



District of Columbia's Managed Care Quarterly Performance Report

(October 2013 - December 2013)

Department of Health Care Finance

June 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 And Member Utilization Patterns
- Care Coordination: Goals and Outcomes

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 \$860 million on MCO services on FY2014
- ❑ More than \$700 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 14,000 members who are enrolled in the District's three full risk-based MCOs
- ❑ 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. 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. DHCF revised the managed care contracts to indicate that the agency will freeze enrollments for any health plans with a RBC level of 150 or less	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

- ❑ The MCO performance review is conducted quarterly. This report focuses on the period from October to December 2013 with some information reported as late as March 2014. The following questions are addressed 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?
 - Are the health plans maintaining 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 benefit?
 - Have the plans been successful in reducing their members' use of 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
2nd Quarter Performance Review	October 2013 to December 2013	June 2014
3 rd Quarter Performance Review	January 2014 to March 2014	October 2014
4 th Quarter Performance Review	April 2014 to June 2014	December 2014
Annual Report Card (4 Quarter Roll-Up)	July 2013 to June 2014	December 2014

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Summary Of Key Findings

- ❑ This second quarter performance review examined the financial condition, administrative performance, case management activities, and the medical spending of the District's three full risk based health plans.

Financial Conditions

- ❑ The financial condition of the health plans changed only marginally from the previous quarter and while the news is slightly mixed, there is no cause for serious concern. While two of the health plans experienced second quarter losses, the amounts are moderate – less than one percent of plan revenue.
- ❑ The Risk-Based Capital (RBC) positions of AmeriHealth and MedStar were strong – considerably above the 200 percent threshold used to measure adequacy. Trusted, however, reported an annual RBC for FY2013 of 1.55 but did inject additional capital into the company to meet the required threshold of 200%.

Summary Of Key Findings

(continued)

Administrative Performance

- ❑ Administratively, the problems that were observed in the first quarter have largely been addressed. Now, on virtually all administrative metrics -- provider network adequacy, reasonable administrative spending, timely payment of claims through an adjudication process using remittance advices, and development of robust and accurate encounter data systems – the three health plans receive high marks.

Case Management

- ❑ Notwithstanding the progress on administrative metrics, the health plans continue to struggle in their efforts to build an extensive system of case management. Somewhat surprisingly, the percentage of MCO members who require case management remains small – AmeriHealth (7.8%), MedStar (3.4%), and Trusted (12.9%). While enrollment efforts have increased, only MedStar appears able to recruit a significant portion of the eligible membership (48.7%) into case management.

Summary Of Key Findings

(continued)

Case Management (continued)

- ❑ Given that those who are eligible for case management have greater and more complex health problems than other plan members, the MCOs must increase the penetration rate for this group if they hope to improve the health outcomes for their sickest members
- ❑ With the existing limits on administrative spending, the health plans will not be able to speak to this issue by simply hiring more staff. Accordingly, the plans should seriously consider developing partnerships with the community of providers --clinics, hospitals, the DC Primary Health Care Association -- to assist their case management and care coordination efforts. Strong thought should be given to working with the federally-supported Capital Clinical Integrated Network to leverage resources, expand the capacity for managing beneficiary care and test the efficacy of this approach.

Summary Of Key Findings

(continued)

Medical Expenses

- ❑ It remains too soon to offer clear findings around health plan medical spending, except that all three MCOs continue to satisfy the requirement that at least 85% of their revenue from the District's capitated payments be spent on beneficiary medical care – AmeriHealth (85%), MedStar (90%), and Trusted (89%). And the primary care visit rate for adults and children remain high.
- ❑ Moreover, the wide and troublesome variation in the per-member, per-month (PMPM) medical expenses that was observed across health plans in the previous quarter has been significantly reduced. Most conspicuously, the extremely low spending on medical care for children witnessed in Trusted's expense data is no longer apparent. While Trusted's PMPM spending on children is still the lowest among the three health plans, the level of expenses incurred -- \$161 PMPM -- appears reasonable.

