like to see an action plan as to what is achievable for 2008 reimbursements and long-term.

You mentioned vasculatory disease opportunities, screening opportunities, etc with huge \$ opportunities. Lets turn on the gas! What can we do to make sure we are being reimbursed fairly for the members and risk we take on more than what we are currently doing.

When we meet next on our steering committee, I'd like to see what it would take to add another \$100M to our 2008 revenue from where we are. What would be doable? What resources would you need? What technology would you need?

Also, I'd like to explore the question of: With us paying Optum something like \$125M this year, including newly delivered disease management and clinical programs, I'd like to understand how you can leverage off of that investment. As our members are being engaged clinically, what can you leverage? Add questions to the HRA? Get you "suspect lists" from the Optum clinical engagement, etc?

I believe Ben is supporting you from outside, so use him to help navigate Ovatinos - but lets go after it.

jk

EXHIBIT 3

INGENIX®

Ovations Risk Adjustment Programs

September 21, 2007



Agenda

- I. Risk Score Trends
 - A. Trends/Budgets
 - B. September Submission
 - C. Disease Prevalence
- II. Chart Validation
- III. Staffing Plan
- IV. Key Initiatives
- V. IT
- VI. Commercialization

Risk Adjustment – Lump Sum Payments

Elimination of Lag

	Part A/B				Part D				Total			
	2005	2006	2007	2008	2005	2006	2007	2008	2005	2006	2007	2008
SH												
West	\$ 140.7	\$ 139.2	\$ 146.9	\$ 142.0		\$ 9.9	\$ 3.2	\$ 2.9	\$ 140.7	\$ 149.1	\$ 150.1	\$ 144.9
East	\$ 26.8	\$ 10.3	\$ 102.8	\$ 79.0		\$ (1.3)	\$ 5.0	\$ 4.4	\$ 26.8	\$ 9.0	\$ 107.8	\$ 83.4
SH Total	\$ 167.5	\$ 149.5	\$ 249.7	\$ 221.0	\$ -	\$ 8.6	\$ 8.2	\$ 7.3	\$ 167.5	\$ 158.1	\$ 257.9	\$ 228.3
EVC												
Community	\$ 1.4	\$ 6.0	\$ 17.1	\$ 16.8		\$ 0.5	\$ 1.1	\$ 1.0	\$ 1.4	\$ 6.5	\$ 18.2	\$ 17.8
Institutional	\$ 4.6	\$ (5.4)	\$ 15.8	\$ 5.5		\$ 0.4	\$ 1.3	\$ 0.4	\$ 4.6	\$ (5.0)	\$ 17.1	\$ 5.9
EVC Total	\$ 6.0	\$ 0.6	\$ 32.9	\$ 22.3	\$ -	\$ 0.9	\$ 2.4	\$ 1.4	\$ 6.0	\$ 1.5	\$ 35.3	\$ 23.7
Ovations Total	\$ 173.5	\$ 150.2	\$ 282.6	\$ 243.3	\$ -	\$ 9.5	\$ 10.6	\$ 8.7	\$ 173.5	\$ 159.7	\$ 293.2	\$ 252.0

Final

	Part A/B				Part D				Total			
	2005	2006	2007	2008	2005	2006	2007	2008	2005	2006	2007	2008
SH												
West	\$ 106.4	\$ 136.5				\$ 12.2			\$ 106.4	\$ 148.7	\$ -	\$ -
East	\$ 14.0	\$ 139.8				\$ 17.5			\$ 14.0	\$ 157.3	\$ -	\$ -
SH Total	\$ 120.5	\$ 276.3	\$ 150.0	\$ 126.0	\$ -	\$ 29.7	\$ 15.0	\$ 12.6	\$ 120.5	\$ 306.0	\$ 165.0	\$ 138.6
EVC												
Community	\$ 1.8	\$ 10.2				\$ 1.4			\$ 1.8	\$ 11.6	\$ -	\$ -
Institutional	\$ (11.9)	\$ 11.6				\$ 3.0			\$ (11.9)	\$ 14.6	\$ -	\$ -
EVC Total	\$ (10.0)	\$ 21.8	\$ 12.0	\$ 10.0	\$ -	\$ 4.4	\$ 2.0	\$ 1.5	\$ (10.0)	\$ 26.2	\$ 14.0	\$ 11.5
Ovations Total	\$ 110.4	\$ 298.1	\$ 162.0	\$ 136.0	\$ -	\$ 34.1	\$ 17.0	\$ 14.1	\$ 110.4	\$ 332.2	\$ 179.0	\$ 150.1

*2007 Final Range of \$142 to \$162

Risk Adjustment HCAI Measurement

	2007 HCAI		2008 HCAI
Jul 06 RAF	0.941	Jul 07 RAF	0.998
Jul 07 RAF	0.998	Jul 08 RAF	1.029
Change	0.057	Change	0.031
PMPM Rate	\$ 800.00	PMPM Rate	\$ 800.00
MMs	16,150,000	MMs	17,000,000
HCAI Total	\$ 734,000,000	HCAI Total	\$ 420,000,000
2006 Final	\$ 298,000,000	2007 Final	\$ 18,000,000
2007 Final	\$ 144,000,000	2008 Final	\$ 135,000,000
Total	\$ 1,176,000,000	Total	\$ 573,000,000

Submission and Payment Dates

Jan 08 ----- Jun 08 Jul 08 ----- Dec 08

Preliminary Risk Payment →

Data Collection Period: Jul 06 – Jun 07
Data Submitted: Sep 07
Cash Received: Jan 08 – Jun 08

Adjusted Risk Payment →

Data Collection Period: Jan 07 – Dec 07
Data Submitted: Mar 08
Cash Received: Jul 08 – Dec 08

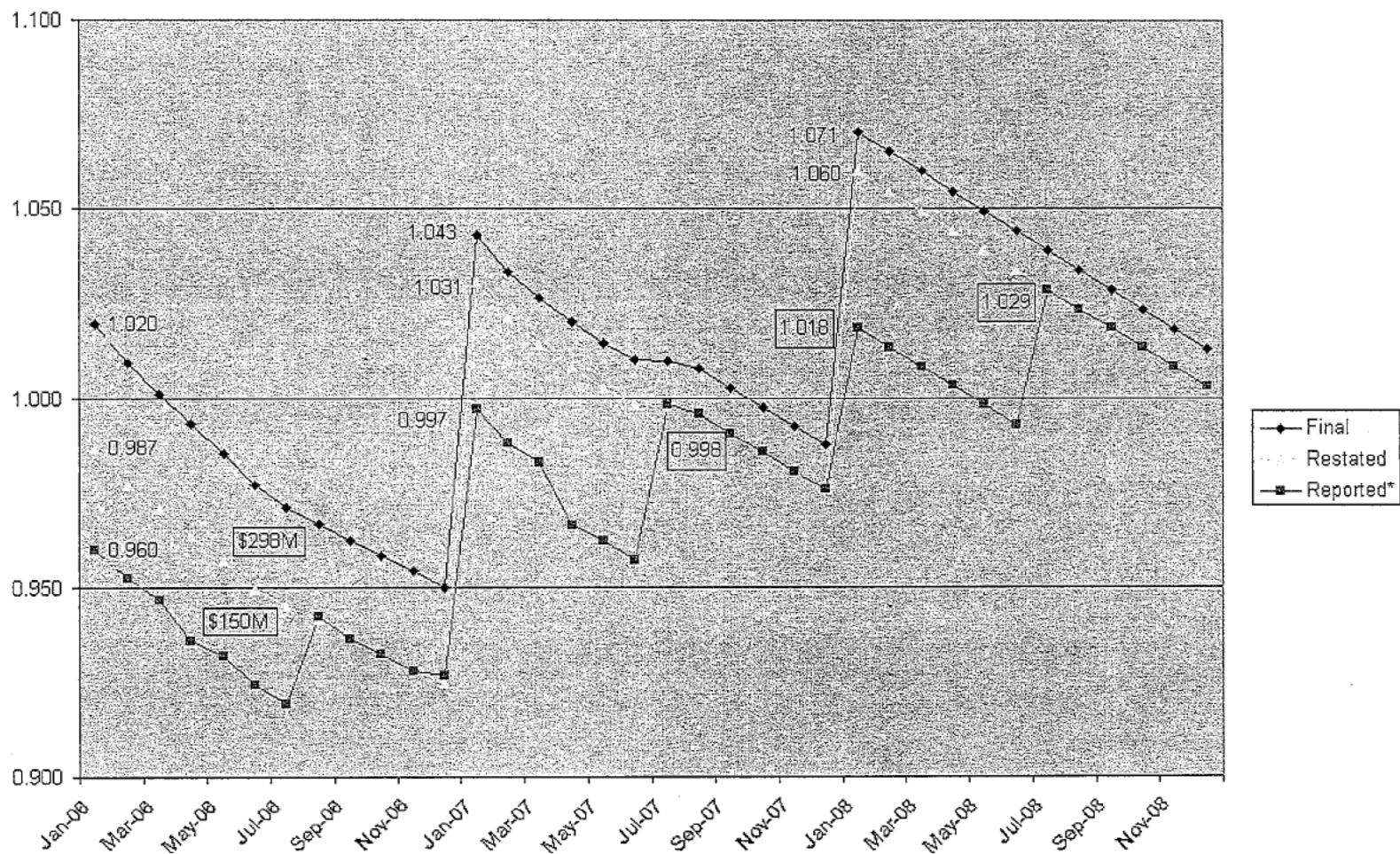
Retroactive Risk Payment →

Data Collection Period: Jan 07 – Dec 07
Data Submitted: Mar 08
Cash Received: Q3 08

Final Risk Payment →

Data Collection Period: Jan 07 – Dec 07
Data Submitted: Jan 09
Cash Received: TBD 09

Ovations Risk Score Trend



Ovations Disease Prevalence - Summary

HCC	Description	2006 Prevalence	2007 Prevalence	2008 Target	Change	Avg RAF	Impact	Target
Vascular Disease								
104	Vascular Disease w/complications	1.46%	1.64%					
105	Vascular Disease w/o complications	8.36%	9.71%					
	Subtotal Vascular Disease	9.82%	11.35%	13.00%	1.65%	0.315	0.0052	35%
Pulmonary Disease								
107	Cystic Fibrosis	0.02%	0.20%					
108	COPD	11.49%	12.24%					
	Subtotal Pulmonary Disease	11.50%	12.44%	13.44%	1.00%	0.387	0.0039	18%
Diabetes								
015	Diabetes w/Renal/Peripheral Circ Manifestations	2.90%	4.04%					
016	Diabetes w/Neurologic Manifestations	3.15%	3.18%					
017	Diabetes w/ Acute Complications	0.24%	0.13%					
018	Diabetets w/ Ophthalmic Complications	2.14%	2.38%					
	Subtotal Diabetic Complications	8.44%	9.73%	11.23%	1.50%	0.267	0.0040	15%
019	Diabetes w/o complication	15.32%	15.68%	15.68%				
	Subtotal Diabetes	23.75%	25.41%	26.91%	1.50%			35%
Renal Conditions								
130	Dialysis Status	0.09%	0.29%	0.29%				
131	Renal Failure	3.56%	6.30%	7.80%	1.50%	0.378	0.0057	20%
132	Nephritis	0.56%	0.62%	0.62%				
	Subtotal Renal Conditions	4.21%	7.21%	8.71%	1.50%			
Mental Health								
055	Major Depressive Disorder/Bipolar	2.45%	3.12%					
054	Schizophrenia	0.35%	0.39%					
052	Drug/Alcohol Dependence	0.50%	0.59%					
051	Drug/Alcohol Psychosis	0.28%	0.33%					
	Subtotal Mental Health Disorders	3.58%	4.43%	5.43%	1.00%	0.360	0.0036	7%

Ovations Disease Prevalence - Summary

HCC	Description	2006 Prevalence	2007 Prevalence	2008 Target	Change	Avg RAF	Impact	Target
Cardiac Conditions								
080	CHF	9.18%	10.10%					
081	Acute MI	0.88%	0.95%					
082	Unstable Angina, Acute Ischemic Heart Disease	2.33%	2.05%					
083	Angina/Old MI	4.88%	4.74%					
092	Specified Heart Arrhythmias	9.21%	10.15%					
	Subtotal Cardiac Conditions	26.48%	27.99%	29.00%	1.01%	0.340	0.0034	32%
Cancers								
007	Metastatic Cancer	0.78%	0.82%					
008	Lung/Other Severe Cancers	0.85%	0.73%					
009	Lymphatic/Other Major Cancers	1.35%	1.24%					
010	Breast/Prostate/Colorectal Cancer	7.26%	7.06%					
	Subtotal Cancers	10.24%	9.85%	9.85%	0.00%	0.400	0.0000	10%
Other								
071	Polyneuropathy	3.47%	4.65%	5.40%	0.75%	0.315	0.0024	6%
Institutional Items - Much higher prevalence in Institutional Population								
031	Intestinal Obstruction	1.21%	1.31%					
148	Decubitus Ulcer	0.30%	0.65%					
021	Protein Calorie Malnutrition	0.52%	0.70%					
	Subtotal - Key Institutional Items	2.03%	2.66%	2.66%	0.00%			
All Other Conditions (42 HCCs)		26.87%	29.14%	30.14%	1.00%	0.300	0.0030	33%
Total		121.97%	135.13%	144.54%	9.41%		0.0311	

Evercare Institutional – Draft – Very Preliminary

HCC Description	Relative Risk Factor	07 Prev Rate%	08 Prev Rate %
105 Vascular Disease	0.158	39.26%	46.96%
131 Renal Failure	0.395	18.66%	41.77%
080 Congestive Heart Failure	0.222	25.97%	34.53%
108 COPD	0.314	17.45%	22.65%
055 Major Depression	0.296	13.97%	21.96%
015 Diabetes with Renal CC	0.448	11.11%	18.16%
021 Protein-Calorie Malnutrition	0.380	6.09%	11.51%

*Increase appears overstated as by the time we reach the end of 2008 some of these members will leave due to death.

