



District of Columbia's Managed Care Quarterly Performance Report

(July 2013 - September 2013)

Department of Health Care Finance

February 2014
Washington DC

Presentation Outline

- Overview Of Managed Care And Focus of Presentation**
- Summary of Key Findings
- The Financial Condition of The District's Health Plans
- The Administrative Performance Of The Health Plans
- MCO Medical Spending
- Next Steps

Overview of The District's Managed Care Program

- ❑ Medicaid is the largest health insurance program in the District
 - 220,000 Medicaid beneficiaries (1 in 3 District residents)
 - 97,000 children in the District of Columbia are enrolled in Medicaid
 - Nearly 70% of program recipients are in one of four Managed Care Organizations (MCO)
 - ❖ AmeriHealth DC (AmeriHealth)
 - ❖ MedStar Family Choice (MedStar)
 - ❖ Trusted Health Plan (Trusted)
 - ❖ Child and Adolescent Supplemental Security Income Program (CASSIP)
- ❑ Three of these health plans offer comprehensive benefits and operate under full risk-based contracts with the District
- ❑ The District will spend more than \$820 million on MCO services on FY2014
- ❑ More than \$658 million of this amount will be for the full risk-based contracts signed by AmeriHealth DC, MedStar Family Choice, and Trusted
 - ❖ These plans are the focus of this performance review

Overview of The District's Managed Care Program (continued)

- ❑ The District also funds managed health care services for the Alliance program which offers health care to District residents who would be eligible for Medicaid but for their citizenship status
- ❑ Alliance has more than 14,800 members who are enrolled in the District's three full risk-based MCO
- ❑ Benefits offered through the Alliance program are virtually identical to those provided in Medicaid but do not include non-emergency transportation or mental health services
- ❑ In FY2014, the District is projected to spend approximately \$38 million on the Alliance program

Goals Of The District's Managed Care Program

- ❑ The District developed its MCO program in pursuit of three broad goals:
 1. Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members
 2. Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services
 3. Establish greater control and predictability over the District's spending on health care

Medicaid Rate-Setting For Health Plans Governed By Federal Requirements

- ❑ For the full risk-based MCOs, the Department of Health Care Finance (DHCF) pays a capitated, per-member, per-month (PMPM) rate
 - The capitated rate is a set amount to cover projected costs for all benefits
- ❑ Medicaid federal regulations impose specific requirements to govern rate-setting
 - Rates must be actuarially sound, developed by a credentialed actuary and certified by CMS
 - Rates must be appropriate for covered populations and benefit package
 - Uncertified rates are not eligible for federal match
- ❑ Alliance program does not need federal approval
 - Actuarial soundness requirement for this program is a District contract requirement
- ❑ DHCF contracts with Mercer Consulting to establish the actuarially sound rates for the program and assist with data analytics on measuring MCO program performance

Key Program Requirements Faced By The District's Health Plans

Program Area	Requirement	Source
Network Adequacy	The District must ensure that each MCO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. The network of providers must be sufficient in number, service mix (e.g. primary care, specialty care, dental etc.) and geographic distribution to meet the needs of the anticipated number of enrollees in the health plans.	Federal Requirement and District Contract
Member Choice of Plan	Beneficiaries who are required to enroll in managed care must be given a choice among at least two plans.	Federal Regulation
Navigation Support For Enrollees	The District must ensure that all services covered under the State plan are available and accessible to enrollees of the plans. Each MCO must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	Federal Regulation
Health Assessments	Health plans must assess each Medicaid enrollee identified by the District and the MCO as having special health care needs. The purpose of the assessment is to ascertain any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. In addition, the District's Enrollment Broker must complete a health assessment for every newly eligible enrollee. The information is submitted to the respective health plan to which the member is assigned for use in establishing an initial plan of care for the enrollee as needed.	Federal Requirement and District Contract

Key Program Requirements Faced By The District's Health Plans (continued)

Program Area	Requirement	Source
Out-of-Network Care	Health plans must afford enrollees the opportunity to seek a second medical opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain a second opinion from outside the network, at no cost to the enrollee. If the health plan's network is unable to provide necessary services covered under the contract, the MCO must adequately and timely cover these services out-of-network for the enrollee.	Federal Requirement
Medical Loss Ratio	The District requires its health plans to meet a medical loss ratio (MLR) which requires that they spend at least 85 cents of every premium dollar on medical care. The health plans must report their premium dollar expenditures to DHCF to facilitate an independent assessment of whether this requirement is met. Plans that do not reach this 85 percent threshold face a number of possible actions, including monetary penalties assessed by DHCF	District Contract
Risk-Based Capital	Risk-based Capital is a widely used financial metric to measure the solvency of managed care plans. Expressed in this report as a plan's Total Adjusted Capital as a percent of their estimated Authorized Control level (measured by the value of incurred claims), the District's insurance regulator requires plans to maintain assets equal to 200 percent of their Risk-based Capital. Under District law, DISB has the authority to initiate preventive and corrective measures that vary depending on the capital deficiency indicated by the Risk-based Capital review	District Regulation

DHCF Implements A Performance Review Of Its Managed Care Program

- ❑ To coincide with the new five-year MCO contracts, DHCF initiated a comprehensive review process in FY2014 to assess and evaluate the performance of its health plans

- ❑ The goal of this project is three-fold:
 1. Evaluate the degree to which DHCF's three risk-based health plans successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of health care services
 2. Provide objective data on the performance of the health plans across a number of domains to inform decision making about possible policy changes for the managed care program
 3. Facilitate an annual report card evaluation of each MCO to help guide decisions regarding contract renewals for the health plans

Focus Of The Performance Review

- ❑ This performance review is conducted quarterly and addresses the following questions for each MCO:
 - What is the financial health of the MCOs including the risk profile of the plans? Are plan revenues sufficient to cover claims and operating cost?
 - What is the demonstrated ability of the MCOs to meet the administrative requirements for plan management – claims processing, development of encounter systems, and establishing an effective care management program?
 - Have the plans established adequate provider networks? What are early results on MCO medical spending across the various health care service categories?
 - Is there evidence that MCO members are accessing primary care as an appropriate gateway to other services, especially for children under the EPSDT program?
 - To what extent are MCO members using hospital emergency rooms for non-emergency purposes?

Annual MCO Performance Report Schedule For 2014

Nature of Report	Review Period	Report Date
1 st Quarter Performance Review	July 2013 to September 2013	February 2014
2 nd Quarter Performance Review	October 2013 to December 2013	May 2014
3 rd Quarter Performance Review	January 2014 to March 2014	August 2014
4 th Quarter Performance Review	April 2014 to June 2014	November 2014
Annual Report Card (4 Quarter Roll-Up)	July 2013 to June 2014	December 2014

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Summary Of Key Findings

- ❑ This first quarter performance review examined the financial condition, administrative performance, limited care management outcomes, and the medical spending of the District's three full risk based health plans.

Financial Conditions

- ❑ The findings with respect to the MCOs' financial conditions were generally favorable. Allowing for the expected higher start-up cost associated with the new entrants into the DC market, the first quarter data show that all three health plans had sufficient revenue to cover the claims cost in the reporting period. AmeriHealth DC reported a small net loss for the 1st quarter but their higher start-up administrative cost is partially responsible for this outcome.
- ❑ Less favorable, Trusted's Risk-Based Capital position of 1.53 is only slightly higher than the minimum requirement of 1.50 to avoid an enrollment freeze by DHCF. Trusted officials indicate that a plan is in place to ensure that the company has sufficient capital to grow its membership

Summary Of Key Findings

(continued)

Administrative Performance

- ❑ Administratively, all three health plans were impacted by the District's protracted procurement process which sharply reduced the time period available to transition plans into the program.
- ❑ Despite a truncated timeline, two of the three health plans were able to establish effective claims processing systems that allowed the MCOs to pay more than 90 percent of the submitted claims on time and with the documentation needed to allow provider reconciliation of payments.
- ❑ As a start-up, however, Trusted experienced significant struggles with claims processing and timely payments. In the five month observation period, Trusted was only able to pay approximately four of every 10 claims on time and they processed more than \$15 million in payments – 42% of their total claims value for the period – outside of the system for administering claims. However, the company has made considerable progress in recent weeks and their performance is trending upward.

