DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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Date: April 24, 2015

From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Title: EDGE Server Data Bulletin -- INFORMATION

Subject: Evaluation of EDGE Data Submissions

I. Purpose

This bulletin provides guidance on the operational processes that CMS will use to evaluate issuers' EDGE server data. This analysis will help CMS determine whether an issuer has provided access to EDGE server data that is sufficient for CMS to calculate reinsurance payments and apply the Department of Health and Human Services (HHS) risk adjustment methodology.

II. Background

The integrity of payments and charges under the HHS-operated risk adjustment program and payments under the reinsurance program depend upon the data submitted by issuers to their EDGE servers. For example, risk adjustment data submissions for one issuer can materially affect the risk adjustment transfers for all other issuers in a market in a state.

Under 45 CFR §153.740(b), if an issuer of a risk adjustment covered plan fails to establish an EDGE server or fails to provide HHS with access to the required data on the EDGE server, such that CMS cannot apply the Federally certified risk adjustment methodology, a default risk adjustment charge will be assessed. Similarly, under 45 CFR §153.420 and §153.740(a), if an issuer eligible for reinsurance payments fails to establish an EDGE server or meet certain data requirements, the issuer may forgo reinsurance payments that it otherwise might have received.

In this bulletin, we describe how CMS intends to evaluate the sufficiency in terms of quantity and quality of the data made accessible to CMS on an issuer's EDGE server.

III. Description of Evaluation Process for Data Quantity

CMS will evaluate the enrollment and claims data that issuers make accessible on their EDGE servers, and notify any issuer failing to meet expected data quantity thresholds, established based

on issuers' previously submitted baseline enrollment and claims counts. An issuer may notify CMS that its previously submitted baseline enrollment or claims count is incorrect by sending an email to RARIpaymentoperations@cms.hhs.gov, also described below. An issuer with a low enrollment count following the submission deadline may forgo reinsurance payments, and will be subject to a default risk adjustment charge. An issuer with a low claims count following the submission deadline may forgo reinsurance payments, and will be subject to a default risk adjustment charge if the default charge is lower than the charge it would have otherwise received.

IV. Description of Evaluation Process for Data Sufficiency

CMS will assess issuers' data sufficiency using ten metrics – five key metrics, three of which measure risk adjustment data quality, and two of which measure reinsurance data quality, and five secondary metrics, which measure EDGE claims and enrollment data quality.

Data Evaluation Metrics	
Key Metrics	
Percent of all enrollees with at least one HCC[1]	**Risk Adjustment**
Average number of conditions per enrollee with at least one HCC	
Issuer average risk score	
Percent of individual market enrollees with reinsurance payments	**Reinsurance**
Average reinsurance payment per enrollee receiving reinsurance payment	
Secondary Metrics	
Claims per enrollee ratio	**EDGE Claims/Enrollment**
Percent of enrollees without claims	
Percent of claims without enrollees	
Percent of medical claims that are institutional claims	
Percent of pharmacy claims	

CMS will identify outliers for each metric using the following process:

- Issuers will be divided into two groups – issuers with 10,000 enrollees or more, and issuers with fewer than 10,000 enrollees.
- A national distribution will be created for each of the two groups, for each of the 10 metrics.
- An internal technical committee composed of actuaries, risk adjustment experts, and reinsurance experts will establish outlier thresholds for those distributions.

[1] Hierarchical Condition Category

If the issuer's data fails the outlier analysis for any of the five key metrics, CMS will provide the issuer with a notification each week until the final data submission deadline. The issuer will be provided an opportunity to provide an explanation of the data anomaly with respect to the key metrics for which it is an outlier and any secondary metrics for which the issuer's data does not meet the applicable threshold. The internal technical committee will assess each issuer's explanation, with the assistance of an external review panel, and will provide feedback to the issuer.

If, following the final risk adjustment and reinsurance run, an issuer's data continues to trigger an outlier threshold without an acceptable explanation, we will offer the issuer a final opportunity to submit an explanation, and to attest to the accuracy of their data. The window for this final explanation will close **10 calendar days** after CMS's distribution of outlier notifications following the final risk adjustment and reinsurance run. If CMS's technical committee, with the assistance of the external review panel, deems the explanation to be insufficient, CMS will assess a default risk adjustment charge and the issuer will forfeit reinsurance payments for the benefit year.

V. Default Risk Adjustment Charge

Under 45 CFR §153.740(b),[2] the default risk adjustment charge will equal a per member per month (PMPM) amount multiplied by the plan's enrollment. The PMPM amount is set equal to the 75th percentile PMPM amount along a distribution of the absolute value of transfers under HHS risk adjustment in all states, expressed as a percentage of premium. All compliant risk adjustment covered plans – including those assessed risk adjustment charges, as well as those making risk adjustment payments – in the risk pool will receive a portion of the default charges collected from a noncompliant issuer in the risk pool. The final default charge amount will be calculated from the final calculation of transfers. We expect that default charges will be invoiced on the same timeline as risk adjustment payments and charges.

If a plan subject to a default risk adjustment charge has not provided enrollment data to CMS, CMS will seek from the issuer an attestation of the plan's total billable member months, which will be used to calculate the default risk adjustment charge. An issuer will have **10 calendar days** to respond to the request for an attestation of enrollment. If an issuer does not submit attested enrollment data, CMS will estimate noncompliant plans' enrollment using available data.

VI. How to Notify CMS of Changes to Baseline Enrollment Data

An issuer who believes its baseline data is not accurate should notify CMS by sending an email to RARIpaymentoperations@cms.hhs.gov. The email should indicate the issuer's HIOS ID and updated enrollment, medical claims, and pharmacy claims baseline data. Please contact your account manager if you have questions about how to submit baseline date updates.

[2] Also described in preamble at 78 FR 65061-65062, 79 FR 13790-13791, and 80 FR 10780-10781.