HCC	Description	EVC INST - AZ - H0319		EVC INST - TN - H0406		EVC INST - CO - H0620		EVC INST - CT - H0710		EVC INST - GA - H1106		EVC INST - MULTI - H2111		EVC INST - MA-RI - H2228		EVC INST - OH - H2406		EVC INST - IA-NE - H2802		EVC INST - NJ - H3113		EVC INST - NM - H3209		EVC INST - NY - H3379 - 002		EVC INST - NY - H3379 - 022		EVC INST - NC - H3456		EVC INST - OR - H3812		EVC INST - PA - H3912		EVC INST - HI - H5008		EVC INST - WI - H5253		EVC INST - FL - H5417		EVC INST - GA - H7254		EVC INST - CT - H7254	
		Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)	Plan Prevalence Rate (%)	Rate (%)		
105	Vascular Disease	33.24%	14.50%	38.44%	43.58%	39.92%	48.54%	57.82%	36.04%	28.70%	59.05%	24.30%	59.83%	43.58%	24.98%	20.39%	60.00%	31.94%	47.89%	40.28%	44.40%	51.85%																					
131	Renal Failure	13.26%	22.90%	62.04%	23.92%	56.69%	26.78%	49.34%	20.75%	49.24%	61.59%	16.82%	29.20%	50.42%	54.88%	48.03%	59.78%	47.16%	59.82%	47.72%	45.52%	23.70%																					
080	Congestive Heart Failure	26.07%	27.48%	31.15%	26.63%	44.11%	28.08%	33.72%	33.88%	33.33%	51.75%	34.58%	38.62%	31.49%	32.79%	34.87%	40.77%	32.24%	34.11%	39.02%	33.96%	28.15%																					
108	COPD	18.89%	26.72%	26.92%	19.50%	21.76%	20.21%	21.08%	24.31%	37.12%	16.51%	21.50%	24.44%	19.03%	21.62%	21.71%	23.61%	20.00%	20.60%	28.81%	17.54%	28.15%																					
055	Major Depression	6.99%	29.77%	9.45%	20.36%	57.82%	20.91%	19.71%	24.40%	31.82%	14.60%	13.08%	14.54%	12.65%	9.91%	29.61%	22.19%	14.63%	9.82%	39.12%	54.48%	6.67%																					
015	Diabetes with Renal CCC	19.35%	12.98%	16.44%	14.78%	20.63%	18.35%	20.68%	14.36%	12.88%	12.38%	7.48%	16.22%	18.46%	20.61%	17.76%	19.67%	17.61%	21.59%	18.03%	18.28%	15.56%																					
021	Protein-Calorie Malnutrition	4.09%	0.76%	31.28%	12.15%	32.91%	4.92%	3.36%	7.75%	0.76%	4.76%	3.74%	5.89%	1.31%	13.82%	3.95%	13.11%	13.43%	3.41%	27.41%	14.55%	5.93%																					

September Submission Update

	Jul-07	Jan-08	Change	% Change	Budget	Variance
Legacy SRS	0.959	0.961	0.003	0.3%	2.0%	-1.7%
JDR	0.905	0.905	0.000	0.0%	2.0%	-2.0%
OXF	0.927	0.947	0.020	2.1%	2.0%	0.1%
PFFS	0.913	0.911	(0.002)	-0.2%	0.0%	-0.2%
West	0.956	0.988	0.032	3.3%	2.0%	1.3%
Secure Total	0.951	0.971	0.020	2.1%	1.9%	0.2%

- EVCC estimated flat – requires more analysis as most of the members were not enrolled for 12 months in the data collection period.
- EVCI – Seeing a marked increase needs additional analysis for member not enrolled for 12 months in the data collection period.
- Key risk to PMPM revenue projection is member growth/mix. Important to break out existing and new members and track their impact on overall risk score.

Risk Adjustment Data Validation

Status of Reviewed Records to date:				
Total HCCs to Validate	Total HCCs Confirmed	HCCs NOT supported & Sent to CMS	"Maybe" - most likely "No" but depends on reviewer	Received No Records for This Patient
1160	836	208	98	18
	72%	18%	8%	2%

*2005 Dates of Service

2006 CMS Chart Validation Summary

	Totals	Percent
HCC Found	731	59%
HCC Not Found	399	32%
Questionable HCC Submitted	63	5%
Higher HCC Found w/in Hierarchy	11	1%
Lower HCC Found w/in Hierarchy	27	2%
Total	1,231	

**DATES OF SERVICE 2004 (PY 2005)

Key Initiatives

- Chart Audit
 - 2006 (600k Audits)
 - ROI 15 to 1 = Recovery \$450/Cost \$30 per chart
 - All EVC Inst.
 - All East (Except OXF & Partial NC)
 - PFFS
 - 2007 (400k Audits Complete)
 - NY, NC, CA, CO, TX, NV, OK
 - 2007 Q4 – (200k Audits to Complete)
 - AZ, NY/NJ/CT, NW
- Facilitated Visits (20k members in non groups)
- Patient Assessment Forms

ACS Staffing Update

	FTEs
Transferred FTEs	81
Terms	-5
Adds	12
Current	88
Posted	63
To be Posted 10/1/07	38
Year End FTEs	189

Key Position Status

National Field Lead	Candidate Identified
Product Lead	Candidate Identified
Medical Director	Candidate Identified
Field Leads	
East Field Lead	Candidate Identified
FL	Hired
NY	Start Date 10/1
AL	Offer Outstanding
TX	Offer Outstanding
MO	Candidate Identified
AZ	Director Open
AZ Mgr	Start Date 10/8
CO Mgr	Candidate Identified
Finance/Ops/Analytics	
Director Analytics	Final Round of Interviews
EIQ Lead	Hired
Director of Rev Projections	Open
Director of Medicare Ops	Open
Manager of Revenue Recon	Hired
Director of Encounter Ops	Replaced - Internal Promotion

IT

- IRADs
- CERTs
- CMS Repository
- Reporting Portal
- IT Road Map
 - Problem List tied to eligibility checks
 - Scanned Chart Review (Storage and Management)

Commercialization

- Sierra
- Americhoice
- HealthNet (April 2008)
 - Currently Contract with
 - Leprechaun
 - MMC 20/20
 - Clear Vision
 - Outcomes Inc
 - The Coding Source
 - Social Service Coordinators
 - Key Markets CA, AZ and CT

EXHIBIT 4

Ovations & CAS Executive Steering Committee

July 1, 2009

Information is the lifeblood of health care.

INGENIX®

Agenda

- 2008 and 2009 Payment Projections
- Risk Adjustment Programs Activity
- Validation, Compliance and Control Initiatives
- Future Direction

MA Payment Trends

Elimination of Lag

	Part A/B				
	2005	2006	2007	2008	2009
SH					
<i>West</i>	\$ 140.7	\$ 139.2	\$ 146.9	\$ 180.0	\$ 116.9
<i>East</i>	\$ 26.8	\$ 10.3	\$ 102.8	\$ 81.3	\$ 106.6
SH Total	\$ 167.5	\$ 149.5	\$ 249.7	\$ 261.3	\$ 223.6
EVC					
<i>Community</i>	\$ 1.4	\$ 6.0	\$ 17.1	\$ 40.7	\$ 45.2
<i>Institutional</i>	\$ 4.6	\$ (5.4)	\$ 15.8	\$ 21.1	\$ 11.7
EVC Total	\$ 6.0	\$ 0.6	\$ 32.9	\$ 61.8	\$ 56.9
Ovations Total	\$ 173.5	\$ 150.2	\$ 282.6	\$ 323.1	\$ 280.5

Final

	Part A/B				
	2005	2006	2007	2008	2009
SH					
<i>West</i>	\$ 106.4	\$ 136.5	\$ 165.7	\$ 224.8	
<i>East</i>	\$ 14.0	\$ 139.8	\$ 64.4	\$ 75.1	
SH Total	\$ 120.5	\$ 276.3	\$ 230.1	\$ 299.9	
EVC					
<i>Community</i>	\$ 1.8	\$ 10.2	\$ 13.7	\$ 41.4	
<i>Institutional</i>	\$ (11.9)	\$ 11.6	\$ 4.3	\$ 5.1	
EVC Total	\$ (10.0)	\$ 21.8	\$ 18.0	\$ 46.5	
Ovations Total	\$ 110.4	\$ 298.1	\$ 248.1	\$ 346.4	

Forecast Variance Summary

EOL Forecast Variance Summary

Under-Value of West Market Deletes (Best/Legacy PHS Systems)	(\$42.0)
Incomplete Data Assumptions (members with < 12 months in DCP)	(\$3.4)
Total Variance	<u>(\$45.4)</u>

Under-Value of West Market Deletes (Best/Legacy PHS Systems)

WellMed / DataRaps (Texas)	(\$31.7)	Provider Group defaulting all submissions to 99090
California	(\$3.9)	
AZ/WA/CO/OR/OK/NV/Other TX	(\$6.4)	
Total Under-Value of West Deletes	<u>(\$42.0)</u>	←

- 7/1 Meeting w/ WellMed (Dr. Rapier)

Operational Issues

■ Audit of Core Transaction Systems

- PacifiCare Professional Encounter System (PES)
 - Final System Audit in December 2008
 - Key Findings of Encounters without a From DOS
- All systems have now been through audit reconciliation process

■ Filter Logic Review

- Non-Face to Face Procedure Code Deletes
 - Valid providers but with CPT codes that do not indicate face to face visit
- Future logic changes run in test environment to fully understand impacts

■ Revenue Projections

- Pulling from multiple systems to capture all RAPs file
- Underestimated value of deletes (Overestimate of EOL)
- Issue Corrected – Single source of truth

■ WellMed/Data Raps

- Use of default code 99090

2009 Activities for 2008 DOS

2008 DOS drive 2009 Revenue

- Chart Review (08 DOS) through Jan sweep
- Hospital Data Capture
- ASM/encounter data processing

2009 Activities – 2009 DOS

- **Focus on High Risk Suspects**
 - 220K members
 - Increase # of suspects with enhanced clinical logic
 - Lab data (CKD, neuropathy) started 5/09
 - Identify whether members had visit or not to date in 09
 - Members with visit
 - Member focused chart review/multiple providers
 - Members w/out visit
 - Clinical calls (starting 7/09)
 - PAFs faxed to physician

2009 Activities – 2009 DOS

- **Provider focused/broad based chart review**
 - ~770K CAS led
- **MWOV call campaign**
 - Targeting 120K members
 - Currently 12% able to impact with PAFs
- **Insite deployment**
 - CA – Nearly all groups deployed
 - PHP/Integris deployed
 - CO/WA Q409
 - National 2010
- **Embedded Coding Pilot (CA/TX)**

Validation Audits

■ RAF outlier audits

Identified capitated/gain share providers that are outside of the mean range of prevalence rates at HCC level DOS: CY 2008

–California

– 20 groups / 45 locations

–TX

- Wellmed – 14 locations
- Estimated Audit Start Date: July 2009
- Estimated Audit Completion Date: October 2009
- Audit results with HCC error for CMS correction & reporting before 01/01/2010

Validation Audits

■ **OIG Audits**

- TX (H4590) – audit sample size: 100 members/247 HCCs
 - Audit deadline/completed: 01/15/2009
 - Received OIG's partial preliminary review results and responded with comments
 - Final Review Results from OIG not yet received

- CA (H0543)– audit sample size: 100 members/ 302 HCCs
 - Audit deadline/completed: 03/20/2009
 - Initial Review Results from OIG, not yet received
 - In preparation, Market Consult outreached to MG's for addt'l record chase on HCCs assessed as non-validating

Validation Audits

■ CMS Audits

- WA (H5005)– audit sample size: 200 members/ 744 HCCs
 - Audit deadline/completed: 09/15/2008
 - Initial Review Results from CMS, not yet received.
- National Sample Audit (26 HP's for Ovations & 2 HP's for AmeriChoice)
 - Review Results from CMS not yet received
- Pending RADV Audits:
 - AL (H0151)
 - CO (H0609)
 - Notification Date 11/10/2008. Estimated audit sample size: 200 members per H contract
 - No known start date; on indefinite hold

Compliance & Controls

■ Compliance

– PHI protection

- Instituted significant CAS PHI training activity
- All CAS personnel underwent re-training on HIPAA
- Issued new data distribution guidelines w/ QA & controls on validating content appropriate to recipient

– Program Controls

- Coding accuracy oversight
 - Vendor auditing
 - Insourcing of chart review/internal controls

Operational Controls

Ensure controls and accuracy of CAS end to end process of encounter submissions and revenue projections

- On-going E & Y testing of forecasting model
- Ingenix Consulting engagement on deep dive of controls and processes of CAS encounter processing and forecasting
 - Commenced Q1 2009
 - Focus on 6 key areas: ASM Data Exchange Management, Data Quality Controls, (Primary Channel), IRADS Project Controls, Policies and Procedures, Core Client System Extract Logic and Revenue Projection
- External audit engagement to test deployment of IC engagement

Sierra Integration

- **CAS is actively managing:**
 - Chart audit/embedded coder
 - Provider engagement
 - Provider and member analysis
- **Staff fully transitioned to CAS**
- **On Track for IRADS targeted go live date of late July / early August for September sweep**
 - Initial test run of member and provider files have uncovered no issues
- **Evaluating remaining PDM transition (suspect tracking and chart review results)**
 - PDM has agreed to month-to-month if necessary

2010 Initiatives (PY 2011)

- **Finish National InSite Rollout**
- **EMR Integration**
 - To enable physician/user prompting related to HCC related chronic diseases and accurate coding
- **RAVAS**
 - Risk Adjustment Validation / Audit Services (RAVAS) will support internal validation audits as well as:
 - Chart review services
 - Chart validation capabilities
 - Chart Scan with chart note mapping to member HCCs
- **Improved Suspect Identification and Close Rate**
 - Alternative sources (lab, HRA, etc)
 - Algorithms