Summary Of Key Findings

(continued)

Administrative Performance

- ❑ Each of the three MCOs have begun the process of transmitting important patient encounter data to DHCF electronically. DHCF's actuary relies upon this information to support the annual rate setting process and accurate encounter data is needed by the health plans to facilitate patient care management. AmeriHealth will need to improve the accuracy of its data transmissions to DHCF and Trusted must continue to increase the volume of its reported claims.
- ❑ All three health plans have been slow to establish robust and effective care management systems. None of the MCOs have contacted and assessed more than 11 percent of their members for possible admission into case management. Further, the MCOs have been unable to bring a significant percentage of those assessed for case management into the program – across all three health plans only 1,571 members are in case management.

Summary Of Key Findings

(continued)

Medical Expenses

- ❑ The three MCOs have aggressively established health care provider networks substantially exceeding the standards prescribed in the managed care contracts.
- ❑ It is too early to draw definitive conclusions from the medical expense data reported by the health plans. However, it is worth noting that in the first quarter of this reporting period, all three health plans satisfied the requirement that at least 85% of their revenue from the District's capitated payments be spent on beneficiary medical care.
- ❑ The expense data examined for this review also point to a few areas of concern. Specifically, there is wide variation in the per-member, per-month medical expenses across plans – especially for MedStar and Trusted – which raises questions about possible over and under utilization of health care resources. In Trusted's case, the per-member, per-month cost for medical services to children in Medicaid was only \$58. The underlying reason for this will have to be determined. 16

Summary Of Key Findings

(continued)

Medical Expenses

- ❑ Data for the members in each of the three health plans whose enrollment in Medicaid was continuous for one year through September 30, 2013 reveal high utilization rates for primary care and well child visits. However, medical spending for behavioral health services is negligible – two plans are spending less than \$2.00 per member per month. Additional analysis suggests that some managed care members who are in need of mental health services are accessing this care through the Medicaid fee-for-service system. The issue of the health plans' management of mental health services clearly warrants more attention.
- ❑ Finally, while a more comprehensive and detailed analysis of MCO management of hospital utilization will be implemented in the future, these very preliminary data raise questions about beneficiaries' use of emergency departments. Specifically, nearly half of all the visits made to the emergency room by members in all three health plans were for non-emergencies.

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Financial Collapse Of Chartered Heightened DHCF's Oversight Of Health Plans' Financial Status

- ❑ Quarterly assessments of MCOs' financial health is designed to determine whether the health plans meet financial net worth requirements or are trending towards financial deterioration

- ❑ Two key measures are used to evaluate the MCOs' financial conditions
 1. The MCOs' net revenue gain or loss which is determined by subtracting claims expenses from health plan revenue, excluding investment income

 2. Risk-based Capital Ratio – a measure of the MCOs' *Total Adjusted Capital Levels as a percent of the health plans' **Authorized Control Levels

*Adjusted Capital reflects total capital and surplus cash. **Authorized control level for this analysis reflects one half month of incurred claims.

Data On MCOs' Net Gains (Or Losses) Do Not Raise Significant Concerns At This Time

MCO Revenue and Expense Data for YTD as of September 2013

$$\boxed{\text{Revenue}^*} - \boxed{\text{Claims}^{**}} - \boxed{\text{Administrative Cost}^{***}} = \text{Net Gain (Loss)}$$

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	\$158.1M	\$135.8M	\$25.8M	(\$3.5M)
MedStar	\$51.3M	\$45.4M	\$4.8M	\$1.1M
Trusted	\$24.6M	\$21.7M	\$2.4M	\$0.5M

Notes: *MCO revenue does not include investment income.

**Total claims include incurred but not reported amounts for YTD as of September 2013.

***Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings.

Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking (DISB)

Estimated Risk-Based Capital Measures

Provide A Reliable Indicator Of MCO Solvency

- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims
- ❑ MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) and provide to DISB for review
- ❑ Health plans with RBC levels that fall below 200 percent face greater scrutiny from DISB (as described on the next slide) to ensure that they raise their capital level above 200% RBC
- ❑ For this review, DHCF uses a proxy measure calculated by Mercer Consulting to assess the RBC levels for each plan on a quarterly basis. RBC is defined here as the MCOs' **Adjusted Capital Levels** as a percent of the health plans' **Authorized Control Levels** – an estimate of about one half month of incurred claims is used for this assessment
- ❑ This quarterly proxy measure will allow DHCF to track RBC changes during the fiscal year, possibly providing an early alert to emerging problems rather than waiting for DISB's year end, more precise measure, which is reported in March of each year

Insurance Regulators Track Insurers Risk-Based Capital Levels And Have Guidelines For Taking Action

❑ Based on the level of reported risk, the National Association of Insurance Commissioners indicates that a number of actions (described below) are available if warranted:

1. **No action** - Total Adjusted Capital of 200% or more of Authorized Control Level.
2. **Company Action Level** - Total Adjusted Capital of 150% to 200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.
3. **Regulatory Action Level** - Total Adjusted Capital of 100 to 150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems
4. **Authorized Control Level** - Total Adjusted Capital 70 to 100% of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.
5. **Mandatory Control Level** - Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

❑ MCOs with RBC levels that consistently trend below 200 percent will experience considerable fiscal stress if they take on significant numbers of new members without a fresh infusion of capital

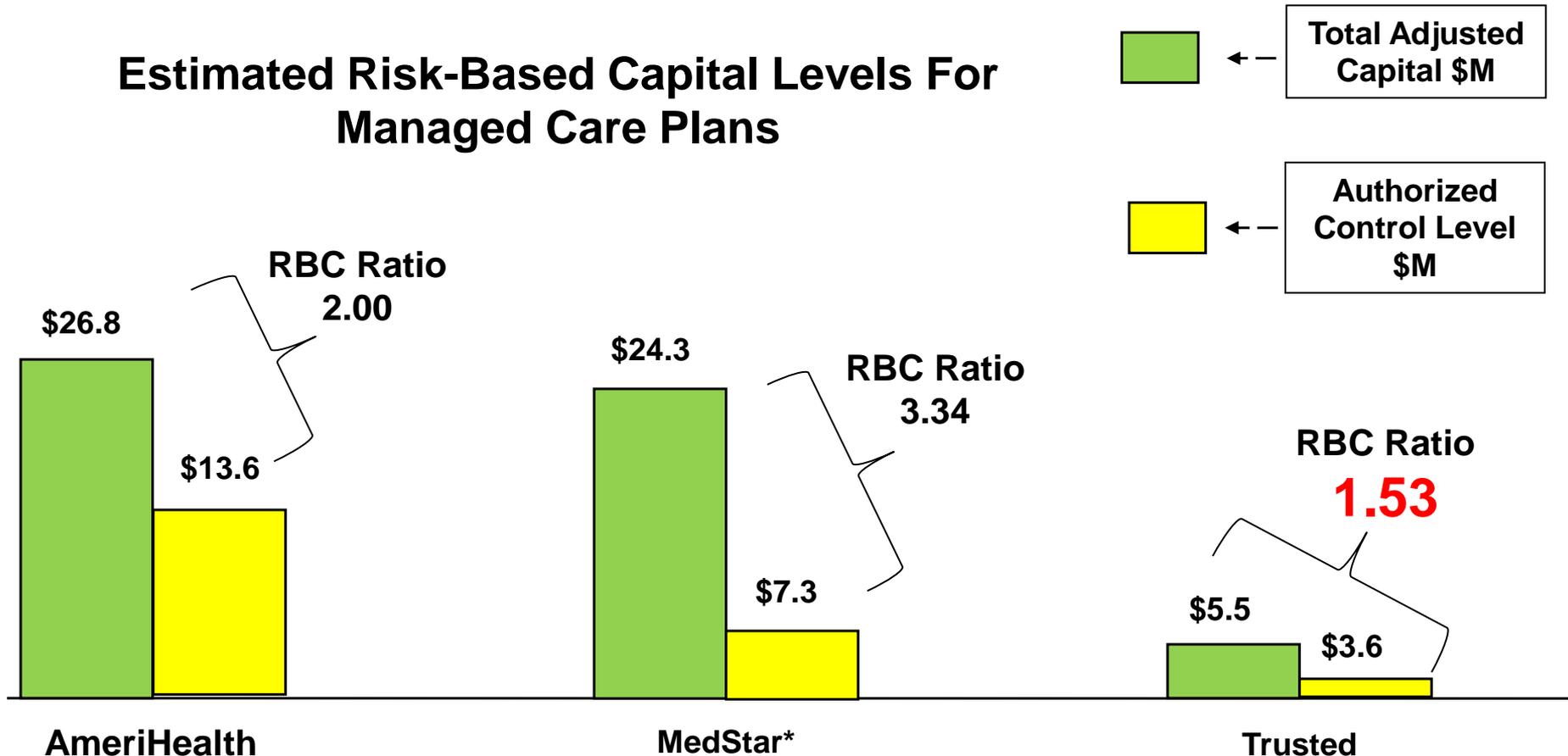
AmeriHealth Is The Only Plan That Experienced Enrollment Growth In The 1st Quarter of The Fiscal Year

MCO	July 2013 Enrollment	September 2013 Enrollment	Net Change
AmeriHealth	98,019	102,565	4,546
MedStar	35,911	34,104	(1807)
Trusted	28,803	26,811	(1992)

Source: Department of Health Care Finance Medicaid Management Information System (MMIS)

Beginning May 1, 2014 Health Plans With Risk-Based Capital Levels Below 1.50 Will Face An Enrollment Freeze By The Department of Health Care Finance

Estimated Risk-Based Capital Levels For Managed Care Plans



Notes: The RBC ratio reported here is a proxy. Current and actual RBC ratios are actually higher due to the partial year of coverage in 2013.