Summary Of Key Findings

(continued)

Medical Expenses (continued)

- ❑ Despite this progress, the MCO's chronic problem of low spending on mental health services -- especially for children -- persists and will need to be addressed. To that end, the work of DC Collaborative for Mental Health in Pediatric Primary Care, along with the plans underway to document all components of a well-child visit to facilitate improved care management activities, hold the promise of a solution in the near term. The high "well visit" utilization rates observed for children, once again, in all three MCOs for the second consecutive quarter will be beneficial to this project moving forward.
- ❑ In terms of care coordination outcomes, it will be at least another quarter before reliable data are available to measure MCO progress in reducing low acuity hospital admissions as well as slowing the readmission rate for persons being treated for the same illness. However, a third metric for which data are available point to continued problems for the health plans. Specifically, nearly half of all emergency room (ER) visits paid for by each plan, are for members who relied on the ER for routine care.

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DHCF's Oversight Of Managed Care Plans' Includes A Close Look At Their Financial Health

- ❑ 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. An Annual Risk-based Capital Ratio is reported in the health plans financial and used in this report. In addition, a proxy measure is calculated by the District's actuary and reported on a quarterly basis reflecting the health plans *Total Adjusted Capital Levels as a percent of the health plans' **Authorized Control Levels.

AmeriHealth Is The Only Plan That Has Experienced Meaningful Growth In Its Membership Since July 2013

MCO	July 2013 Enrollment	March 2014 Enrollment	Net Change
AmeriHealth	98,019	103,950	5931 (6%)
MedStar	35,911	36,260	349 (1%)
Trusted	28,803	26,764	(-2039) (-7%)

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

Two Of The Three Health Plans Ended The Calendar Year In The Red But The Losses Are Moderate

MCO Revenue and Expense Data for YTD as of December 2013

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

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	\$255.5M	\$218.3M	\$40.9M	(\$3.7M)
MedStar	\$86.2M	\$77.6M	\$8.5M	\$0.1
Trusted	\$50.5M	\$45.1M	\$5.6M	(\$0.2M)

Notes: *MCO revenue does not include investment income.

**Total claims include incurred but not reported amounts for YTD as of December 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

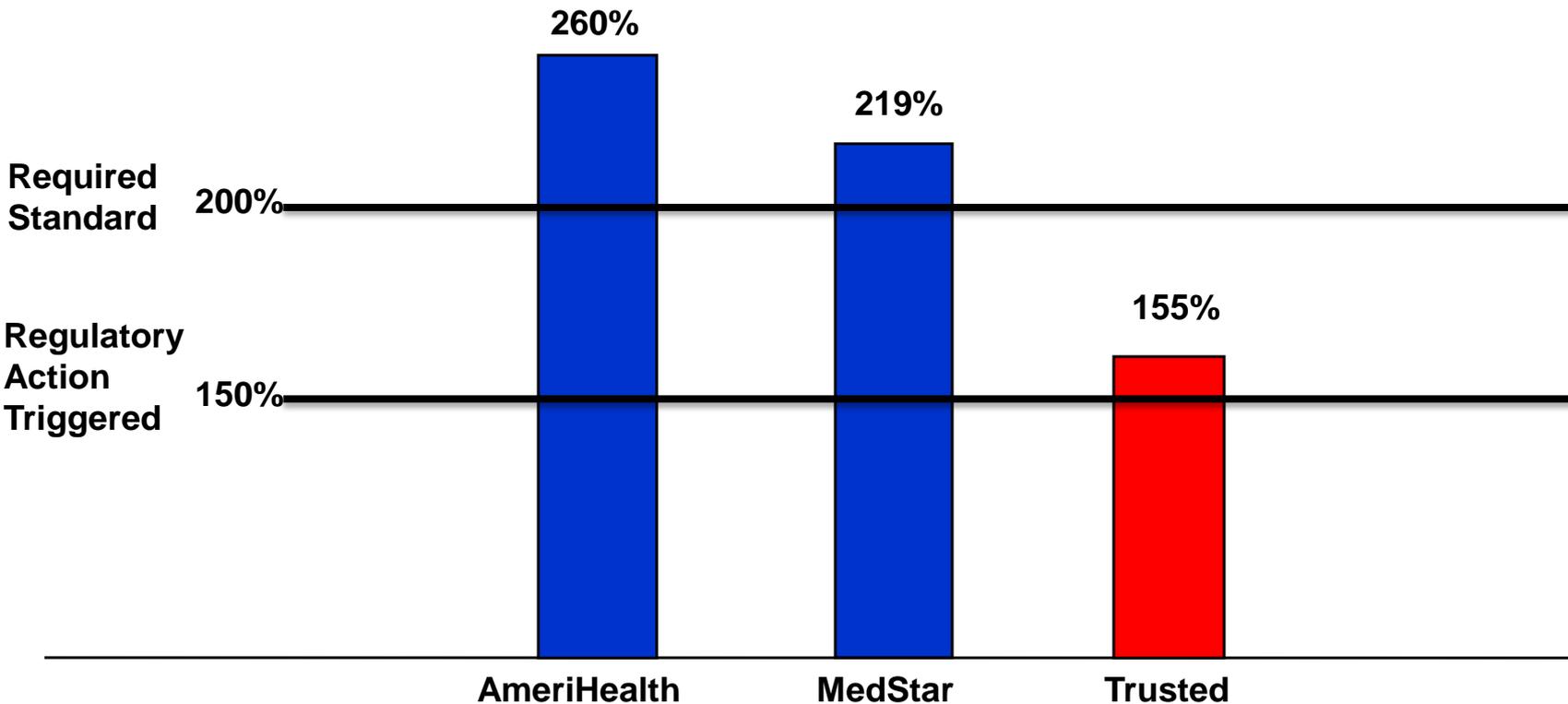
- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims
- ❑ MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) which is provided to the Department of Insurance, Securities and Banking (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
- ❑ In the previous quarterly report, DHCF used a proxy measure calculated by Mercer Consulting to assess the RBC levels for each plan. This report relies on the annual RBC measure reported by the plans in their official 2013 financial statement filed with DISB. The proxy quarterly measure is footnoted.