Next Steps

- **WellMed and other EOL action items**
- **Regional deep dives July through September**
- **2010 financial projections**

Appendix

Risk Adjustment Programs

Additional Compensation Program (ACP)/COI

■ Status

- 33 Groups with a PCP count of 2,114 and membership of 42K
- '08 Final Measurement Reports Completed & Distributed
- '09 Initial Diabetes Reports
 - Reviewed w/PIP team and reports are being delivered by Market Consultation to groups
 - 5 groups have data issues (network #'s); CAS working with PIP team to resolve
- '09 Chronic Conditions Reports
 - Reviewed w/PIP team and reports are being delivered to groups

■ Milestones

- Collaboration with PIP team to clearly define COI processes, reporting, and guidelines
- Incorporate CAS activities into ACP group business plans by 8/1/09

Risk Adjustment Programs

Stand Alone (SA) COI

■ Status

- 7 current SA COI agreements (4 existing from prior year; 3 new in '09)
- 22 groups included on target list (for '09 effective dates)
 - 7 active negotiations (FL, MA, AZ markets)

■ Milestones

- SA Alone Criteria and Targeting process completed and implemented
- Diabetic COI has been clearly defined and is currently being rolled out to targeted groups for '09
- Chronic Conditions reporting is being revised and SA program will be available for 2010

■ SA Dependencies and Challenges

- Provider setup (TIN, Network ID)

Risk Adjustment Programs

Member Outreach

■ MWOV

- Initiated in May; runs through November
- Approximately 120K members to be contacted
- Completed ~ 15K calls to date
- 12% with appointments/PAFs to send
 - ~ 800 via 3 way appts
 - ~ 1,000 mbrs scheduled

■ Clinical calls

- Target high value suspects w/o claim
- Expected start date July '09

■ WI PFFS

- 11K PFFS & 1.2K PFFS members to be contacted
- Expected start date July '09

Risk Adjustment Programs

Hospital Outreach

■ Status

March 2009 Sweep

(2008 DOS captured through the March Sweep)

<u>Admits/DOS</u>	<u>#Dx</u>	<u>New HCC's</u>
93,223	431,291	14,679

■ Milestones

- September Sweeps currently underway
- Targeting 80% of admits

Risk Adjustment Programs

Chart Review Activity

- 796K Chart Reviews Planned in 2009
 - Targeted by market/provider
- 375K charts are currently in the review process thru June 29th
 - Planned to complete by Sept sweep
- 416K charts will be sent to vendor prior to Sept 1st
 - Planned to complete by Jan sweep (08 DOS)/Mar sweep (09 DOS)
- Additional activity planned in 09 through High Value Suspects initiative
 - Targeted by member/multiple provider

Clinical Laboratory Data

■ Diabetic Nephropathy (0.508)

- 5K High Likely Suspects Identified
- \$19 Million of Opportunity
- \$ 3.8 Million for 2010

■ Chronic Kidney Disease (0.368)

- 120K High Likely Suspects Identified
- \$ 334 Million of Opportunity
- \$ 67 Million for 2010

■ Additional Key Lab Suspects Currently in Process

- Diabetes Mellitus (0.157)
- Metastatic Cancer (2.210)
- Chronic Hepatitis B & C (0.394)
- End Stage Liver Disease (0.950)
- HIV Infection, as allowed by law (0.917)
- Heart Failure (0.398)

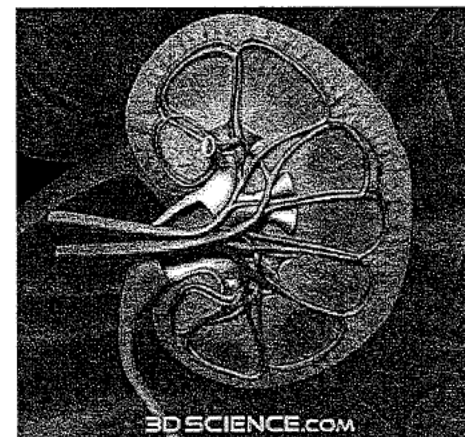


EXHIBIT 5



Coding Accuracy Progress Report

1/04/2010

Confidential

Coding Accuracy Update

Last updated	1/4/10
Initiative Status	Green
IOI Target	\$100M
IOI Achieved	\$M

The 5 ONs: Summary by Initiative

Comments

Program Initiatives	Overall	Time	Scope	Net IOI	Benefit	Quality	
Complete 750,000 Chart Audits in 2009	●	ON	ON	ON	ON	ON	
Receive 75,000 PAFs in 2009	●	OFF	OFF	OFF	ON	ON	- PAFs are currently tracking behind plan – 29K received
Utilize lab data to close 15,000 suspects	●	OFF	OFF	OFF	ON	ON	- Opportunity was too optimistic – tracking to 9K
Recapture 81% of past conditions of existing members	●	ON	ON	ON	ON	ON	- On target – at 78%
Drive Members without visits below 10%	●	ON	ON	ON	ON	ON	- On target to exceed performance – at 9%
Deploy Insight to providers representing 300K members	●	ON	ON	ON	ON	ON	- On track for 384K members

Risk Mitigations for the “Missed-ONs”

- Ingenix suspended distribution of PAFs for 4 weeks pending compliance review.
- The distribution of PAFs has been activated again, but we will not make up the difference
- We are pursuing additional chart audits to make up the difference. The costs associated with doing incremental audits would be almost entirely offset by a reduction in PAF costs.
- Results from September sweep were favorable, providing an indication that we are on track from an overall perspective
- Preliminary views of 2010 revenue per member also appear to be on track, providing an additional positive indication
- Potential changes to general coding accuracy strategy, including chart audits, could significantly impact 2010 results
- Current discussions being held around Coding Accuracy infrastructure and process would increase operating cost structure. Costs are not included in the 2010 budget.

Key Upcoming Milestones

Action Item	Date
January MMR with initial data on RAF scores for members	1/25/10
February MMR with initial data on RAF scores for members	2/22/10
Results from January sweep – data submitted for 2009 Final Payment	End of February
March sweep – data submitted for 2010 EOL	4/1/10



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United for Medicare
Focus on the Care

EXHIBIT 6

From: Polich, Cynthia L
Sent: Thursday, September 09, 2010 8:45 AM
To: Poehling, Benjamin
Subject: RAF Chart Audits

Ben -

Wanted to check back with you on status of the discussions with Ingenix re: increasing the number of chart audits. I did followup with Tom after our brief conversation on this and he felt that we had resolved the issue of concern by agreeing to develop and implement a pilot. We both agreed that this issue should not stand in the way of moving forward with additional chart audits. Let me know if there is more we need to do on this.

Thanks

Cindy

Cindy Polich
President, Ovations
520-615-5204 - AZ office
714-825-5308 - CA office
714-342-0539 - mobile

EXHIBIT 7

RAF and PMPM Build-Up Report

(1) - Actual Projection as of 3/31/10

(2) - 2010 EOL Projection as of 3/31/10

(3) - RAF Degradation: March less January MOR RAF plus a degradation factor of 0.4% per month from March to July

(4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

DEC State	Provider Group Name	Jan 2010 Members (1)	RAF Drivers				PMPM Drivers			
			Jan 2010 Actual RAF (1)	EOL RAF (2)	RAF Degradation (Jan-Jul) (3)	July 2010 Proj. RAF (4)	Jan 2010 PMPM (1)	EOL PMPM (2)	PMPM Degradation (Jan-Jul) (3)	July 2010 Proj. PMPM (4)
CALIFORNIA	Petaluma Health Center	1	3,973	0.127	(0.065)	4,035	\$3,154.09	\$100.01	(\$51.42)	\$3,202.68
CALIFORNIA	UNK	7	2,362	0.150	(0.040)	2,472	\$1,868.50	\$115.93	(\$30.86)	\$1,953.57
CALIFORNIA	FAMILY PRACTICE MEDICAL GROUP	652	2,461	0.060	(0.055)	2,466	\$1,999.58	\$47.14	(\$43.28)	\$2,003.43
CALIFORNIA	SAN DIEGO PHYS MG/HULA VISTA	3	1,897	0.135	(0.032)	1,999	\$1,513.10	\$103.66	(\$24.86)	\$1,591.89
ARIZONA	CARE PLUS NETWORK	261	1,851	0.052	(0.044)	1,859	\$1,476.38	\$40.49	(\$34.31)	\$1,482.56
OREGON	GREEN MOUNTAIN	8	1,008	0.520	(0.024)	1,503	\$840.36	\$418.11	(\$19.55)	\$1,238.92
CALIFORNIA	ACCESS MEDICAL GROUP INC	1,016	1,167	0.343	(0.019)	1,491	\$1,060.89	\$285.15	(\$15.97)	\$1,330.08
TEXAS	PRINCETON IPA OF SAN ANTONIO	34,163	1,383	0.128	(0.038)	1,473	\$1,265.16	\$102.50	(\$30.48)	\$1,337.18
CALIFORNIA	HEALTHCARE PARTNERS MED GRP	29,695	1,226	0.154	(0.027)	1,354	\$1,156.18	\$131.81	(\$22.85)	\$1,265.15
COLORADO	NEW WEST PHYSICIANS/HEALTH ONE	640	1,339	0.029	(0.037)	1,332	\$1,092.93	\$22.90	(\$28.83)	\$1,087.00
TEXAS	UNK	1,281	1,198	0.161	(0.032)	1,327	\$1,093.07	\$129.50	(\$25.50)	\$1,197.07
CALIFORNIA	VALLEY CARE IPA	750	1,259	0.098	(0.030)	1,326	\$1,121.90	\$86.15	(\$26.48)	\$1,181.57
CALIFORNIA	PHYSICIANS ASSOCIATES	4,701	1,228	0.095	(0.029)	1,295	\$1,149.15	\$81.96	(\$24.58)	\$1,206.54
COLORADO	SENIOR CARE COLORADO	1,318	1,222	0.107	(0.036)	1,293	\$987.13	\$83.42	(\$28.35)	\$1,042.19
OKLAHOMA	STEVEN KING	20	1,428	(0.116)	(0.021)	1,291	\$1,163.31	(\$90.93)	(\$16.33)	\$1,056.05
CALIFORNIA	GOLDEN CARE	3	0.933	0.248	0.106	1,287	\$864.18	\$201.28	\$86.38	\$1,151.84
NEVADA	LAS VEGAS NETWORK	1,110	1,184	0.138	(0.037)	1,286	\$1,042.78	\$123.92	(\$33.37)	\$1,133.33
ARIZONA	JOHN C LINCOLN NETWORK	1	0.982	0.324	(0.021)	1,285	\$771.92	\$239.74	(\$15.39)	\$996.28
TEXAS	HOUSTON DCN	19	1,167	0.048	0.039	1,254	\$1,099.34	\$42.47	\$34.39	\$1,176.20
OREGON	THE PORTLAND CLINIC (CMG)	1,449	1,219	0.051	(0.027)	1,242	\$1,005.74	\$41.05	(\$22.12)	\$1,024.67
OREGON	West Linn Pediatric And Women	4	1,420	(0.158)	(0.020)	1,242	\$1,141.25	(\$125.02)	(\$15.84)	\$1,000.39
CALIFORNIA	MERCY PHYSICIANS MEDICAL GROUP	2,964	1,203	0.072	(0.038)	1,236	\$992.52	\$55.86	(\$29.58)	\$1,018.60
OREGON	UNK	46	1,129	0.125	(0.020)	1,234	\$1,005.87	\$112.28	(\$17.90)	\$1,100.24
OREGON	PRIME MED	49	1,227	0.023	(0.038)	1,212	\$1,098.10	\$20.55	(\$34.19)	\$1,084.46
CALIFORNIA	TALBERT MEDICAL GROUP	5,709	1,160	0.049	(0.019)	1,189	\$1,031.76	\$39.63	(\$15.74)	\$1,055.65
OREGON	NORTHWEST PRIMARY CARE (CMG)	1,201	1,104	0.109	(0.026)	1,187	\$904.54	\$87.97	(\$21.02)	\$971.49
CALIFORNIA	OMNI IPA INC-STOCKTON	1	0.875	0.329	(0.019)	1,185	\$772.80	\$275.10	(\$16.01)	\$1,031.89
COLORADO	NEW WEST PHYSICIANS/LUTHERAN	4,135	1,137	0.076	(0.030)	1,183	\$918.29	\$58.79	(\$23.42)	\$953.66
OREGON	Q STREET INTERNISTS	22	1,191	0.071	(0.080)	1,182	\$969.62	\$56.10	(\$63.21)	\$962.51
CALIFORNIA	GREATER NEWPORT PHYS@HOAG HOSP	8,896	1,118	0.085	(0.025)	1,178	\$976.48	\$66.96	(\$19.88)	\$1,023.56
TEXAS	PHYSICIAN PRIMECARE	7,257	1,073	0.130	(0.027)	1,176	\$1,050.59	\$106.69	(\$21.93)	\$1,135.35
CALIFORNIA	AFFINITY WEST COUNTY REGION	1,898	1,142	0.067	(0.036)	1,174	\$1,106.26	\$63.21	(\$33.59)	\$1,135.88
CALIFORNIA	AXMINSTER MEDICAL GROUP INC	966	1,139	0.058	(0.025)	1,172	\$1,086.81	\$50.77	(\$21.96)	\$1,115.61
CALIFORNIA	ALTA BATES MEDICAL GROUP	1,334	1,161	0.055	(0.045)	1,171	\$1,108.31	\$51.34	(\$41.98)	\$1,117.67
OREGON	FIVE RIVERS	10	0.866	0.233	0.066	1,165	\$706.94	\$187.26	\$52.86	\$947.06
CALIFORNIA	SAN JOSE MEDICAL GROUP	2,329	1,152	0.033	(0.027)	1,158	\$1,024.59	\$29.56	(\$23.99)	\$1,030.16
OREGON	HEALTH CARE RESOURCES NW	1,245	1,051	0.120	(0.018)	1,153	\$880.22	\$98.77	(\$14.53)	\$964.46
CALIFORNIA	HEMET COMMUNITY MEDICAL GROUP	6,912	1,036	0.132	(0.025)	1,143	\$902.90	\$103.51	(\$19.36)	\$987.05
CALIFORNIA	EPIC	9,313	1,089	0.074	(0.020)	1,142	\$942.72	\$58.08	(\$15.96)	\$984.83
COLORADO	NEW WEST PHYSICIANS/CENTURA	2,843	1,086	0.082	(0.029)	1,139	\$872.65	\$63.10	(\$22.21)	\$913.54
CALIFORNIA	ENCOMPASS MEDICAL GROUP INC	1,043	1,112	0.046	(0.026)	1,133	\$910.74	\$35.66	(\$19.98)	\$926.41
CALIFORNIA	MONARCH HEALTHCARE	9,468	1,122	0.035	(0.033)	1,123	\$981.05	\$27.21	(\$26.21)	\$982.06
CALIFORNIA	CENTRAL VALLEY MEDICAL GROUP	3,782	1,102	0.046	(0.029)	1,120	\$1,003.07	\$39.96	(\$24.75)	\$1,018.28
TEXAS	CORPUS CHRISTI DIRECT	1,803	1,105	0.041	(0.033)	1,113	\$1,071.86	\$36.71	(\$29.43)	\$1,079.14
CALIFORNIA	APPLECARE	1,974	1,029	0.097	(0.014)	1,112	\$1,005.68	\$85.05	(\$12.23)	\$1,078.50
CALIFORNIA	INLAND HEALTH CARE GROUP	295	1,165	(0.008)	(0.047)	1,111	\$1,040.76	(\$6.54)	(\$38.50)	\$995.72
CALIFORNIA	PRIMARY CARE ASSOCIATED MG	3,905	1,032	0.092	(0.019)	1,104	\$865.84	\$72.37	(\$15.29)	\$922.92
CALIFORNIA	SANTA CLARA COUNTY IPA	3,140	1,052	0.080	(0.029)	1,104	\$928.09	\$70.60	(\$25.56)	\$973.13
CALIFORNIA	MIDCOAST IPA	1,459	1,047	0.076	(0.023)	1,100	\$854.13	\$60.30	(\$18.09)	\$986.34
CALIFORNIA	PIONEER PROVIDER NETWORK A MED	1,126	1,149	(0.023)	(0.031)	1,094	\$1,075.22	(\$20.12)	(\$26.72)	\$1,028.37
CALIFORNIA	SUTTER EAST BAY MEDICAL FOUNDATION	762	1,057	0.086	(0.030)	1,093	\$1,042.11	\$63.76	(\$28.98)	\$1,076.88
CALIFORNIA	RIVERSIDE MEDICAL CLINIC INC	1,405	1,090	0.032	(0.030)	1,092	\$954.12	\$25.88	(\$23.95)	\$956.05
OREGON	CASTILLO	18	0.948	0.184	(0.041)	1,091	\$691.87	\$129.12	(\$28.57)	\$792.42
CALIFORNIA	CHOICE MEDICAL GROUP	427	1,037	0.075	(0.040)	1,072	\$877.43	\$57.14	(\$30.45)	\$904.12
CALIFORNIA	SAN BERNARDINO MEDICAL GROUP	1,481	0.896	0.190	(0.021)	1,066	\$804.38	\$152.17	(\$16.68)	\$939.87
CALIFORNIA	HEALTHCARE PARTNERS	1,431	1,032	0.047	(0.015)	1,064	\$988.90	\$40.49	(\$12.71)	\$1,016.68
CALIFORNIA	SCRIPPS CLINIC	14,133	0.974	0.110	(0.022)	1,062	\$814.44	\$87.08	(\$17.40)	\$884.12
OREGON	PACIFIC MEDICAL	1,794	1,058	0.019	(0.017)	1,060	\$866.44	\$15.55	(\$13.54)	\$868.45
CALIFORNIA	SEAVIEW IPA	3,822	1,025	0.056	(0.023)	1,058	\$933.57	\$49.89	(\$20.45)	\$963.01
OREGON	PROVIDENCE MED GRP	2,684	1,017	0.060	(0.020)	1,057	\$835.90	\$48.22	(\$15.72)	\$868.40
CALIFORNIA	BRISTOL PARK MEDICAL GROUP	1,724	1,017	0.086	(0.026)	1,057	\$905.41	\$52.28	(\$20.63)	\$937.06