MedStar amounts for Total Adjusted Capital and Authorized Control Level include totals from Maryland and the District of Columbia.

Source: Financial Condition values from MCO Quarterly Statement filed with DISB as of September 30, 2013.

MCOs Must Maintain Adequate Reserves To Pay “Pipeline” Claims

- ❑ It is paramount in managed care that MCOs maintain a reserve to pay for services that have been provided but not yet reimbursed
- ❑ This claims liability represents an accrued expense or short-term liability for the MCOs each month
- ❑ Plans that fail to build a sufficient reserve may not be able to pay claims when they eventually clear the billing pipeline
- ❑ Typically, MCOs are expected to retain a reserve equal to between one to two months' worth of claims, depending on how quickly claims are processed.
- ❑ In future reports DHCF will track MCO's reserves available to satisfy claims quarterly. This analysis will be based on calculations provided by Mercer who will rely upon data on the monthly claim's experience for each plan to calculate the reserves on hand

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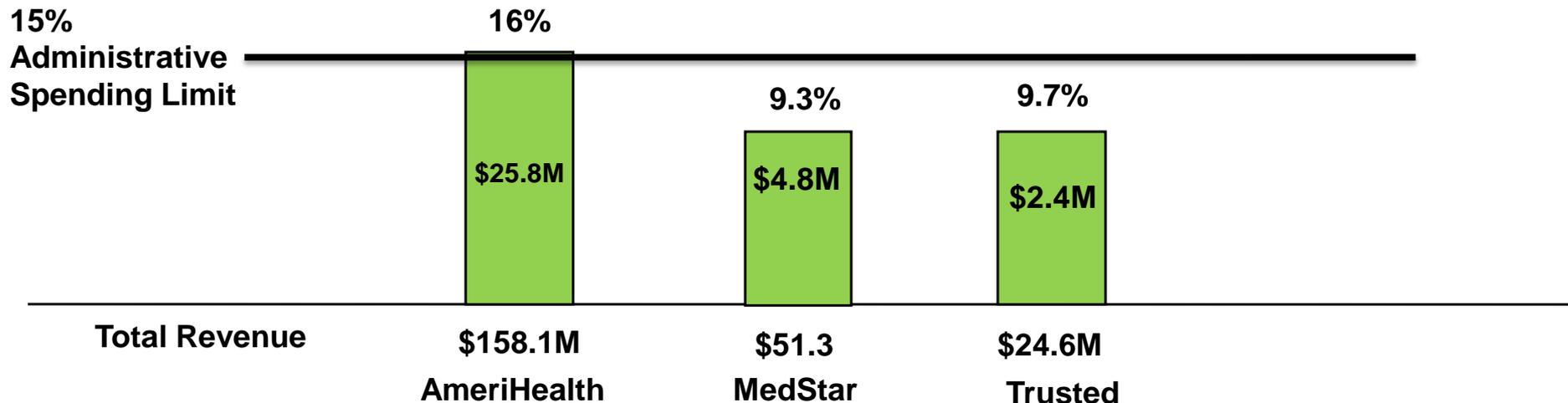
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There Are Several Administrative Requirements Which Are Critical To The Successful Operation Of MCOs

- ❑ As a part of its core mission, MCOs must accomplish the following:
 1. Pay the providers in their networks on time and through an electronic claims process with documentation to facilitate reconciliation of payments
 2. Create an accurate electronic record of all patient health care encounters and transmit the files containing this information to DHCF with a minimal error rate
 3. Establish a system of care management to identify health plan members with special or chronic health care issues and ensure that these beneficiaries receive access to appropriate care based on their needs

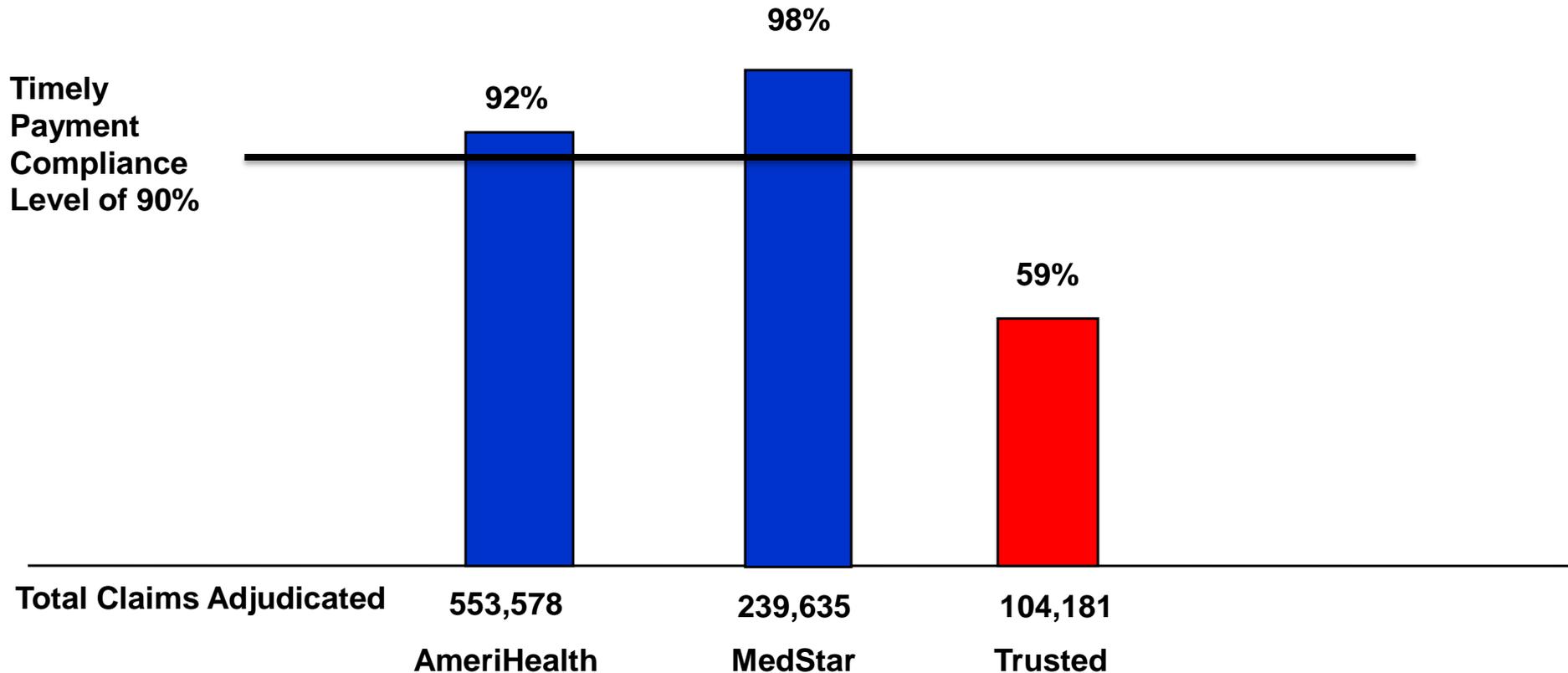
Administrative Spending For The Three Health Plans Is In Line With The 15% Program Limit

Administrative Spending For MCOs As A Percent Of Total Revenue,
July 2013 through September 2013