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).

Trusted's Risk-Based Capital Position For 2013 Was Beneath The Mandated Threshold And The Company Injected The Necessary Capital To Meet The Required Standard

Risk-Based Capital Levels For Managed Care Plans, 2013



Note: Reported figures are from MCO's annual 2013 financial statement filed with DISB. Mercer's quarterly proxy measure determined for each plan are as follows: AmeriHealth (182%); MedStar (219%); and Trusted (93%). Maryland's data for Total Adjusted Capital and authorized Control Level used in Mercer's calculation of the health plan's RBC level, include information from Maryland and the District of Columbia.

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. 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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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. Build an adequate network of providers and pay health care claims to service providers 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 and care coordination to identify health plan members with special or chronic health care issues and ensure that these beneficiaries receive access to appropriate care, while managing the delivery of health care services for all members

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 Continue To Ensure That Members Have Access To An Extensive Network of Health Care Providers

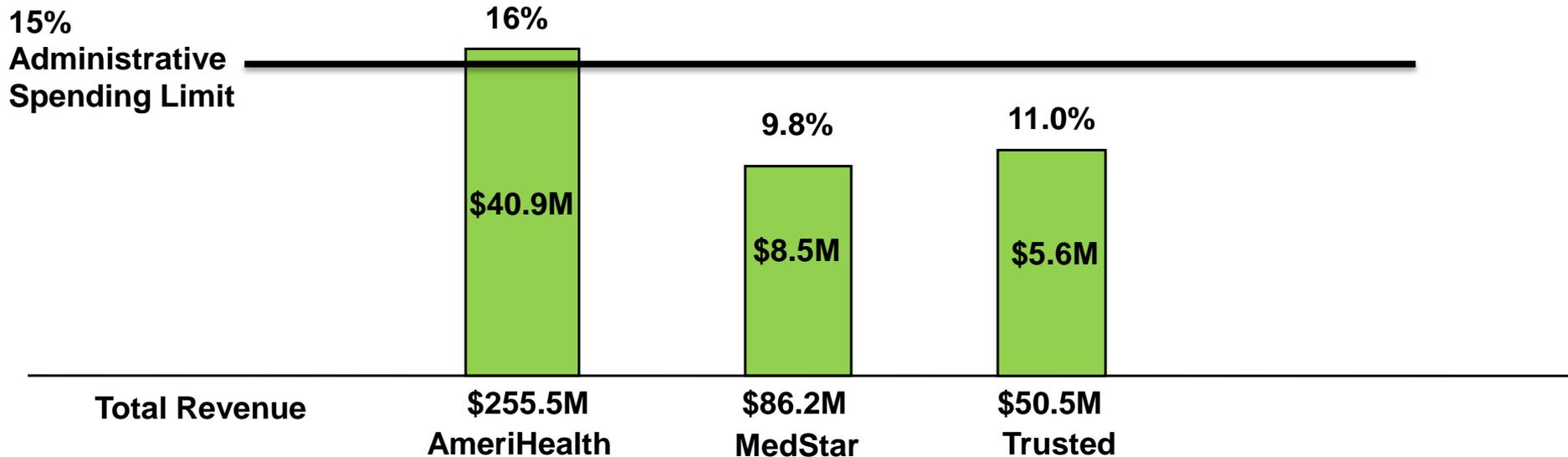
The Number of Providers In The MCO Networks Compared to Contract Requirements, as of March 2014