RAF and PMPM Build-Up Report

(2) - 2010 EOL Projection as of 3/31/10

(2) - 2010 EOL Projection as of 3/31/10

(3) - RAF Degradation: March less January MOR RAF plus a degradation factor of 0.4% per month from March to July

(4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

DEC State	Provider Group Name	Jan 2010 Members (1)	RAF Drivers				PMPM Drivers			
			Jan 2010 Actual RAF (1)	EOL RAF (2)	RAF Degradation (Jan-Jul) (3)	July 2010 Proj. RAF (4)	Jan 2010 PMPM (1)	EOL PMPM (2)	PMPM Degradation (Jan-Jul) (3)	July 2010 Proj. PMPM (4)
OREGON	FAMILY HEALTHPARTNERS	8	1.428	(0.469)	(0.015)	0.943	\$1,146.89	(\$370.09)	(\$12.03)	\$764.77
CALIFORNIA	SUTTER WEST MEDICAL GROUP	135	0.910	0.057	(0.023)	0.943	\$831.30	\$48.61	(\$19.60)	\$860.32
OKLAHOMA	OKC DCN	14,452	0.938	0.028	(0.023)	0.943	\$790.28	\$22.34	(\$18.05)	\$794.57
WASHINGTON	PROVIDENCE HEALTH SYSTEMS	86	0.979	0.032	(0.069)	0.942	\$714.82	\$22.38	(\$47.79)	\$689.41
OKLAHOMA	UNK	1,708	0.945	0.030	(0.033)	0.942	\$797.40	\$24.19	(\$26.71)	\$794.89
WASHINGTON	THURSTON DIRECT	911	0.889	0.073	(0.021)	0.940	\$717.19	\$59.17	(\$17.28)	\$759.07
COLORADO	COLO SPGS HEALTH PARTNERS	3,836	0.955	0.010	(0.025)	0.939	\$770.39	\$7.33	(\$19.33)	\$758.38
WASHINGTON	LEWIS DIRECT	522	0.907	0.064	(0.032)	0.939	\$677.11	\$46.27	(\$22.95)	\$700.43
OREGON	CORVALLIS	135	0.942	0.032	(0.037)	0.937	\$689.97	\$22.39	(\$26.15)	\$686.22
ARIZONA	METRO TUCSON NETWORK	24,800	0.910	0.041	(0.017)	0.935	\$748.09	\$33.84	(\$14.01)	\$767.92
OKLAHOMA	TULSA DCN	2,905	0.937	0.026	(0.030)	0.933	\$774.65	\$21.00	(\$24.17)	\$771.48
WASHINGTON	HEALTH CARE RESOURCES NW	117	0.782	0.142	0.007	0.931	\$625.11	\$110.08	\$5.34	\$740.53
WASHINGTON	PRIMARY CARE OF PUYALLUP	164	0.933	0.013	(0.016)	0.929	\$769.95	\$10.76	(\$13.53)	\$767.18
CALIFORNIA	WOODLAND CLINIC MED GROUP	140	0.952	0.008	(0.032)	0.928	\$825.04	\$6.77	(\$26.03)	\$805.78
OKLAHOMA	Putnam North Family Medical	43	0.933	0.036	(0.043)	0.927	\$779.26	\$28.19	(\$33.21)	\$774.24
OREGON	THE CORVALLIS CLINIC (CMG)	1,657	0.925	0.027	(0.026)	0.926	\$700.82	\$19.40	(\$19.27)	\$700.94
CALIFORNIA	Sonoma DCN PCPs	185	0.924	0.035	(0.040)	0.919	\$774.41	\$28.16	(\$32.44)	\$770.13
WASHINGTON	SEATTLE DIRECT	1,858	0.896	0.055	(0.033)	0.919	\$736.27	\$44.62	(\$26.29)	\$754.61
WASHINGTON	SWEDISH	2,064	0.887	0.061	(0.030)	0.918	\$735.38	\$49.60	(\$24.43)	\$760.55
WASHINGTON	PIERCE COUNTY DIRECT	4,366	0.882	0.057	(0.026)	0.914	\$719.57	\$45.63	(\$20.55)	\$744.65
WASHINGTON	KIRKPATRICK FAMILY CARE PS	186	0.881	0.058	(0.025)	0.914	\$623.53	\$37.61	(\$16.38)	\$644.76
CALIFORNIA	CHINO MEDICAL GROUP INC	423	0.901	0.026	(0.014)	0.913	\$780.42	\$19.75	(\$10.56)	\$789.61
WASHINGTON	WHITEHORSE FAMILY MEDICINE	142	0.932	0.040	(0.060)	0.911	\$747.01	\$30.15	(\$45.75)	\$731.41
WASHINGTON	PORTLAND DIRECT	264	0.934	0.018	(0.041)	0.911	\$739.33	\$13.60	(\$30.70)	\$722.23
CALIFORNIA	PREMIER PHYSICIANS NETWORK	704	0.897	0.031	(0.022)	0.906	\$906.34	\$27.74	(\$19.62)	\$914.47
CALIFORNIA	GOOD SAM MED PRAC ASSOC	647	0.882	0.046	(0.022)	0.905	\$855.70	\$38.94	(\$19.06)	\$875.57
OREGON	SAMARITAN HEALTH SERVICES -PCP	877	0.872	0.050	(0.018)	0.904	\$663.31	\$36.14	(\$12.91)	\$686.53
OREGON	MONTEREY HEALTH	4	1.025	(0.107)	(0.015)	0.903	\$828.80	(\$84.19)	(\$11.52)	\$733.09
CALIFORNIA	OMNICARE MEDICAL GROUP	149	0.938	(0.017)	(0.021)	0.900	\$873.60	(\$14.01)	(\$17.45)	\$842.14
CALIFORNIA	BAY AREA COM MED GRP	450	0.854	0.072	(0.033)	0.893	\$792.35	\$58.06	(\$26.61)	\$823.81
CALIFORNIA	SANTE COMMUNITY PHYS-FRESNO	3,750	0.910	0.012	(0.029)	0.892	\$756.35	\$9.14	(\$23.00)	\$742.49
CALIFORNIA	EMPIRE PHYS MG	2,199	0.880	0.036	(0.024)	0.892	\$774.88	\$28.06	(\$18.77)	\$784.17
CALIFORNIA	MARIN IPA SONOMA	215	0.861	0.068	(0.038)	0.891	\$727.75	\$55.06	(\$31.22)	\$751.59
OREGON	LANE DIRECT	2,824	0.866	0.039	(0.016)	0.889	\$717.36	\$31.54	(\$12.82)	\$736.08
ARIZONA	ABRAZO NETWORK	2	1.403	0.000	(0.514)	0.889	\$1,107.97	\$0.00	(\$446.39)	\$661.58
CALIFORNIA	CENTINELA VALLEY IPA MG INC	343	0.818	0.079	(0.011)	0.886	\$827.15	\$69.34	(\$9.47)	\$887.03
CALIFORNIA	JOHN MUIR HEALTH NETWORK	724	0.851	0.041	(0.008)	0.884	\$842.11	\$39.17	(\$7.39)	\$873.89
WASHINGTON	SNOHOMISH DIRECT	5,231	0.863	0.049	(0.030)	0.882	\$704.51	\$38.00	(\$23.05)	\$719.45
OREGON	VENETA MEDICAL CLINIC	5	1.142	(0.221)	(0.040)	0.882	\$930.61	(\$174.64)	(\$31.60)	\$724.37
TEXAS	Deuteronomy-2	987	0.870	0.035	(0.024)	0.880	\$819.01	\$29.54	(\$20.62)	\$827.93
CALIFORNIA	ST JUDE AFFILIATED PHYSICIANS	685	0.840	0.047	(0.009)	0.878	\$815.00	\$39.18	(\$7.58)	\$846.60
WASHINGTON	UNK	2,162	0.888	0.024	(0.037)	0.875	\$730.86	\$19.19	(\$29.46)	\$720.59
COLORADO	DENVER PROPRIETARY SECURE	12,866	0.860	0.033	(0.020)	0.874	\$701.30	\$25.50	(\$15.19)	\$711.61
CALIFORNIA	TORRANCE HOSPITAL IPA	875	0.870	0.026	(0.024)	0.873	\$818.47	\$21.70	(\$19.44)	\$820.73
WASHINGTON	MULTICARE	2,765	0.867	0.030	(0.027)	0.871	\$696.96	\$23.52	(\$20.71)	\$699.78
CALIFORNIA	Independence IPA	321	0.870	0.040	(0.040)	0.871	\$738.11	\$30.23	(\$30.05)	\$738.29
ARIZONA	PINAL HEALTH CARE NETWORK	2,196	0.869	0.021	(0.021)	0.869	\$712.98	\$16.23	(\$16.34)	\$712.88
CALIFORNIA	OJAI VALLEY MEDICAL GROUP	515	0.857	0.029	(0.017)	0.869	\$765.13	\$24.88	(\$15.03)	\$774.98
COLORADO	LOVELAND PROPRIETARY	2,071	0.874	0.016	(0.026)	0.863	\$710.79	\$12.32	(\$20.19)	\$702.93
TEXAS	Jefferson Phys Grp	1,928	0.872	0.022	(0.033)	0.861	\$852.71	\$19.48	(\$28.99)	\$843.20
CALIFORNIA	Brookwood Internal Medical	46	0.951	(0.058)	(0.034)	0.859	\$770.19	(\$45.50)	(\$27.11)	\$697.58
CALIFORNIA	SONOMA COUNTY PRIMARY CARE IPA	75	0.757	0.126	(0.025)	0.857	\$615.35	\$98.72	(\$19.78)	\$694.29
CALIFORNIA	ADOC-FOUNTAIN VALLEY DIVISION	748	0.839	0.040	(0.023)	0.856	\$801.43	\$33.48	(\$19.50)	\$815.40
COLORADO	COLORADO SPRINGS DIRECT	6,039	0.849	0.031	(0.025)	0.855	\$682.98	\$23.00	(\$18.43)	\$687.55
COLORADO	FREMONT COUNTY SECURE	308	0.764	0.114	(0.025)	0.853	\$569.16	\$77.34	(\$17.15)	\$629.35
WASHINGTON	EASTSIDE DIRECT	1,870	0.850	0.031	(0.030)	0.851	\$692.19	\$24.51	(\$23.92)	\$692.79
ARIZONA	COMPLETE ACCESS NETWORK	5,258	0.823	0.045	(0.021)	0.847	\$673.32	\$35.93	(\$16.83)	\$692.42
COLORADO	PUEBLO PROPRIETARY CENTURA	1,889	0.848	0.018	(0.025)	0.841	\$616.08	\$11.86	(\$16.61)	\$611.33
OKLAHOMA	NORMAN PHO PCPS	346	0.802	0.040	(0.005)	0.838	\$649.95	\$29.74	(\$3.32)	\$676.37
WASHINGTON	PEACEHEALTH MEDICAL GROUP	703	0.798	0.053	(0.027)	0.823	\$577.66	\$34.82	(\$18.15)	\$594.33
CALIFORNIA	LA VIDA MULTISPECIALTY	576	0.828	0.000	(0.013)	0.816	\$839.53	\$0.40	(\$12.02)	\$827.91