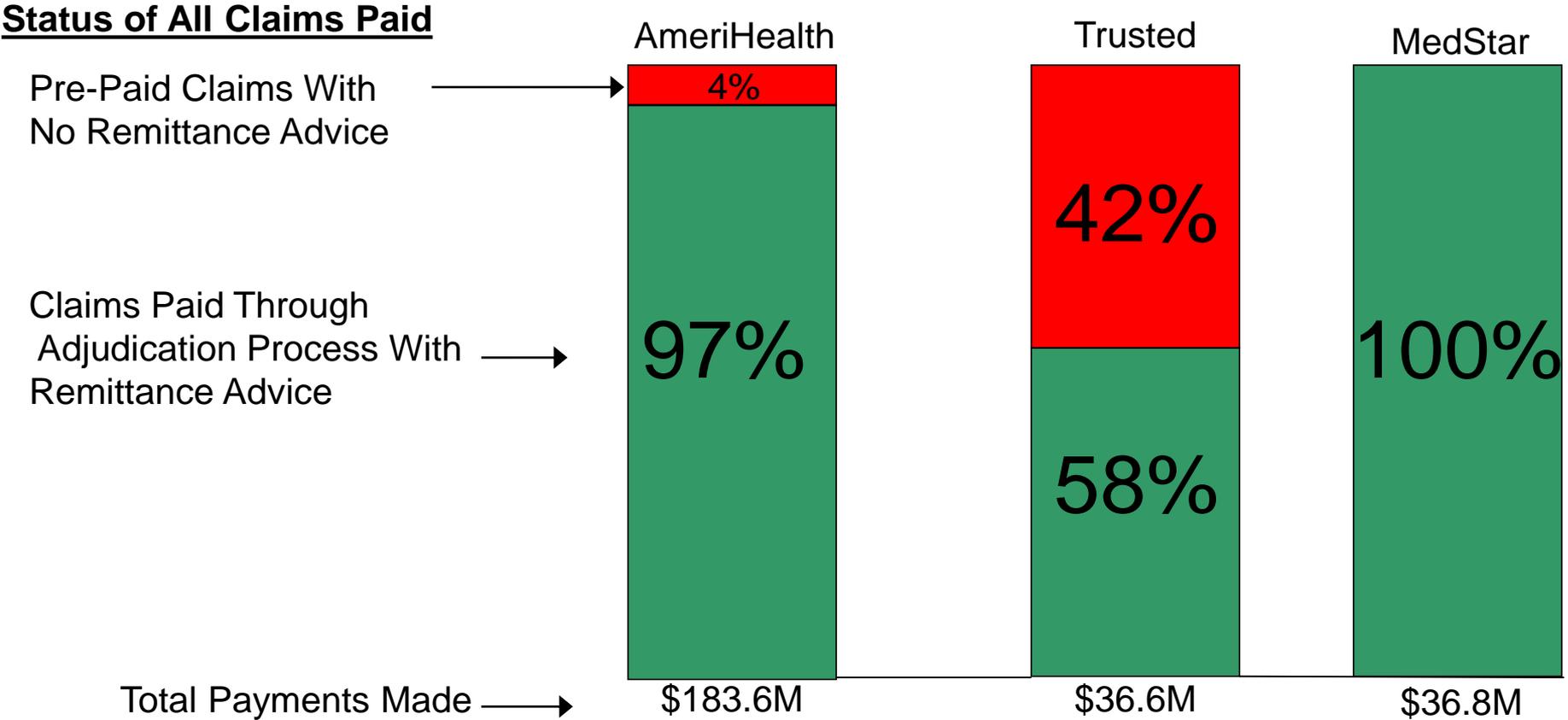
During The Initial Five Months Of The Reporting Period Two Of Three MCOs Operated In Compliance With Timely Payment Requirements

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement, July 2013 through December 2013



Though Progress Has Since Been Made, One Health Plan Struggled To Establish A Properly Operating Claims Payment System And Distributed More Than \$4 Of Every \$10 In Payments Outside Of The Normal Claims Adjudication Process

MCO Compliance Rate For Payments Made To Providers, July 2013-December 2013



Source: MCO claims reports submitted to the Department of Health Care Finance and Trusted bank records.

All Three Plans Have Made Progress In Building Their Encounter Data Systems But Some Work Remains

Number of Recorded Encounters And Accuracy Transfer Rate, July 2013-December 2013

MCO	Average Monthly Enrollment	Total Encounters	Total Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	100,900	477,292	4.7	76%
MedStar	34,339	136,307	3.1	94%
Trusted	27,035	50,564	1.8	85%

Source: Department of Health Care Finance Medicaid Management Information System as of December 31, 2013.

Building A Robust Case Management Program Is An Area That Requires More Attention From All Three Health Plans

Health Plan	Average Monthly Enrollment	Health Staff Working Case Management	Number of Members Assessed For Case Management	Members In Case Management
DC AmeriHealth	100,900	46 (32%)	2,456 (2.4%)	885 (36%)
MedStar FP	34,339	14 (31%)	374 (1.0%)	207 (55%)
Trusted	27,035	8 (16%)	2,967 (11%)	479 (16%)

Source: This information is self reported by the MCOs as of December 31, 2013.

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Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

- ❑ The newly established five-year MCO contracts contain specific provisions to ensure Medicaid and Alliance members have reasonable access to care. The health plans must have:
 - 1 primary care physician for every 1,500 members
 - 1 primary care physician with pediatric training for children through age 20 for every 1,000 members
 - 1 dentist for every 750 children in their networks

- ❑ Additionally plan networks must include:
 - At least 2 hospitals that specialize in pediatric care
 - Department of Behavioral Health core service agencies
 - Laboratories within 30 minutes travel time from the member's residence

- ❑ For pharmacies, each plan must have:
 - 2 pharmacies within 2 miles of the member's residence
 - 1 24-hour, seven (7) day per week pharmacy
 - 1 pharmacy that provides home delivery service within 4 hours
 - 1 mail order pharmacy

All Three Health Plans Have Impaneled Substantially More Physicians Than Required By Contract Standards

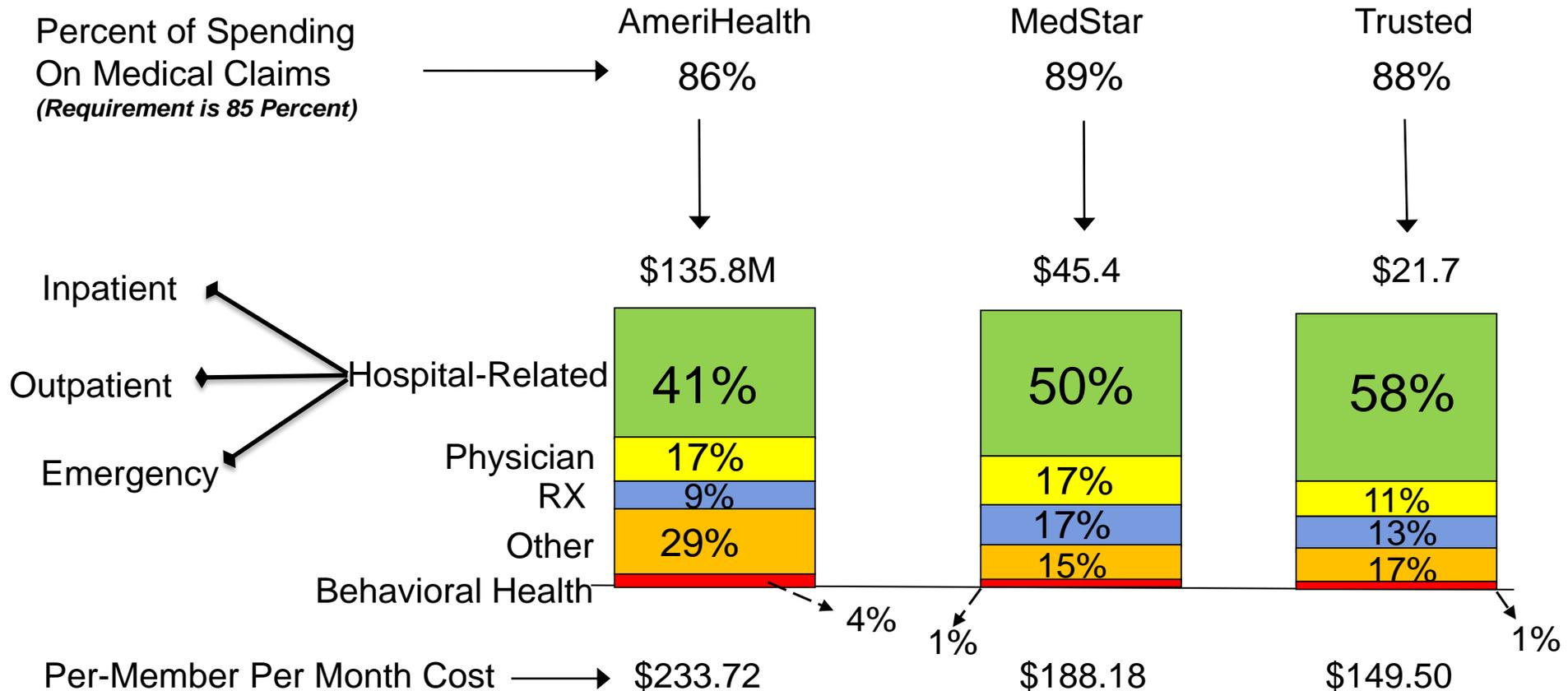
The Number of Providers In The MCO Networks Compared to Contract Requirements, as of December 2013