RAF and PMPM Build-Up Report

(1) - Actual Members as of 2010. Actual Members, RAF & PMPM

(2) - 2010 EOL Projection as of 3/31/10

(3) - RAF Degradation: March less January MOR RAF plus a degradation factor of 0.4% per month from March to July

(4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

DEC State	Provider Group Name	Jan 2010 Members (1)	Jan 2010 Actual RAF (1)	RAF Drivers			Jan 2010 PMPM (1)	PMPM Drivers		
				EOL RAF (2)	RAF Degradation (Jan-Jul) (3)	July 2010 Proj. RAF (4)		EOL PMPM (2)	PMPM Degradation (Jan-Jul) (3)	July 2010 Proj. PMPM (4)
CALIFORNIA	RIVERSIDE PHYS NTKW RSDE COMM	1,348	0.797	0.036	(0.018)	0.815	\$737.29	\$29.07	(\$14.69)	\$751.67
WASHINGTON	VALLEY DIRECT	817	0.779	0.043	(0.008)	0.815	\$642.14	\$33.53	(\$6.04)	\$669.63
WASHINGTON	HIGHLINE MSO (CMG)	551	0.775	0.037	0.001	0.813	\$644.02	\$28.59	\$0.81	\$673.43
OKLAHOMA	CANADIAN VALLEY	631	0.791	0.033	(0.013)	0.811	\$707.10	\$26.73	(\$10.34)	\$723.49
CALIFORNIA	PACIFIC INDEPENDENT PHY ASSOC	1,054	0.814	0.018	(0.030)	0.802	\$822.81	\$15.78	(\$26.22)	\$812.37
CALIFORNIA	SIERRA NEVADA MEDICAL ASSOC	1,019	0.791	0.018	(0.021)	0.788	\$632.11	\$14.17	(\$16.29)	\$629.99
CALIFORNIA	MARIN IPA - SONOMA	39	0.712	0.093	(0.020)	0.785	\$581.67	\$73.45	(\$15.45)	\$639.67
TEXAS	SAN ANTONIO DCN	16	0.647	0.078	0.060	0.785	\$636.29	\$66.55	\$43.18	\$736.02
OKLAHOMA	THE PHYSICIANS GROUP	1,107	0.775	0.028	(0.018)	0.784	\$656.42	\$21.43	(\$14.25)	\$663.60
CALIFORNIA	PORTERVILLE	81	0.797	0.015	(0.029)	0.783	\$645.08	\$11.30	(\$21.49)	\$634.88
ARIZONA	RURAL AREA NETWORK	1,025	0.753	0.041	(0.011)	0.783	\$549.77	\$32.23	(\$8.40)	\$573.59
CALIFORNIA	SIERRA MEDICAL CLINIC, INC	8	0.678	0.155	(0.054)	0.779	\$654.75	\$126.70	(\$44.17)	\$737.27
CALIFORNIA	ALLIED PHYSICIANS OF CALIF	785	0.794	(0.003)	(0.012)	0.779	\$814.24	(\$2.28)	(\$10.85)	\$801.11
WASHINGTON	Meadowbrook Urgent Care	17	0.650	0.137	(0.028)	0.759	\$530.33	\$103.52	(\$20.90)	\$612.96
COLORADO	BOULDER COUNTY SECURE	1,632	0.755	0.010	(0.016)	0.750	\$611.75	\$7.60	(\$11.76)	\$607.59
CALIFORNIA	EL ROSE MG	22	0.619	0.107	0.012	0.737	\$511.38	\$83.60	\$9.34	\$604.31
CALIFORNIA	BROWN & TOLAND MED GRP	1,245	0.698	0.054	(0.019)	0.734	\$599.99	\$41.70	(\$14.30)	\$627.39
CALIFORNIA	IMPERIAL CNTY PHYS MEDICAL GRP	115	0.668	0.062	(0.012)	0.718	\$500.34	\$42.69	(\$8.51)	\$534.52
COLORADO	SECURE ADVANTAGE CO	417	0.726	0.035	(0.045)	0.716	\$580.33	\$25.89	(\$33.13)	\$573.09
CALIFORNIA	Visalia Medical Clinic	97	0.767	0.009	(0.079)	0.697	\$621.20	\$6.41	(\$59.19)	\$568.43
OREGON	FANNO CREEK	36	0.736	(0.035)	(0.008)	0.693	\$599.86	(\$28.07)	(\$6.72)	\$565.07
CALIFORNIA	PRUDENT MEDICAL GROUP	17	0.657	0.077	(0.042)	0.692	\$634.69	\$63.44	(\$34.82)	\$663.31
OKLAHOMA	FAMILY MEDICINE SPECIALISTS	33	0.714	(0.020)	(0.014)	0.679	\$576.67	(\$14.75)	(\$10.51)	\$551.42
CALIFORNIA	UNIVERSAL CARE MEDICAL GROUP	4	0.553	0.076	0.048	0.676	\$539.53	\$59.37	\$37.99	\$636.89
CALIFORNIA	PREMIER CARE IPA	10	0.704	0.021	(0.053)	0.672	\$603.50	\$18.34	(\$45.25)	\$576.59
CALIFORNIA	AMVI	12	0.571	0.028	0.010	0.608	\$536.37	\$22.00	\$7.73	\$566.09
WASHINGTON	PROVIDENCE MED GRP	9	0.585	0.045	(0.032)	0.598	\$468.33	\$33.61	(\$23.74)	\$478.20
CALIFORNIA	KOREAN AMERICAN MEDICAL GROUP	91	0.535	0.057	(0.014)	0.578	\$534.99	\$45.03	(\$11.18)	\$568.84
OREGON	HEALTHMAX	4	0.371	0.195	(0.009)	0.557	\$299.42	\$158.17	(\$7.30)	\$450.29
WASHINGTON	PACIFIC MEDICAL	1	2.416	(0.985)	(0.879)	0.552	\$1,784.97	(\$707.88)	(\$631.85)	\$445.24
NEVADA	SECURE ADVANTAGE NV	0	0.000	0.000	0.526	0.526	\$0.00	\$0.00	\$459.61	\$459.61
ARIZONA	KINO NETWORK	1	0.461	0.006	0.011	0.478	\$378.27	\$4.31	\$8.67	\$391.25
WASHINGTON	TUALITY HEALTH ALLIANCE	1	0.461	0.006	(0.007)	0.459	\$379.54	\$4.22	(\$5.34)	\$378.42
OKLAHOMA	Jerry A Nelms Do Inc	10	0.395	0.009	(0.006)	0.397	\$332.10	\$6.88	(\$5.05)	\$333.93
WASHINGTON	PORTLAND AVENUE FAMILY CLINIC	4	0.398	0.000	(0.006)	0.391	\$317.83	\$0.00	(\$5.13)	\$312.70

RAF by Component Report
 (1) - Actuals as of 7/31/10
 (2) - 2010 EOL Projection as of 3/31/10
 (3) - RAF Degradation: March less January MOR RAF plus a degradation factor of 0.4% per month from March to July
 (4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

DEC State	Provider Group Name	January 2010 RAF Components				July 2010 RAF Components				Avg RAF Improvement (Jan to Jul)				Avg % RAF Improvement (Jan to Jul)			
		Jan Total RAF (1)	HCC (1)	Age/Sex (1)	Special Status (1)	July Total RAF (4)	HCC (4)	Age/Sex (4)	Special Status (4)	RAF	HCC	Age/ Sex	Special Status	RAF	HCC	Age/ Sex	Special Status
CALIFORNIA	Petaluma Health Center	3.973	3.669	0.304	-	4.035	3.735	0.299	-	0.062	0.066	(0.005)	0.000	1.6%	1.8%	-1.6%	0.0%
CALIFORNIA	UNK	2.362	1.555	0.732	0.075	2.472	1.678	0.720	0.074	0.110	0.123	(0.012)	(0.001)	4.7%	7.9%	-1.6%	-1.6%
CALIFORNIA	FAMILY PRACTICE MEDICAL GROUP	2.461	1.997	0.438	0.026	2.466	2.009	0.431	0.025	0.005	0.013	(0.007)	(0.001)	0.2%	0.6%	-1.5%	-3.4%
CALIFORNIA	SAN DIEGO PHYS MG/CHULA VISTA	1.897	1.155	0.559	0.183	1.999	1.269	0.551	0.180	0.102	0.114	(0.009)	(0.003)	5.4%	9.9%	-1.6%	-1.6%
ARIZONA	CARE PLUS NETWORK	1.851	1.058	0.720	0.073	1.859	1.067	0.720	0.071	0.008	0.010	0.000	(0.002)	0.4%	0.9%	0.0%	-2.6%
OREGON	GREEN MOUNTAIN	1.008	0.501	0.463	0.044	1.503	1.005	0.455	0.044	0.495	0.503	(0.007)	(0.001)	49.1%	100.4%	-1.6%	-1.6%
CALIFORNIA	ACCESS MEDICAL GROUP INC	1.167	0.666	0.479	0.021	1.491	0.995	0.475	0.021	0.324	0.329	(0.003)	(0.000)	27.7%	49.3%	-0.5%	-0.5%
TEXAS	PRINCETON IPA OF SAN ANTONIO	1.383	0.906	0.429	0.049	1.473	1.002	0.424	0.047	0.090	0.096	(0.005)	(0.001)	6.5%	10.6%	-1.2%	-2.2%
CALIFORNIA	HEALTHCARE PARTNERS MED GRP	1.226	0.734	0.467	0.026	1.354	0.868	0.461	0.025	0.127	0.134	(0.006)	(0.000)	10.4%	18.3%	-1.4%	-1.9%
COLORADO	NEW WEST PHYSICIANS/HEALTH ONE	1.339	0.869	0.456	0.014	1.332	0.868	0.451	0.013	(0.008)	(0.002)	(0.005)	(0.001)	-0.6%	-0.2%	-1.1%	-6.2%
TEXAS	UNK	1.198	0.729	0.420	0.048	1.327	0.863	0.418	0.046	0.129	0.134	(0.003)	(0.002)	10.8%	18.3%	-0.7%	-3.9%
CALIFORNIA	VALLEY CARE IPA	1.259	0.747	0.484	0.028	1.326	0.825	0.474	0.027	0.068	0.078	(0.010)	(0.001)	5.4%	10.5%	-2.0%	-1.9%
CALIFORNIA	PHYSICIANS ASSOCIATES	1.228	0.757	0.448	0.022	1.295	0.830	0.442	0.022	0.067	0.073	(0.006)	(0.000)	5.4%	9.6%	-1.3%	-0.9%
COLORADO	SENIOR CARE COLORADO	1.222	0.704	0.501	0.017	1.293	0.784	0.491	0.017	0.071	0.080	(0.010)	0.000	5.8%	11.4%	-1.9%	0.1%
OKLAHOMA	STEVEN KING	1.428	0.916	0.487	0.025	1.291	0.787	0.479	0.025	(0.137)	(0.129)	(0.008)	(0.000)	-9.6%	-14.1%	-1.6%	-1.6%
CALIFORNIA	GOLDEN CARE	0.933	0.212	0.666	0.055	1.287	0.533	0.718	0.037	0.354	0.322	0.051	(0.018)	38.0%	152.0%	7.7%	-33.4%
NEVADA	LAS VEGAS NETWORK	1.184	0.760	0.415	0.010	1.286	0.865	0.411	0.009	0.101	0.105	(0.004)	(0.000)	8.5%	13.8%	-0.9%	-1.1%
ARIZONA	JOHN C LINCOLN NETWORK	0.982	0.272	0.554	0.156	1.255	0.586	0.545	0.153	0.303	0.314	(0.009)	(0.002)	30.8%	115.5%	-1.6%	-1.6%
TEXAS	HOUSTON DGN	1.167	0.739	0.372	0.057	1.284	0.829	0.369	0.056	0.023	0.031	(0.003)	(0.001)	7.5%	12.2%	-0.7%	-0.9%
OREGON	THE PORTLAND CLINIC (CMG)	1.219	0.687	0.514	0.018	1.242	0.718	0.507	0.018	0.023	0.031	(0.007)	0.000	1.9%	4.4%	-1.4%	0.3%
OREGON	West Linn Pediatric And Women	1.420	0.877	0.502	0.042	1.242	0.707	0.494	0.041	(0.178)	(0.170)	(0.008)	(0.001)	-12.6%	-19.4%	-1.6%	-1.6%
CALIFORNIA	MERCY PHYSICIANS MEDICAL GROUP	1.203	0.710	0.467	0.026	1.236	0.753	0.459	0.025	0.034	0.043	(0.008)	(0.001)	2.8%	6.1%	-1.8%	-3.4%
OREGON	UNK	1.129	0.585	0.524	0.020	1.234	0.698	0.516	0.020	0.105	0.114	(0.008)	(0.000)	9.3%	19.5%	-1.6%	-1.6%
OREGON	PRIME MED	1.227	0.746	0.439	0.042	1.212	0.742	0.429	0.041	(0.015)	(0.004)	(0.010)	(0.002)	-1.2%	-0.5%	-2.2%	-3.6%
CALIFORNIA	TALBERT MEDICAL GROUP	1.160	0.647	0.484	0.029	1.189	0.583	0.478	0.028	0.030	0.036	(0.006)	(0.001)	2.6%	5.6%	-1.3%	-1.8%
OREGON	NORTHWEST PRIMARY CARE (CMG)	1.104	0.576	0.507	0.021	1.187	0.666	0.500	0.021	0.083	0.090	(0.007)	0.000	7.5%	15.6%	-1.4%	0.8%
CALIFORNIA	OMNI IPA INC-STOCKTON	0.875	0.492	0.383	-	1.185	0.808	0.377	-	0.310	0.316	(0.006)	0.000	35.4%	64.2%	-1.6%	0.0%
COLORADO	NEW WEST PHYSICIANS/LUTHERAN	1.137	0.689	0.436	0.012	1.183	0.741	0.431	0.011	0.046	0.052	(0.008)	(0.000)	4.0%	7.5%	-1.3%	-2.7%
OREGON	Q STREET INTERNISTS	1.191	0.714	0.432	0.046	1.182	0.728	0.413	0.041	(0.009)	0.014	(0.018)	(0.004)	-0.8%	2.0%	-4.3%	-9.8%
CALIFORNIA	GREATER NEWPORT PHYS@HOAG HOSP	1.118	0.656	0.448	0.015	1.178	0.722	0.441	0.014	0.060	0.066	(0.007)	(0.000)	5.3%	10.1%	-1.5%	-1.9%
TEXAS	PHYSICIAN PRIMECARE	1.073	0.591	0.423	0.059	1.176	0.701	0.417	0.057	0.103	0.110	(0.006)	(0.002)	9.6%	18.6%	-1.4%	-2.6%
CALIFORNIA	AFFINITY WEST COUNTY REGION	1.142	0.628	0.489	0.025	1.174	0.670	0.479	0.025	0.103	0.104	(0.010)	(0.000)	2.8%	6.7%	-2.1%	-1.0%
CALIFORNIA	AXMINSTER MEDICAL GROUP INC	1.139	0.618	0.477	0.044	1.172	0.657	0.472	0.043	0.033	0.039	(0.005)	(0.001)	2.9%	6.3%	-1.0%	-2.5%
CALIFORNIA	ALTA BATES MEDICAL GROUP	1.161	0.655	0.478	0.028	1.171	0.676	0.469	0.026	0.010	0.020	(0.009)	(0.001)	0.9%	3.1%	-1.8%	-5.2%
OREGON	FIVE RIVERS	0.866	0.413	0.406	0.056	1.165	0.702	0.406	0.056	0.299	0.290	0.000	0.009	34.5%	70.2%	0.0%	18.9%
CALIFORNIA	SAN JOSE MEDICAL GROUP	1.152	0.615	0.514	0.022	1.158	0.631	0.505	0.021	0.006	0.016	(0.009)	(0.001)	0.5%	2.6%	-1.7%	-4.4%
OREGON	HEALTH CARE RESOURCES NW	1.051	0.556	0.470	0.025	1.153	0.665	0.464	0.025	0.102	0.109	(0.007)	(0.000)	9.7%	19.6%	-1.4%	-0.6%
CALIFORNIA	HEMET COMMUNITY MEDICAL GROUP	1.036	0.560	0.449	0.027	1.143	0.675	0.441	0.027	0.107	0.116	(0.008)	(0.000)	10.3%	20.7%	-1.9%	-1.6%
CALIFORNIA	EPIC	1.089	0.603	0.461	0.025	1.142	0.663	0.455	0.025	0.054	0.060	(0.006)	(0.000)	4.9%	10.0%	-1.4%	-1.6%
COLORADO	NEW WEST PHYSICIANS/CENTURA	1.086	0.633	0.436	0.017	1.139	0.692	0.430	0.017	0.053	0.059	(0.006)	(0.000)	4.9%	9.3%	-1.3%	-2.0%
CALIFORNIA	ENCOMPASS MEDICAL GROUP INC	1.112	0.640	0.451	0.021	1.133	0.670	0.443	0.020	0.020	0.029	(0.008)	(0.001)	1.8%	4.6%	-1.8%	-4.7%
CALIFORNIA	MONARCH HEALTHCARE	1.122	0.629	0.477	0.016	1.123	0.639	0.468	0.016	0.001	0.010	(0.008)	(0.000)	0.1%	1.6%	-1.8%	-2.0%
CALIFORNIA	CENTRAL VALLEY MEDICAL GROUP	1.102	0.630	0.444	0.028	1.120	0.654	0.438	0.027	0.018	0.025	(0.007)	(0.001)	1.6%	4.0%	-1.5%	-2.2%
TEXAS	CORPUS CHRISTI DIRECT	1.105	0.615	0.401	0.088	1.113	0.632	0.396	0.085	0.008	0.017	(0.006)	(0.004)	0.7%	2.8%	-1.4%	-4.1%
CALIFORNIA	APPLECARE	1.029	0.533	0.451	0.045	1.112	0.623	0.445	0.044	0.008	0.090	(0.006)	(0.001)	8.1%	16.9%	-1.3%	-1.4%
CALIFORNIA	INLAND HEALTH CARE GROUP	1.165	0.679	0.438	0.048	1.111	0.631	0.432	0.048	(0.055)	(0.048)	(0.006)	(0.001)	-4.7%	-7.1%	-1.3%	-1.2%
CALIFORNIA	PRIMARY CARE ASSOCIATED MG	1.032	0.535	0.483	0.014	1.104	0.614	0.477	0.013	0.073	0.079	(0.006)	(0.000)	7.0%	14.7%	-1.2%	-2.1%
CALIFORNIA	SANTA CLARA COUNTY IPA	1.052	0.535	0.498	0.019	1.104	0.595	0.489	0.019	0.051	0.060	(0.008)	(0.000)	4.9%	11.2%	-1.7%	-2.3%
CALIFORNIA	MIDCOAST IPA	1.047	0.547	0.476	0.024	1.100	0.611	0.466	0.023	0.053	0.064	(0.010)	(0.001)	5.1%	11.7%	-2.0%	-4.7%
CALIFORNIA	PIONEER PROVIDER NETWORK A MED	1.149	0.656	0.466	0.027	1.094	0.610	0.459	0.026	(0.054)	(0.046)	(0.008)	(0.000)	-4.7%	-7.1%	-1.6%	-1.4%
CALIFORNIA	SUTTER EAST BAY MEDICAL FOUNDATION	1.057	0.548	0.485	0.024	1.093	0.594	0.475	0.024	0.036	0.045	(0.009)	0.000	3.4%	8.3%	-1.9%	0.3%
CALIFORNIA	RIVERSIDE MEDICAL CLINIC INC	1.090	0.651	0.412	0.026	1.092	0.657	0.409	0.026	0.002	0.006	(0.003)	(0.001)	0.2%	1.0%	-0.8%	-2.1%
OREGON	CASTILLO	0.948	0.513	0.417	0.018	1.091	0.660	0.415	0.017	0.143	0.146	(0.002)	(0.001)	15.1%	28.5%	-0.4%	-6.8%
CALIFORNIA	CHOICE MEDICAL GROUP	1.037	0.587	0.420	0.030	1.072	0.630	0.413	0.028	0.035	0.043	(0.006)	(0.001)	3.4%	7.2%	-1.5%	-4.7%
CALIFORNIA	SAN BERNARDINO MEDICAL GROUP	0.896	0.416	0.448	0.033	1.066	0.592	0.442	0.032	0.169	0.176	(0.006)	(0.001)	18.9%	42.2%	-1.3%	-1.7%
CALIFORNIA	HEALTHCARE PARTNERS	1.032	0.529	0.477	0.025	1.064	0.567	0.472	0.025	0.032	0.038	(0.005)	(0.000)	3.1%	7.2%	-1.1%	-1.6%
CALIFORNIA	SCRIPPS CLINIC	0.974	0.486	0.472	0.015	1.062	0.582	0.465	0.015	0.088	0.086	(0.007)	(0.000)	9.0%	19.7%	-1.6%	-2.4%
OREGON	PACIFIC MEDICAL	1.058	0.518	0.518	0.022	1.060	0.528	0.510	0.022	0.002	0.011	(0.006)	(0.001)	0.2%	2.1%	-1.5%	-2.4%
CALIFORNIA	SEAVIEW IPA	1.025	0.515	0.484	0.027	1.058	0.556	0.476	0.026	0.032	0.041	(0.007)	(0.001)	3.2%	7.9%	-1.5%	-3.0%
OREGON	PROVIDENCE MED GRP	1.017	0.489	0.504	0.025	1.057	0.538	0.495	0.024	0.040	0.050	(0.009)	(0.000)	4.0%	10.2%	-1.8%	-1.6%
CALIFORNIA	BRISTOL PARK MEDICAL GROUP	1.017	0.562	0.438	0.017	1.057	0.609	0.431	0.016	0.040	0.048	(0.007)	(0.000)	3.9%	8.5%	-1.7%	-2.6%

RAF by Component Report
(1) - Actual Performance for 2010 (Actuals) - RAF & PNM
(2) - 2010 EOL Projection as of 3/31/10
(3) - RAF Degradation: March less January MOR RAF plus a degradation factor of 0.4% per month from March to July
(4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