Health Plan	Primary Care Doctors Required In Network (1:1500)	Primary Care Doctors In The MCO Network	Primary Care Doctors With Pediatric Specialty Required In Network (1:1000)	Doctors With Pediatric Specialty In Network	Dentist For Children Required In Network (1:750)	Dentist For Children In Network
DC AmeriHealth	67	479	52	2263	69	546
MedStar FP	23	453	12	1442	16	509
Trusted	18	459	10	1734	13	554

Source: This information is self reported by the MCOs to the District's Enrollment Broker as of December 31, 2013 and verified by Department of Health Care Finance through a sampling of providers. 35

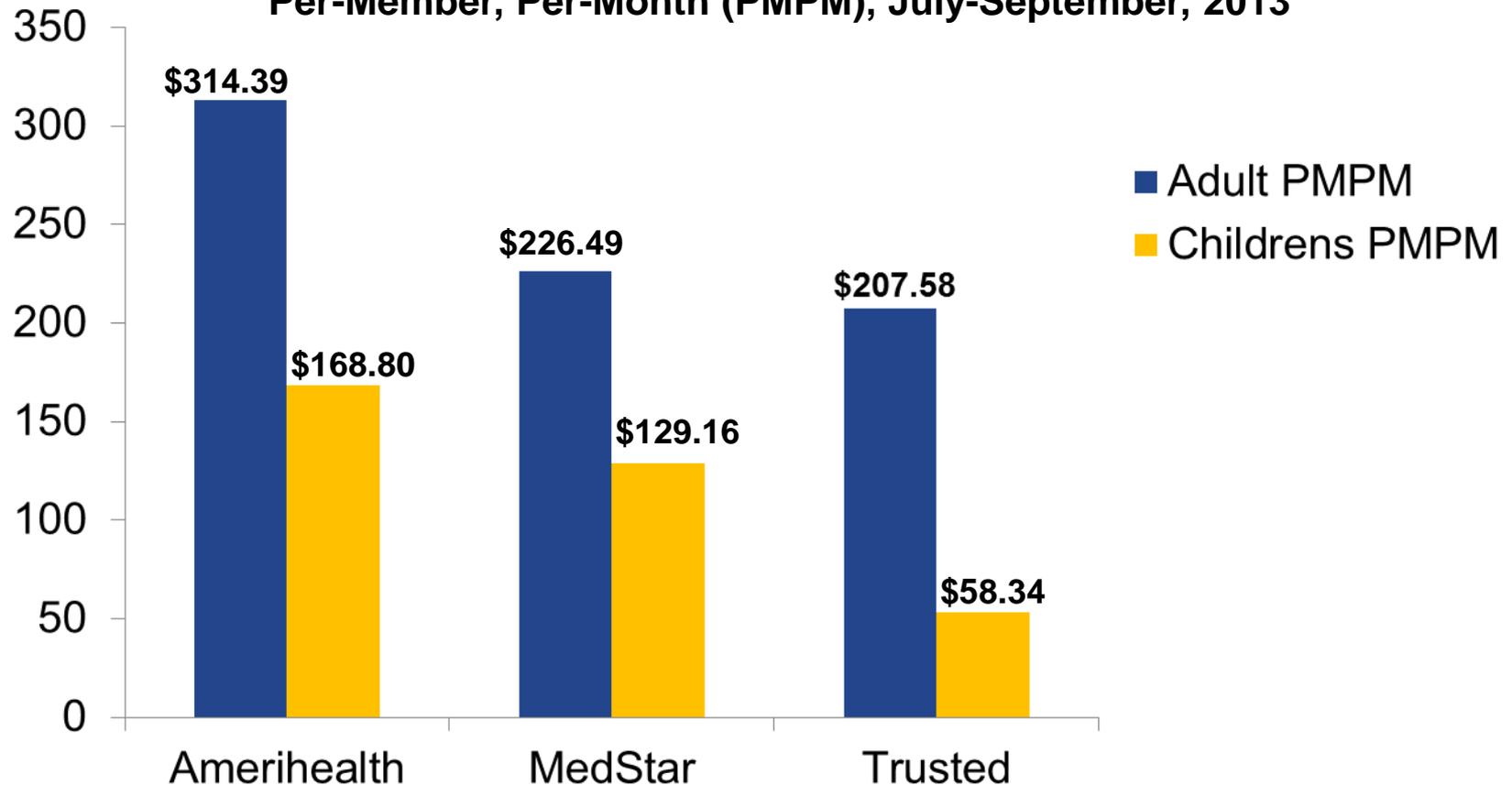
A First Quarter Snapshot Indicates That MCOs Met The Medical Loss Spending Requirements In Their Contracts And Most of The Expenses Are Hospital-Related

MCO Medical Spending In Major Health Care Service Categories, July-September, 2013



However Sharp Differences Exist Across Health Plans In Medicaid Per-Member Per-Month Expenses For Adults And Children And Are Especially Low For Trusted

MCO Adult And Children Medical Expenses
Per-Member, Per-Month (PMPM), July-September, 2013



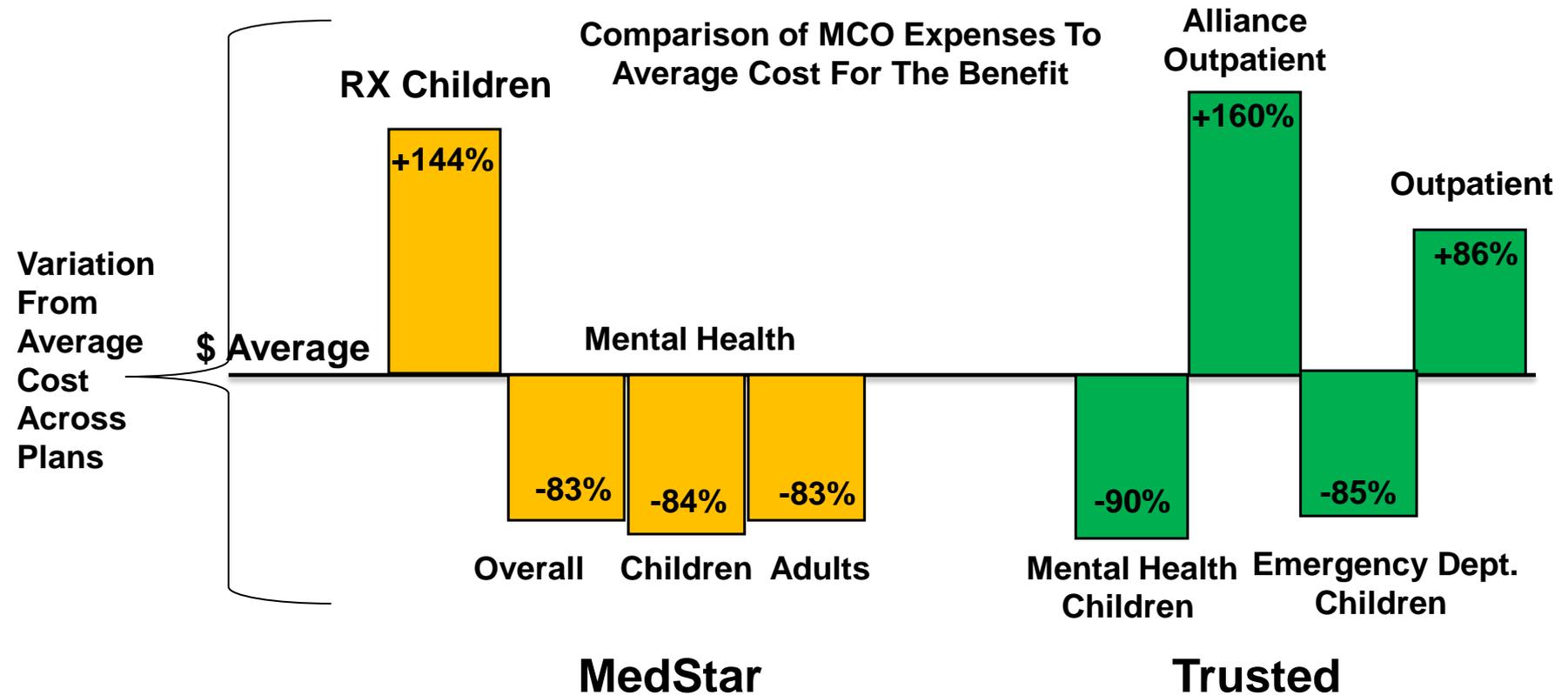
Note: Children defined as persons up to age 21 in this analysis.

Source: MCO PMPM based on encounter data submitted directly to the Department of Health Care Finance with one month run out.

The Underlying Reasons For The Low Medical Expenses For Children Assigned To Trusted Must Be Further Explored

- ❑ There are two potential reasons that could possibly explain the low outlier \$58 per-member per-month in medical expenses for children in Trusted:
 - The first is incomplete data relative to the information available for other plans. The data for this report consisted of claims paid by the end of October for services incurred between July and September
 - ❖ Trusted reported limited payments in July (5 percent) but 62 percent in September. So possibly, a disproportionately larger number of claims are outstanding which would be less concerning
 - A second reason that would create real concern is the possibility that this alarmingly low expenditure level reflects problems with the children in Trusted's plan accessing their extensive network of health care services. Even if the children assigned to Trusted have a tendency towards lower utilization, the health plan must ensure that their care needs are not being neglected
- ❑ DHCF will work with Trusted, its actuary, and in-house research staff to expedite the collection of an updated set of reports and analytics to hopefully surface a more complete picture of the MCO's claims run out and any associated spending shifts

Variation In The Expenses Incurred By Two Of The MCOs For Certain Benefits Is Unusually Large And If This Trend Continues It Will Complicate Future Rate Setting



Notes: Expenses incurred from July 1, 2013 to September 30, 2013 and paid as of October 30, 2013. The expenses do not reflect adjustments to account for INBR claims. Historically, overall claims in a quarter with one month run out for Medicaid and Alliance are 75 to 90 percent complete. Children defined as persons up to age 21 in this analysis.
 Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

MCO's Face Pressing Care Coordination Issues For The Medicaid And Alliance Population

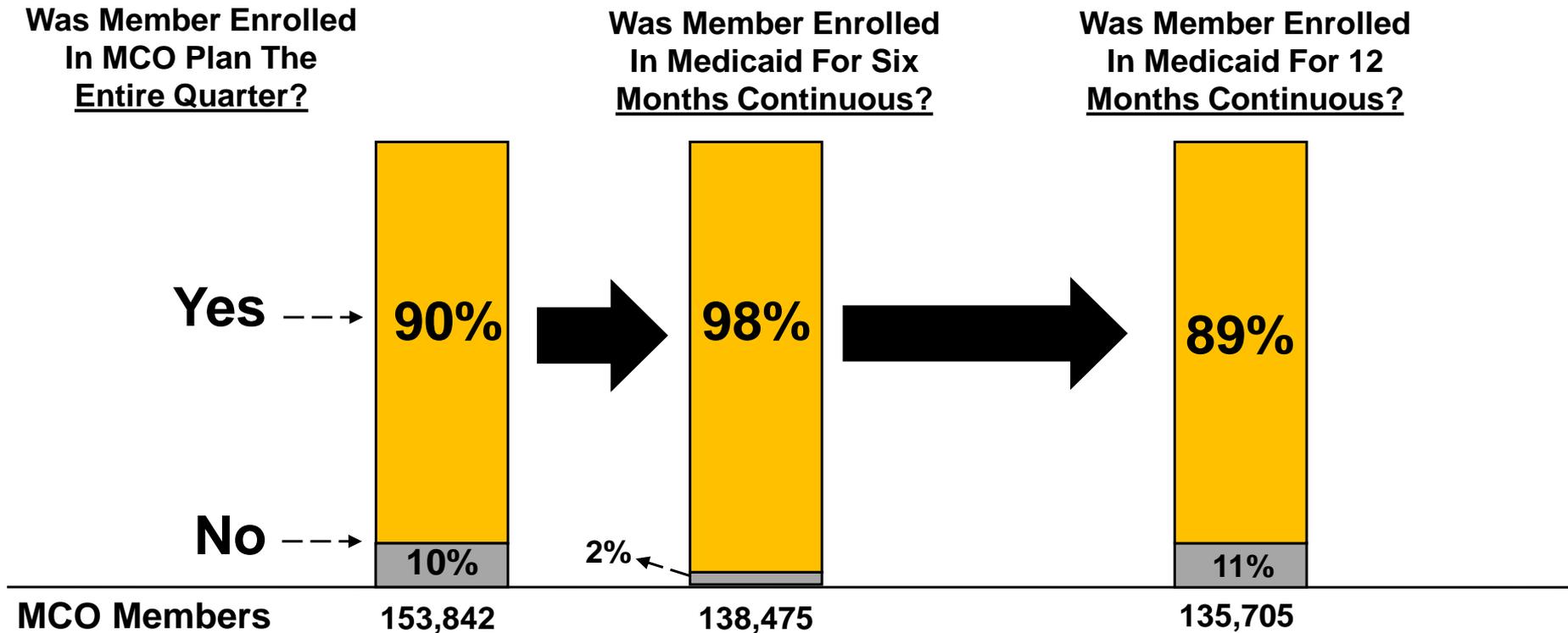
- ❑ Over the next year DHCF will closely monitor the ability of the three full-risk base health plans to address key issues in the delivery and utilization of health care service for its members. Notably the focus will be on:
 - Proper and efficient utilization of hospital-related services
 - ❖ Reducing the use of emergency room for non-emergency visits
 - ❖ Reducing the number of potentially avoidable hospital admissions
 - ❖ Reducing the frequency of hospital readmissions within 30 days for the same diagnosis
 - Access to primary care for adults and well child visits for children through the EPSDT program
 - Increased coordination of mental health services for children

- ❑ Sufficient data are not available to assess the performance of the District's three health plans on these measures at this time