DEC State	Provider Group Name	January 2010 RAF Components				July 2010 RAF Components				Avg RAF Improvement (Jan to Jul)				Avg % RAF Improvement (Jan to Jul)			
		Jan Total RAF (1)	HCC (1)	Age/Sex (1)	Special Status (1)	July Total RAF (4)	HCC (4)	Age/Sex (4)	Special Status (4)	RAF	HCC	Age/ Sex	Special Status	RAF	HCC	Age/ Sex	Special Status
CALIFORNIA	MEMORIAL HEALTHCARE IPA/LB	0.980	0.518	0.440	0.022	1.056	0.602	0.432	0.022	0.076	0.084	(0.008)	(0.001)	7.8%	16.3%	-1.7%	-3.2%
CALIFORNIA	COAST HEALTHCARE	1.002	0.528	0.446	0.028	1.054	0.587	0.439	0.028	0.052	0.059	(0.007)	(0.000)	5.1%	11.2%	-1.6%	-1.6%
CALIFORNIA	SHARP REES-STEALY MEDICAL GRP	0.936	0.438	0.478	0.020	1.050	0.561	0.470	0.020	0.115	0.123	(0.008)	(0.000)	12.2%	28.0%	-1.8%	-2.3%
TEXAS	DALLAS COUNTY HOSPITAL DISTRICT	0.981	0.483	0.404	0.093	1.048	0.554	0.409	0.085	0.067	0.071	0.005	(0.009)	6.8%	14.6%	1.3%	-9.4%
CALIFORNIA	SUTTER INDEPENDENT PHYSICIANS	1.040	0.544	0.467	0.029	1.039	0.552	0.459	0.028	(0.001)	0.008	(0.008)	(0.000)	-0.1%	1.4%	-1.7%	-1.6%
TEXAS	DALLAS DCN	1.008	0.553	0.420	0.034	1.038	0.591	0.414	0.033	0.304	0.037	(0.006)	(0.001)	3.0%	6.7%	-1.4%	-3.4%
COLORADO	UNK	0.973	0.504	0.457	0.012	1.037	0.576	0.449	0.012	0.064	0.072	(0.008)	(0.001)	6.5%	14.3%	-1.7%	-4.5%
CALIFORNIA	PHYS MED GRP OF SANTA CRUZ COU	0.972	0.462	0.491	0.018	1.036	0.537	0.481	0.018	0.064	0.075	(0.010)	(0.000)	6.6%	16.2%	-2.1%	-1.6%
CALIFORNIA	CENTRE FOR HEALTH CARE	0.994	0.514	0.469	0.012	1.035	0.560	0.463	0.012	0.040	0.045	(0.005)	(0.000)	4.0%	8.8%	-1.1%	-0.8%
CALIFORNIA	UNITED FAMILY CARE OF RIALTO	0.992	0.502	0.443	0.047	1.034	0.551	0.437	0.046	0.042	0.049	(0.006)	(0.001)	4.3%	9.7%	-1.3%	-1.5%
OREGON	PORTLAND DIRECT	1.024	0.528	0.472	0.023	1.032	0.546	0.464	0.023	0.008	0.018	(0.009)	(0.000)	0.8%	3.3%	-1.8%	-2.1%
COLORADO	PRIMARY PHYSICIAN PARTNERS	0.967	0.503	0.442	0.022	1.031	0.574	0.436	0.021	0.064	0.071	(0.006)	(0.001)	6.6%	14.1%	-1.4%	-3.0%
NEVADA	UNK	0.889	0.306	0.504	0.080	1.026	0.452	0.496	0.079	0.137	0.146	(0.008)	(0.001)	15.4%	47.8%	-1.6%	-1.6%
TEXAS	NORTH TX SPEC PHYSICIANS (PCP)	0.979	0.522	0.431	0.026	1.026	0.575	0.424	0.026	0.047	0.054	(0.006)	(0.001)	4.8%	10.3%	-1.4%	-3.1%
OREGON	SALEM CLINIC PC (CMG)	0.935	0.434	0.471	0.030	1.022	0.529	0.464	0.029	0.087	0.095	(0.008)	(0.001)	9.3%	21.9%	-1.6%	-2.0%
CALIFORNIA	HIGH DESERT PRIMARY CARE MG	0.956	0.505	0.418	0.033	1.021	0.577	0.412	0.032	0.065	0.071	(0.005)	(0.001)	6.8%	14.1%	-1.3%	-2.6%
CALIFORNIA	MILLS PENINSULA	1.039	0.522	0.504	0.013	1.019	0.512	0.494	0.013	(0.020)	(0.009)	(0.010)	(0.000)	-1.9%	-1.8%	-2.0%	-2.0%
OREGON	SOUTH TAFOR FAMILY PHYS (CMG)	0.975	0.476	0.481	0.018	1.018	0.525	0.475	0.017	0.043	0.049	(0.006)	(0.000)	4.4%	10.3%	-1.2%	-2.2%
CALIFORNIA	ALLCARE IPA	1.021	0.565	0.429	0.027	1.017	0.568	0.423	0.026	(0.004)	0.003	(0.006)	(0.001)	-0.4%	0.5%	-1.4%	-3.1%
CALIFORNIA	UCLA MEDICAL GROUP/PA	0.986	0.487	0.487	0.022	1.014	0.512	0.480	0.021	0.018	0.026	(0.007)	(0.001)	1.8%	5.3%	-1.4%	-2.6%
TEXAS	TARRANT DCN	0.986	0.533	0.421	0.033	1.011	0.564	0.415	0.032	0.025	0.031	(0.006)	(0.001)	2.5%	5.8%	-1.3%	-2.8%
CALIFORNIA	PRIMECARE OF REDLANDS	0.983	0.510	0.445	0.028	1.011	0.544	0.439	0.028	0.027	0.034	(0.006)	(0.000)	2.8%	6.7%	-1.4%	-1.5%
OREGON	OREGON CITY INTERNAL MEDICINE	1.047	0.491	0.536	0.020	1.010	0.469	0.522	0.019	(0.037)	(0.022)	(0.014)	(0.000)	-3.5%	-4.4%	-2.7%	-2.3%
OKLAHOMA	BROKEN ARROW	0.905	0.386	0.477	0.043	1.006	0.517	0.451	0.039	0.101	0.131	(0.026)	(0.004)	11.1%	34.1%	-5.6%	-9.3%
CALIFORNIA	MERCY MEDICAL GROUP	1.028	0.521	0.481	0.027	1.006	0.508	0.472	0.026	(0.022)	(0.013)	(0.008)	(0.001)	-2.1%	-2.5%	-1.8%	-3.0%
CALIFORNIA	BRIGHT HEALTH PHYSICIANS	0.969	0.484	0.467	0.019	1.006	0.529	0.459	0.018	0.036	0.044	(0.008)	(0.000)	3.7%	9.2%	-1.7%	-1.7%
OREGON	PROVIDENCE MEDICAL GROUP	1.148	0.613	0.526	0.008	1.004	0.484	0.513	0.008	(0.144)	(0.130)	(0.013)	(0.001)	-12.5%	-21.2%	-2.5%	-6.5%
CALIFORNIA	PROSPECT MEDICAL GROUP/NORTH	0.934	0.455	0.454	0.025	1.003	0.531	0.448	0.024	0.069	0.076	(0.006)	(0.001)	7.4%	16.7%	-1.3%	-2.3%
CALIFORNIA	SANTA BARBARA SELECT IPA	0.909	0.377	0.514	0.016	1.003	0.479	0.505	0.018	0.093	0.103	(0.009)	(0.001)	10.3%	27.3%	-1.7%	-2.8%
OKLAHOMA	Jenks Family Physicians	1.094	0.646	0.424	0.024	1.002	0.558	0.421	0.024	(0.091)	(0.088)	(0.003)	(0.000)	-8.4%	-13.7%	-0.7%	-0.1%
CALIFORNIA	SUTTER GOULD MEDICAL FOUNDATIO	0.984	0.494	0.460	0.030	1.001	0.519	0.452	0.030	0.017	0.026	(0.008)	(0.001)	1.8%	5.2%	-1.7%	-1.9%
CALIFORNIA	HILL PHYSICIANS SAN FRANCISCO	0.989	0.498	0.468	0.024	1.001	0.518	0.460	0.024	0.012	0.020	(0.008)	(0.000)	1.2%	4.1%	-1.7%	-1.0%
CALIFORNIA	FACEY MEDICAL FOUNDATION	0.959	0.466	0.470	0.023	1.000	0.514	0.463	0.023	0.040	0.048	(0.008)	(0.000)	4.2%	10.3%	-1.6%	-1.2%
OREGON	OAK STREET MEDICAL PC	0.984	0.524	0.397	0.063	0.993	0.542	0.390	0.061	0.009	0.018	(0.007)	(0.003)	0.9%	3.5%	-1.7%	-4.3%
ARIZONA	SUN HEALTH NETWORK	0.984	0.519	0.440	0.025	0.992	0.535	0.433	0.024	0.008	0.016	(0.007)	(0.001)	0.9%	3.0%	-1.5%	-3.4%
CALIFORNIA	SLO SELECT IPA SO CNTY	0.967	0.443	0.506	0.018	0.990	0.477	0.496	0.017	0.023	0.033	(0.009)	(0.000)	2.4%	7.5%	-1.9%	-2.3%
CALIFORNIA	SANSUM CLINIC	0.953	0.457	0.482	0.014	0.989	0.504	0.472	0.013	0.036	0.047	(0.010)	(0.000)	3.8%	10.3%	-2.1%	-3.4%
CALIFORNIA	SUTTER MEDICAL GROUP	0.982	0.487	0.473	0.022	0.987	0.501	0.465	0.021	0.005	0.013	(0.008)	(0.000)	0.5%	2.7%	-1.6%	-1.6%
CALIFORNIA	ST JOSEPH HERITAGE MEDICAL GRO	0.969	0.500	0.450	0.019	0.984	0.522	0.442	0.019	0.015	0.022	(0.007)	(0.000)	1.5%	4.4%	-1.6%	-1.0%
CALIFORNIA	ST VINCENT MEDICAL GROUP IPA	0.901	0.395	0.476	0.029	0.983	0.484	0.471	0.028	0.082	0.090	(0.005)	(0.001)	9.2%	22.8%	-1.0%	-1.9%
OKLAHOMA	Dubois Medical Clinic	0.962	0.485	0.423	0.054	0.982	0.516	0.415	0.052	0.021	0.030	(0.008)	(0.002)	2.2%	6.3%	-1.8%	-3.3%
CALIFORNIA	GREATER TRI-CITIES IPA MEDICAL	0.928	0.421	0.486	0.021	0.980	0.480	0.480	0.021	0.053	0.058	(0.005)	(0.000)	5.7%	13.8%	-1.0%	-2.0%
OREGON	TUALITY HEALTH ALLIANCE	0.898	0.397	0.468	0.033	0.979	0.487	0.460	0.032	0.081	0.090	(0.008)	(0.001)	9.1%	22.7%	-1.7%	-2.4%
COLORADO	AVISTA	0.960	0.508	0.429	0.023	0.978	0.535	0.421	0.022	0.018	0.027	(0.007)	(0.001)	1.9%	5.2%	-1.7%	-3.8%
ARIZONA	THUNDERBIRD NETWORK	0.956	0.507	0.421	0.029	0.977	0.534	0.415	0.028	0.016	0.027	(0.006)	(0.001)	2.1%	5.4%	-1.3%	-5.1%
CALIFORNIA	ST JOSEPH HOSPITAL AFFILIATED	0.968	0.492	0.456	0.021	0.973	0.505	0.448	0.020	0.005	0.013	(0.008)	(0.000)	0.6%	2.7%	-1.7%	-1.8%
ARIZONA	PHX SECURE HOSPITAL NETWORK	0.955	0.491	0.434	0.031	0.969	0.512	0.427	0.030	0.014	0.022	(0.007)	(0.001)	1.5%	4.4%	-1.6%	-2.9%
CALIFORNIA	PALO ALTO MEDICAL FOUNDATION	0.987	0.485	0.487	0.014	0.968	0.476	0.479	0.013	(0.019)	(0.010)	(0.009)	(0.000)	-2.0%	-2.0%	-1.8%	-3.0%
WASHINGTON	PHYSICIANS CARE NETWORK (CMG)	0.966	0.477	0.473	0.016	0.967	0.487	0.465	0.016	0.001	0.010	(0.008)	(0.000)	0.1%	2.0%	-1.8%	-1.7%
WASHINGTON	PACMED	0.922	0.423	0.473	0.026	0.963	0.474	0.464	0.026	0.041	0.051	(0.009)	(0.000)	4.5%	12.0%	-1.9%	-1.9%
OREGON	MARTIN L JONES	0.943	0.476	0.462	0.004	0.961	0.502	0.454	0.004	0.019	0.026	(0.007)	(0.000)	2.0%	5.4%	-1.6%	-1.6%
WASHINGTON	CLARK COUNTY DIRECT	0.930	0.448	0.458	0.025	0.960	0.487	0.449	0.024	0.030	0.039	(0.009)	(0.001)	3.2%	8.8%	-1.9%	-2.6%
COLORADO	EXEMPLA MEDICAL SECURE	0.884	0.419	0.426	0.039	0.958	0.419	0.044	0.035	0.074	0.076	(0.007)	0.005	8.4%	18.1%	-1.6%	12.1%
CALIFORNIA	SHARP COMMUNITY MEDICAL GROUP	0.942	0.457	0.463	0.022	0.956	0.479	0.456	0.021	0.014	0.022	(0.007)	(0.001)	1.5%	4.9%	-1.6%	-2.5%
CALIFORNIA	ST JUDE HERITAGE MEDICAL GROUP	0.939	0.477	0.449	0.014	0.955	0.500	0.441	0.014	0.016	0.024	(0.008)	(0.000)	1.7%	5.0%	-1.7%	-2.0%
(blank)	UNK	0.955	0.484	0.432	0.038	0.952	0.490	0.425	0.037	(0.002)	0.006	(0.007)	(0.001)	-0.2%	1.2%	-1.6%	-3.5%
ARIZONA	BANNER MESA/BAYWOOD NETWORK	0.935	0.465	0.440	0.030	0.950	0.488	0.432	0.029	0.015	0.024	(0.007)	(0.001)	1.6%	5.1%	-1.7%	-3.3%
CALIFORNIA	CEDARS SINAI MEDICAL GROUP	0.903	0.376	0.491	0.036	0.950	0.431	0.485	0.035	0.047	0.055	(0.007)	(0.001)	5.2%	14.5%	-1.3%	-4.1%
WASHINGTON	CASTLE ROCK	0.788	0.402	0.386	-	0.949	0.580	0.370	-	0.161	0.177	(0.016)	0.000	20.4%	44.0%	-4.2%	0.0%
CALIFORNIA	HERITAGE PROVIDER NETWORK	0.924	0.447	0.449	0.028	0.949	0.478	0.443	0.028	0.025	0.031	(0.006)	(0.001)	2.7%	6.9%	-1.3%	-2.0%
OREGON	LAKESIDE CLINIC	0.852	0.400	0.405	0.047	0.949	0.505	0.398	0.046	0.097	0.104	(0.006)	(0.001)	11.4%	26.1%	-1.6%	-1.6%

RAF by Component Report

1 - Quarterly RAF as of 7/1/2011, MOR RAF & PMA

(2) - 2010 EOL Projection as of 3/31/10

(3) - RAF Degradation: March less January MOR RAF plus a degradation factor of 0.4% per month from March to July