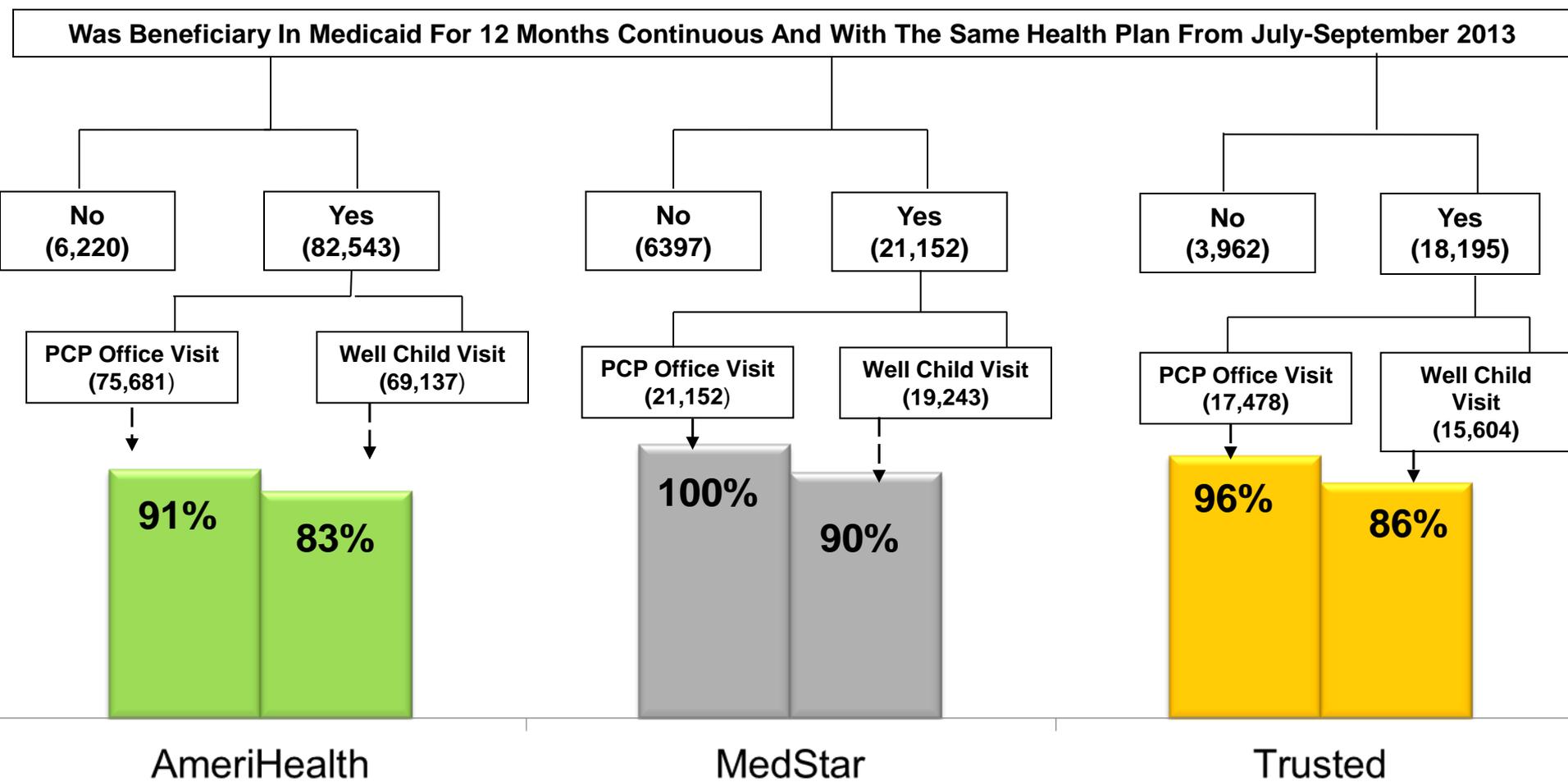
- ❑ However, historical data clearly demonstrates that these issues have presented problems which plagued the District's managed care program

The Enrollment Patterns For Members In The Three MCOs Appear Largely Static Which Greatly Improves Care Coordination Opportunities For The Health Plans

Eligibility And Plan Membership Patterns For Beneficiaries Who Were Enrolled In Managed Care During The Period Of July 1, 2013 Through September 30, 2013



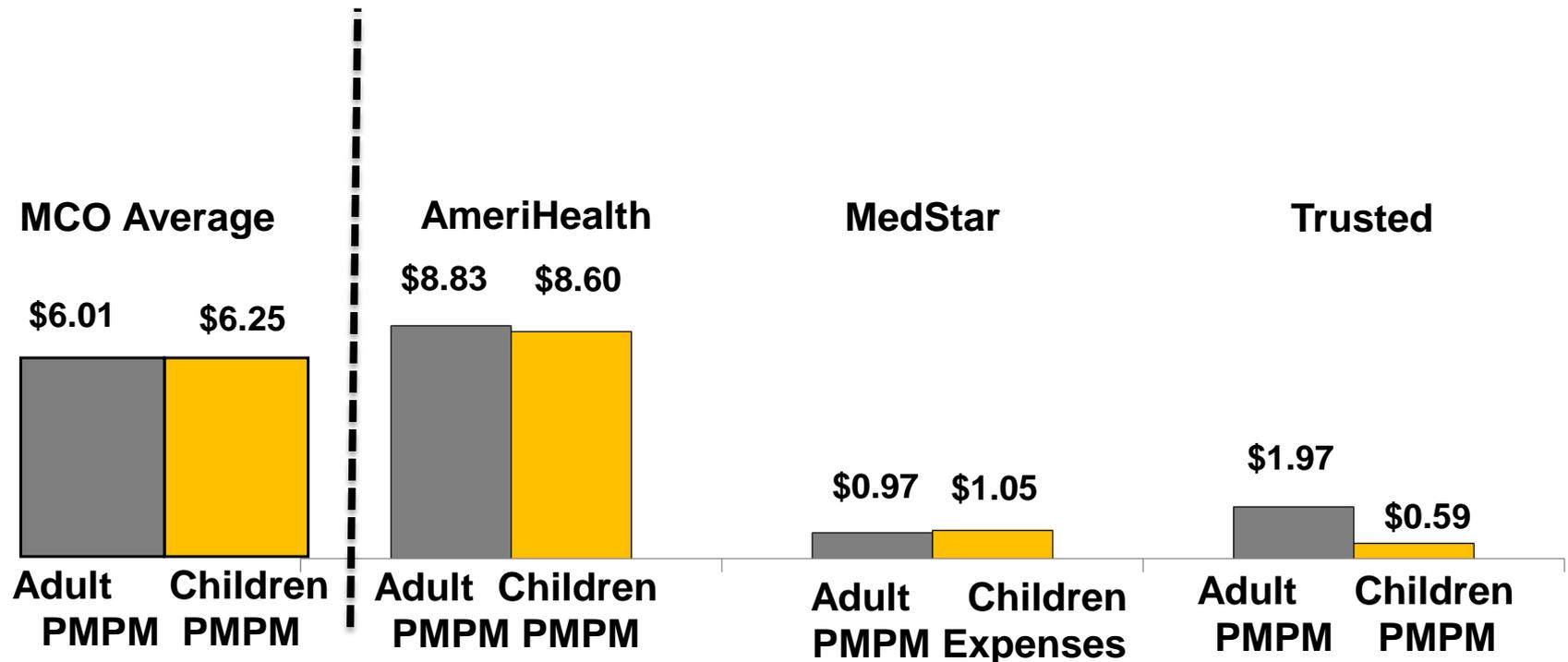
All Three Plans Have Inherited Beneficiaries Who Accessed Primary Care And Well Child Services At Exceptionally High Levels In The 12 Month Period From September 2012 to September July 2013



Note: Only members who were enrolled with the health plan for three months continuously and had 12 months of continuous Medicaid participation are included in this analysis. Categories of PCP Office Visit and Well Child Visit are not mutually exclusive. Source is Encounter data submitted by MCOs to DHCF.

Despite High Primary Care And Well Child Visit Rates MCO Spending On Behavioral Health Remains Low

The Per-Member Per-Month MCO Expenses For Behavioral Health Services, July 1, 2013 – September 30, 2013



Notes: Expenses incurred from July 1, 2013 to September 30, 2013 and paid as of October 30, 2013. The expenses do not reflect adjustments to account for INBR claims. 43
 Children defined as person up to age 21 in this analysis.

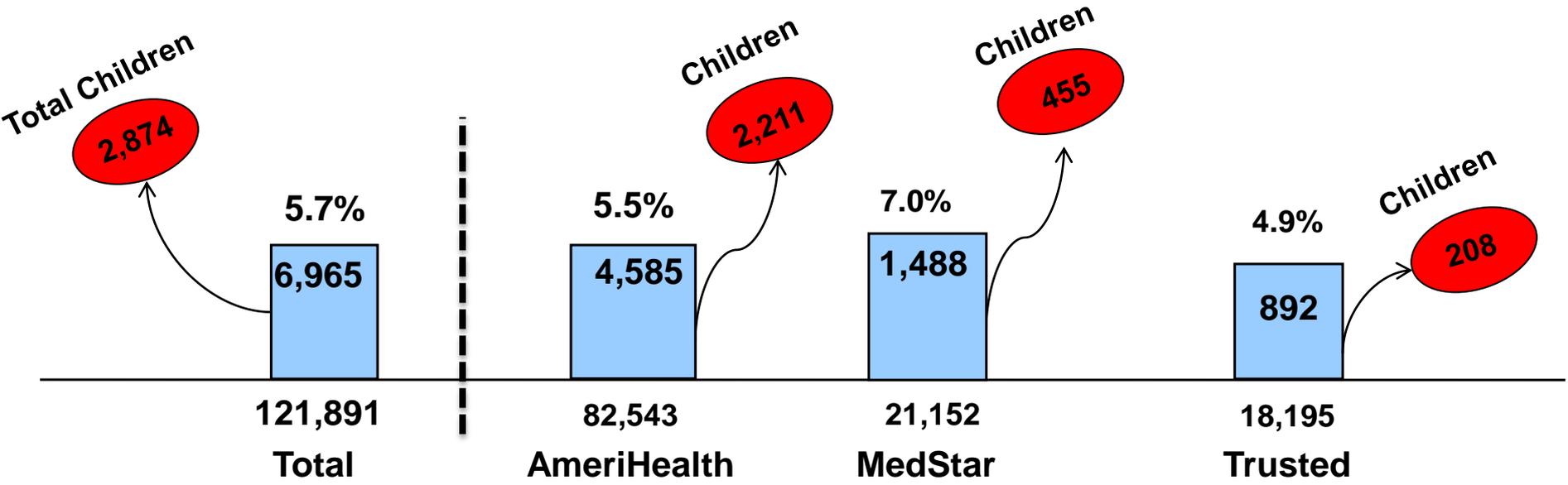
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