(4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

DEC State	Provider Group Name	January 2010 RAF Components				July 2010 RAF Components				Avg RAF Improvement (Jan to Jul)				Avg % RAF Improvement (Jan to Jul)			
		Jan Total RAF (1)	HCC (1)	Age/Sex (1)	Special Status (1)	July Total RAF (4)	HCC (4)	Age/Sex (4)	Special Status (4)	RAF	HCC	Age/ Sex	Special Status	RAF	HCC	Age/ Sex	Special Status
OREGON	FAMILY HEALTHPARTNERS	1.428	0.936	0.444	0.047	0.943	0.459	0.437	0.047	(0.484)	(0.476)	(0.007)	(0.001)	-33.9%	-50.9%	-1.6%	-1.6%
CALIFORNIA	SUTTER WEST MEDICAL GROUP	0.910	0.439	0.444	0.027	0.943	0.485	0.432	0.026	0.034	0.046	(0.011)	(0.001)	3.7%	10.5%	-2.5%	-4.4%
OKLAHOMA	OKC DCN	0.938	0.484	0.420	0.034	0.943	0.497	0.414	0.033	0.005	0.013	(0.006)	(0.001)	0.6%	2.6%	-1.5%	-2.7%
WASHINGTON	PROVIDENCE HEALTH SYSTEMS	0.979	0.528	0.418	0.032	0.942	0.504	0.403	0.035	(0.037)	(0.025)	(0.015)	0.003	-3.7%	-4.7%	-3.6%	9.1%
OKLAHOMA	UNK	0.945	0.490	0.417	0.038	0.942	0.493	0.413	0.036	(0.003)	0.004	(0.004)	(0.003)	-0.3%	0.7%	-1.0%	-6.8%
WASHINGTON	THURSTON DIRECT	0.889	0.432	0.438	0.020	0.940	0.490	0.431	0.019	0.052	0.059	(0.007)	(0.000)	5.8%	13.6%	-1.6%	-2.1%
COLORADO	COLO SPGS HEALTH PARTNERS	0.955	0.486	0.450	0.019	0.939	0.479	0.442	0.019	(0.016)	(0.007)	(0.009)	(0.000)	-1.7%	-1.5%	-1.9%	-0.6%
WASHINGTON	LEWIS DIRECT	0.907	0.412	0.457	0.038	0.939	0.457	0.447	0.035	0.032	0.045	(0.010)	(0.002)	3.5%	10.8%	-2.2%	-6.4%
OREGON	CORVALLIS	0.942	0.467	0.449	0.027	0.937	0.472	0.440	0.025	(0.005)	0.005	(0.009)	(0.002)	-0.6%	1.1%	-2.0%	-6.4%
ARIZONA	METRO TUCSON NETWORK	0.910	0.438	0.442	0.030	0.935	0.469	0.436	0.030	0.024	0.032	(0.007)	(0.001)	2.7%	7.2%	-1.5%	-2.6%
OKLAHOMA	TULSA DCN	0.937	0.472	0.436	0.029	0.933	0.476	0.429	0.028	(0.004)	0.004	(0.007)	(0.001)	-0.4%	0.8%	-1.6%	-2.2%
WASHINGTON	HEALTH CARE RESOURCES NW	0.782	0.327	0.427	0.028	0.931	0.488	0.418	0.025	0.149	0.161	(0.009)	(0.002)	19.1%	49.1%	-2.2%	-7.9%
WASHINGTON	PRIMARY CARE OF PUYALLUP	0.933	0.453	0.450	0.029	0.929	0.459	0.441	0.029	(0.003)	0.006	(0.009)	(0.000)	-0.4%	1.3%	-2.0%	-0.8%
CALIFORNIA	WOODLAND CLINIC MED GROUP	0.952	0.481	0.455	0.015	0.928	0.463	0.448	0.017	(0.024)	(0.018)	(0.007)	0.001	-2.5%	-3.8%	-1.5%	7.9%
OKLAHOMA	Putnam North Family Medical	0.933	0.510	0.406	0.017	0.927	0.522	0.389	0.015	(0.008)	0.012	(0.017)	(0.002)	-0.7%	2.4%	-4.2%	-10.0%
OREGON	THE CORVALLIS CLINIC (CMG)	0.925	0.421	0.483	0.022	0.926	0.431	0.474	0.021	0.000	0.010	(0.009)	(0.001)	0.0%	2.4%	-1.8%	-4.1%
CALIFORNIA	Sonoma DCN PCPs	0.924	0.457	0.455	0.012	0.919	0.461	0.446	0.012	(0.005)	0.003	(0.009)	0.000	-0.6%	0.7%	-1.9%	0.1%
WASHINGTON	SEATTLE DIRECT	0.896	0.402	0.474	0.020	0.919	0.436	0.464	0.019	0.023	0.034	(0.011)	(0.001)	2.5%	8.6%	-2.3%	-4.9%
WASHINGTON	SWEDISH	0.887	0.383	0.486	0.018	0.918	0.426	0.474	0.018	0.031	0.044	(0.012)	(0.001)	3.5%	11.4%	-2.5%	-3.7%
WASHINGTON	PIERCE COUNTY DIRECT	0.882	0.407	0.450	0.025	0.914	0.450	0.439	0.024	0.032	0.043	(0.011)	(0.001)	3.6%	10.5%	-2.3%	-2.8%
WASHINGTON	KIRKPATRICK FAMILY CARE PS	0.881	0.426	0.412	0.043	0.914	0.463	0.412	0.039	0.033	0.037	(0.000)	(0.005)	3.7%	8.8%	0.0%	-10.9%
CALIFORNIA	CHINO MEDICAL GROUP INC	0.901	0.405	0.465	0.031	0.913	0.424	0.460	0.029	0.012	0.019	(0.005)	(0.002)	1.3%	4.7%	-1.2%	-5.4%
WASHINGTON	WHITEHORSE FAMILY MEDICINE	0.932	0.452	0.450	0.030	0.911	0.440	0.443	0.028	(0.020)	(0.012)	(0.007)	(0.002)	-2.2%	-2.6%	-1.6%	-7.6%
WASHINGTON	PORTLAND DIRECT	0.934	0.447	0.458	0.028	0.911	0.438	0.446	0.027	(0.023)	(0.009)	(0.012)	(0.001)	-2.4%	-2.1%	-2.6%	-5.2%
CALIFORNIA	PREMIER PHYSICIANS NETWORK	0.897	0.419	0.439	0.040	0.906	0.436	0.431	0.039	0.009	0.017	(0.007)	(0.001)	1.0%	4.0%	-1.6%	-1.6%
CALIFORNIA	GOOD SAM MED PRAC ASSOC	0.882	0.397	0.450	0.036	0.905	0.428	0.443	0.034	0.023	0.032	(0.007)	(0.001)	2.6%	8.0%	-1.6%	-4.0%
OREGON	SAMARITAN HEALTH SERVICES -PCP	0.872	0.422	0.421	0.029	0.904	0.460	0.418	0.027	0.032	0.038	(0.004)	(0.002)	3.7%	9.0%	-0.9%	-7.3%
OREGON	MONTEREY HEALTH	1.025	0.493	0.484	0.047	0.903	0.381	0.476	0.047	(0.121)	(0.113)	(0.008)	(0.001)	-11.8%	-22.9%	-1.6%	-1.6%
CALIFORNIA	OMNICARE MEDICAL GROUP	0.938	0.449	0.419	0.070	0.900	0.415	0.417	0.069	(0.038)	(0.034)	(0.003)	(0.001)	-4.1%	-7.6%	-0.7%	-1.8%
CALIFORNIA	BAY AREA COM MED GRP	0.854	0.393	0.441	0.021	0.893	0.438	0.435	0.020	0.039	0.045	(0.006)	(0.001)	4.5%	11.6%	-1.3%	-4.2%
CALIFORNIA	SANTE COMMUNITY PHYS-FRESNO	0.910	0.417	0.468	0.025	0.892	0.409	0.458	0.024	(0.018)	(0.007)	(0.010)	(0.000)	-1.9%	-1.7%	-2.2%	-1.6%
CALIFORNIA	EMPIRE PHYS MG	0.880	0.398	0.462	0.020	0.892	0.419	0.454	0.019	0.012	0.021	(0.008)	(0.001)	1.4%	5.2%	-1.7%	-4.0%
CALIFORNIA	MARIN IPA SONOMA	0.861	0.385	0.462	0.014	0.891	0.422	0.454	0.014	0.029	0.037	(0.008)	0.000	3.4%	9.6%	-1.7%	1.9%
OREGON	LANE DIRECT	0.866	0.393	0.447	0.027	0.889	0.424	0.439	0.026	0.023	0.031	(0.007)	(0.001)	2.7%	8.0%	-1.6%	-2.4%
ARIZONA	ABRAZO NETWORK	1.403	1.020	0.382	-	0.889	0.511	0.377	-	(0.514)	(0.509)	(0.005)	0.000	-36.6%	-49.9%	-1.4%	0.0%
CALIFORNIA	CENTINELA VALLEY IPA MG INC	0.818	0.339	0.436	0.043	0.886	0.413	0.433	0.040	0.068	0.074	(0.003)	(0.003)	8.3%	21.8%	-0.7%	-6.2%
CALIFORNIA	JOHN MUIR HEALTH NETWORK	0.851	0.388	0.447	0.016	0.884	0.426	0.442	0.016	0.033	0.038	(0.005)	0.000	3.9%	9.9%	-1.2%	0.7%
WASHINGTON	SNOHOMISH DIRECT	0.863	0.401	0.441	0.021	0.882	0.429	0.433	0.020	0.019	0.028	(0.008)	(0.001)	2.2%	7.0%	-1.9%	-2.7%
OREGON	VENETA MEDICAL CLINIC	1.142	0.682	0.460	-	0.882	0.441	0.440	-	(0.260)	(0.240)	(0.020)	0.000	-22.8%	-35.3%	-4.3%	0.0%
TEXAS	Deuteronomy-2	0.870	0.434	0.412	0.023	0.880	0.452	0.406	0.023	0.011	0.017	(0.006)	(0.001)	1.2%	4.0%	-1.5%	-2.2%
CALIFORNIA	ST JUDE AFFILIATED PHYSICANS	0.840	0.380	0.445	0.014	0.878	0.425	0.439	0.014	0.038	0.044	(0.006)	(0.000)	4.5%	11.6%	-1.4%	-2.1%
WASHINGTON	UNK	0.888	0.394	0.472	0.023	0.875	0.396	0.458	0.022	(0.013)	0.002	(0.014)	(0.001)	-1.5%	0.5%	-2.9%	-4.4%
COLORADO	DENVER PROPRIETARY SECURE	0.860	0.411	0.432	0.018	0.874	0.430	0.426	0.017	0.013	0.019	(0.005)	(0.000)	1.6%	4.6%	-1.2%	-2.6%
CALIFORNIA	TORRANCE HOSPITAL IPA	0.870	0.432	0.420	0.018	0.873	0.440	0.416	0.017	0.003	0.008	(0.004)	(0.001)	0.3%	1.7%	-1.0%	-3.6%
WASHINGTON	MULTICARE	0.867	0.405	0.442	0.021	0.871	0.418	0.433	0.021	0.004	0.013	(0.009)	(0.000)	0.4%	3.2%	-2.0%	-1.4%
CALIFORNIA	Independence IPA	0.870	0.402	0.430	0.038	0.871	0.410	0.423	0.038	0.000	0.007	(0.007)	(0.000)	0.0%	1.8%	-1.6%	-0.9%
ARIZONA	PINAL HEALTH CARE NETWORK	0.869	0.419	0.414	0.035	0.869	0.427	0.408	0.033	(0.000)	0.009	(0.007)	(0.002)	0.0%	2.1%	-1.6%	-5.4%
CALIFORNIA	OJAI VALLEY MEDICAL GROUP	0.857	0.351	0.485	0.022	0.869	0.371	0.476	0.022	0.011	0.020	(0.008)	(0.000)	1.3%	5.7%	-1.7%	-1.5%
COLORADO	LOVELAND PROPRIETARY	0.874	0.411	0.443	0.020	0.863	0.411	0.433	0.019	(0.010)	(0.000)	(0.009)	(0.000)	-1.2%	-0.1%	-2.1%	-1.6%
TEXAS	Jefferson Phys Grp	0.872	0.434	0.410	0.029	0.861	0.428	0.406	0.027	(0.011)	(0.005)	(0.004)	(0.002)	-1.2%	-1.2%	-0.9%	-6.1%
CALIFORNIA	Brookwood Internal Medical	0.951	0.464	0.487	-	0.859	0.383	0.476	-	(0.092)	(0.081)	(0.012)	0.000	-9.7%	-17.4%	-2.4%	0.0%
CALIFORNIA	SONOMA COUNTY PRIMARY CARE IPA	0.757	0.296	0.451	0.010	0.857	0.399	0.448	0.011	0.101	0.103	(0.003)	0.001	13.3%	34.8%	-0.7%	5.4%
CALIFORNIA	ADOC-FOUNTAIN VALLEY DIVISION	0.839	0.384	0.427	0.029	0.856	0.405	0.422	0.029	0.017	0.021	(0.004)	(0.000)	2.0%	5.5%	-1.0%	-0.4%
COLORADO	COLORADO SPRINGS DIRECT	0.849	0.401	0.428	0.020	0.855	0.413	0.422	0.019	0.006	0.012	(0.005)	(0.001)	0.7%	3.0%	-1.3%	-3.5%
COLORADO	FREMONT COUNTY SECURE	0.764	0.330	0.412	0.022	0.853	0.422	0.410	0.020	0.089	0.092	(0.002)	(0.001)	11.6%	28.0%	-0.5%	-6.3%
WASHINGTON	EASTSIDE DIRECT	0.850	0.371	0.466	0.013	0.851	0.383	0.455	0.012	0.001	0.013	(0.011)	(0.001)	0.1%	3.4%	-2.3%	-8.1%
ARIZONA	COMPLETE ACCESS NETWORK	0.823	0.376	0.428	0.018	0.847	0.408	0.421	0.017	0.024	0.032	(0.006)	(0.001)	2.9%	8.5%	-1.5%	-5.9%
COLORADO	PUEBLO PROPRIETARY CENTURA	0.848	0.381	0.435	0.032	0.841	0.380	0.429	0.031	(0.007)	(0.001)	(0.006)	(0.001)	-0.8%	-0.2%	-1.3%	-2.1%
OKLAHOMA	NORMAN PHO PCPS	0.802	0.341	0.437	0.024	0.838	0.379	0.436	0.022	0.036	0.038	(0.000)	(0.002)	4.5%	11.3%	-0.1%	-9.2%
WASHINGTON	PEACEHEALTH MEDICAL GROUP	0.798	0.354	0.413	0.032	0.823	0.386	0.408	0.030	0.025	0.032	(0.005)	(0.002)	3.2%	9.1%	-1.3%	-5.7%
CALIFORNIA	LA VIDA MULTISPECIALTY	0.828	0.349	0.453	0.026	0.816	0.345	0.446	0.025	(0.013)	(0.005)	(0.008)	(0.001)	-1.5%	-1.3%	-1.7%	-2.6%

(4) - Projected July 2010 RAF based on Jan 2010 actuals plus EOL plus RAF Degradation

1/31/2011

EXHIBIT 8

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(i) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

EXHIBIT 9

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE (Medicare #) ☐ MEDICAID (Medicaid #) ☐ TRICARE CHAMPUS (Sponsor's SSN) ☐ CHAMPVA (Member ID#) ☐ GROUP HEALTH PLAN (SSN or D) ☐ FECA BLK LUNG (SSN) ☐ OTHER (ID) ☐										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐										7. INSURED'S ADDRESS (No., Street)																																							
CITY										STATE										CITY										STATE																													
ZIP CODE										TELEPHONE (Include Area Code) ()										ZIP CODE										TELEPHONE (Include Area Code) ()																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. S PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐										b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? ☐ YES ☐ NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO If yes, return to and complete item 9 a-d.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																																	
SIGNED _____ DATE _____										SIGNED _____																																																	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
										17b. NPI _____																																																	
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES ☐ YES ☐ NO										22. MEDICAL RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										23. PRIOR AUTHORIZATION NUMBER																																																	
1. _____										3. _____																																																	
2. _____										4. _____																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POSITIVE										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSTOT Family Plan										I. ID. QUAL										J. RENDERING PROVIDER ID. #									
1																																																											
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6																																																											
25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI										b. _____										a. NPI										b. _____																			

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.