Only A Small Number Of Members Who Were Enrolled In The Three Health Plans Received Fee-For-Service Funded Mental Health Treatment In The 12 Months Preceding September 2013

Percent of MCO Members Who Received Fee-For-Service Mental Health, September 2012 to September 2013

Total Child FFS MH Expenditures	=	\$8,423,316
Per-Member Per-Month	=	\$10.95
Average Cost	=	\$142

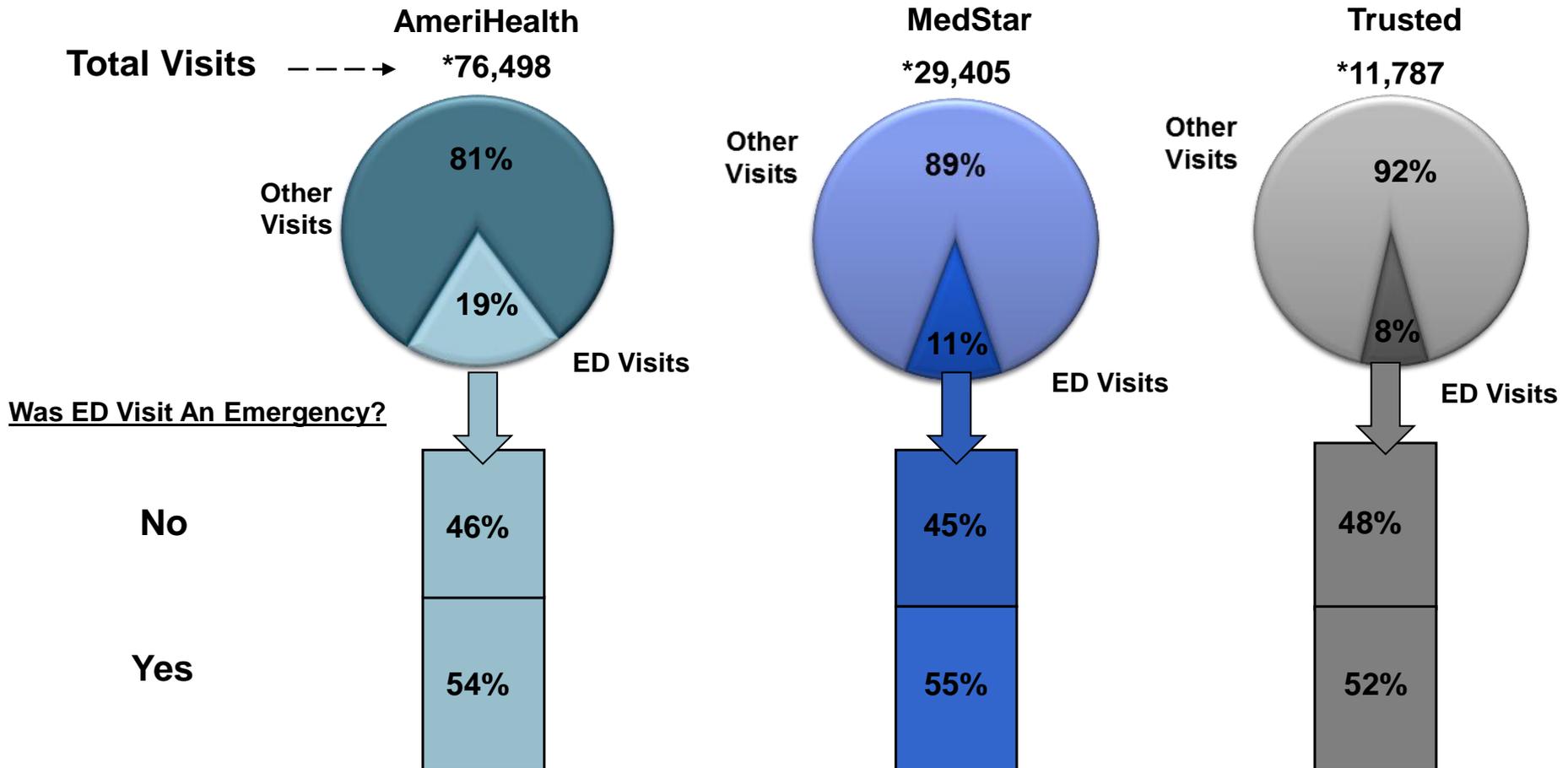
Total Adult FFS MH Expenditures	=	\$8,120,876
Per-Member Per-Month	=	\$11.87
Average Cost	=	\$133



Note: Only members who were enrolled with the health plan for three months continuously and had 12 months of continuous Medicaid participation are included in this analysis. Children defined as persons up to age 19 in this analysis. Source: Encounter data submitted by MCOs to DHCF.

Opportunities Exist To Improve Utilization Of Emergency Departments As Nearly Half Of All ED Visits That Occur For Members In Each Health Plan Are For Non-Emergencies

Type And Frequency Of Emergency Dept. Visits For MCO Members, July 2013 to September, 2013



*Total visits defined as hospital inpatient and outpatient, emergency department, clinics, and private practice physicians. Only members who were enrolled with the health plan for three months continuously are included in this analysis. Source is Encounter data submitted by MCOs to DHCF.

Presentation Outline

- Overview Of Managed Care And Focus of Presentation
- Summary of Key Findings
- The Financial Condition of The District's Health Plans
- The Administrative Performance Of The Health Plans
- MCO Medical Spending
- Next Steps**

Next Steps For The District's Managed Care Program

- ❑ DHCF's next steps for managed care are informed by Chartered's insolvency, the MCO transition process, readiness testing, and findings of this first quarterly review

- ❑ Some, key changes under consideration in advance of the next contract year are:
 - Institute enrollment cap for plans that do not meet quarterly and estimated Risk-based Capital levels

 - Strengthen language that caps enrollment for non-compliance with timely payment requirement

 - Clarify Medical Loss Ratio program requirements as well as consequences for non-compliance, including failure to provide required reports

 - Clarify language on staffing requirements with respect to the number of case managers and other key personnel based on plan membership size

 - Develop specific definitions of allowable administrative costs

Integrating Primary Care with Developmental, Behavioral and Oral Health

- ❑ One of the Mayor's goals with respect to Medicaid is to identify and address the physical, developmental and behavioral health needs of children with greatest needs to improve school readiness

- ❑ Accordingly the District's MCOs work to ensure that children receive appropriate and timely EPSDT services and these well-child visits should include all components on the District's periodicity schedule

- ❑ Problem - providers use general preventive visit or evaluation and monitoring procedure codes to bill well-child visits currently which does not allow DHCF to.
 - Confirm that all components of a well-child visit were performed
 - Detail the need for diagnostic or treatment services; or
 - Hold the MCOs accountable for linking and tracking children in need of EPSDT services to the appropriate providers

- ❑ MCOs and DHCF will be working with providers to address these problems and specify clearer billing instructions

DC Collaborative for Mental Health in Pediatric Primary Care

- Partnership with Children's National Health System (CN), Georgetown University, DHCF, DBH and Children's Law Center involving the following:
 - Primary Care and mental health providers surveys completed
 - Mental health screening tools recommendations to DHCF for pediatric primary care providers
 - Develop electronic tool-kits for pediatric practices and financial incentives to increase physician participation
 - CN Quality Improvement Learning Collaborative to train pediatricians on mental health screening and referrals (beginning February 2014)

Project Timeline

- Decide on new billing method (January 2014)
- Discuss with stakeholders (February/March)
- Finalize procedures and rates (February/March)
- Update billing manual (by April)
- Coding/Systems Changes (TBD)
- Training Period: 2-3 months (TBD: July, August, & September)
- Go live start of FY15 (October 1, 2014)

District of Columbia's Managed Care Quarterly Performance Report

(July 2013 - September 2013)

February 2014