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	68	617	52	152	70	477
MedStar FP	23	491	13	308	17	441
Trusted	18	463	10	101	13	533

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. 29

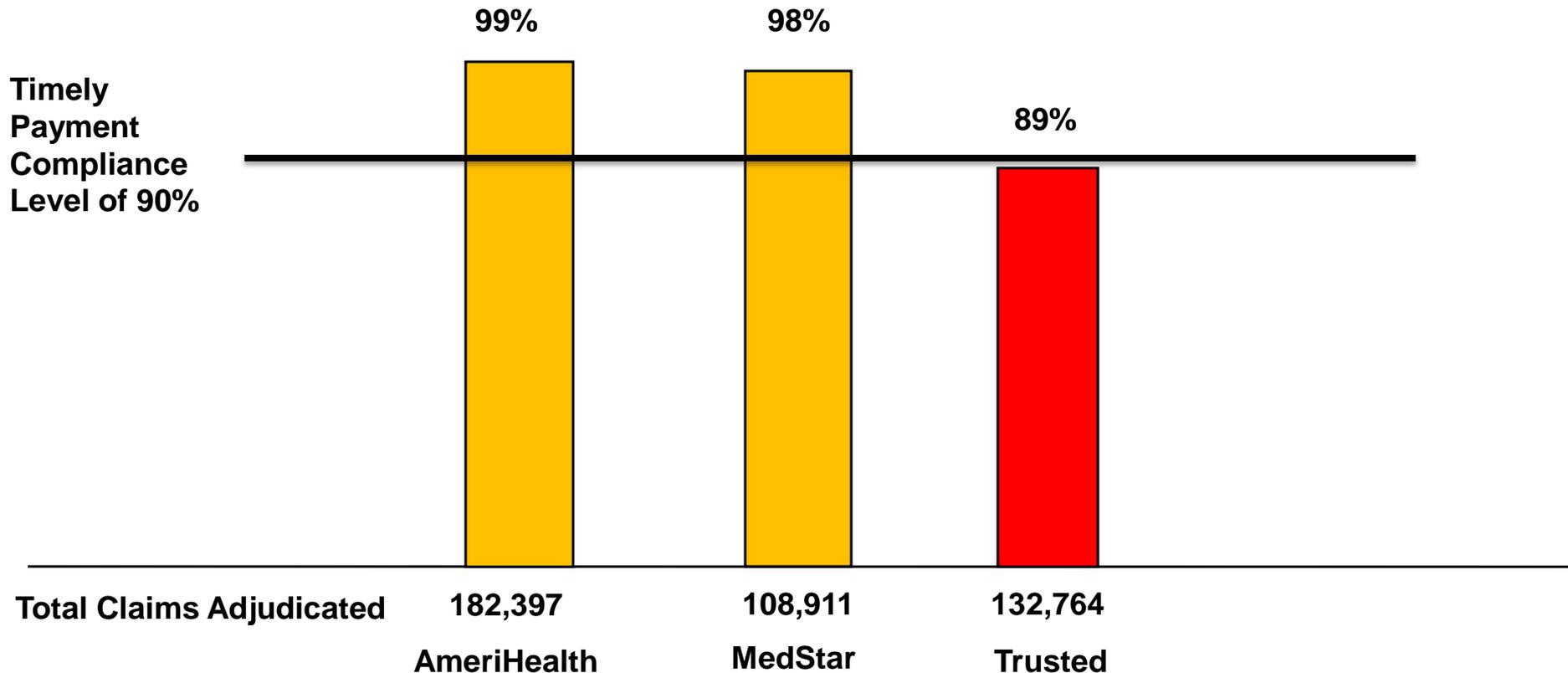
Administrative Spending For The Three Health Plans Remain In Line With The 15% Program Limit

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



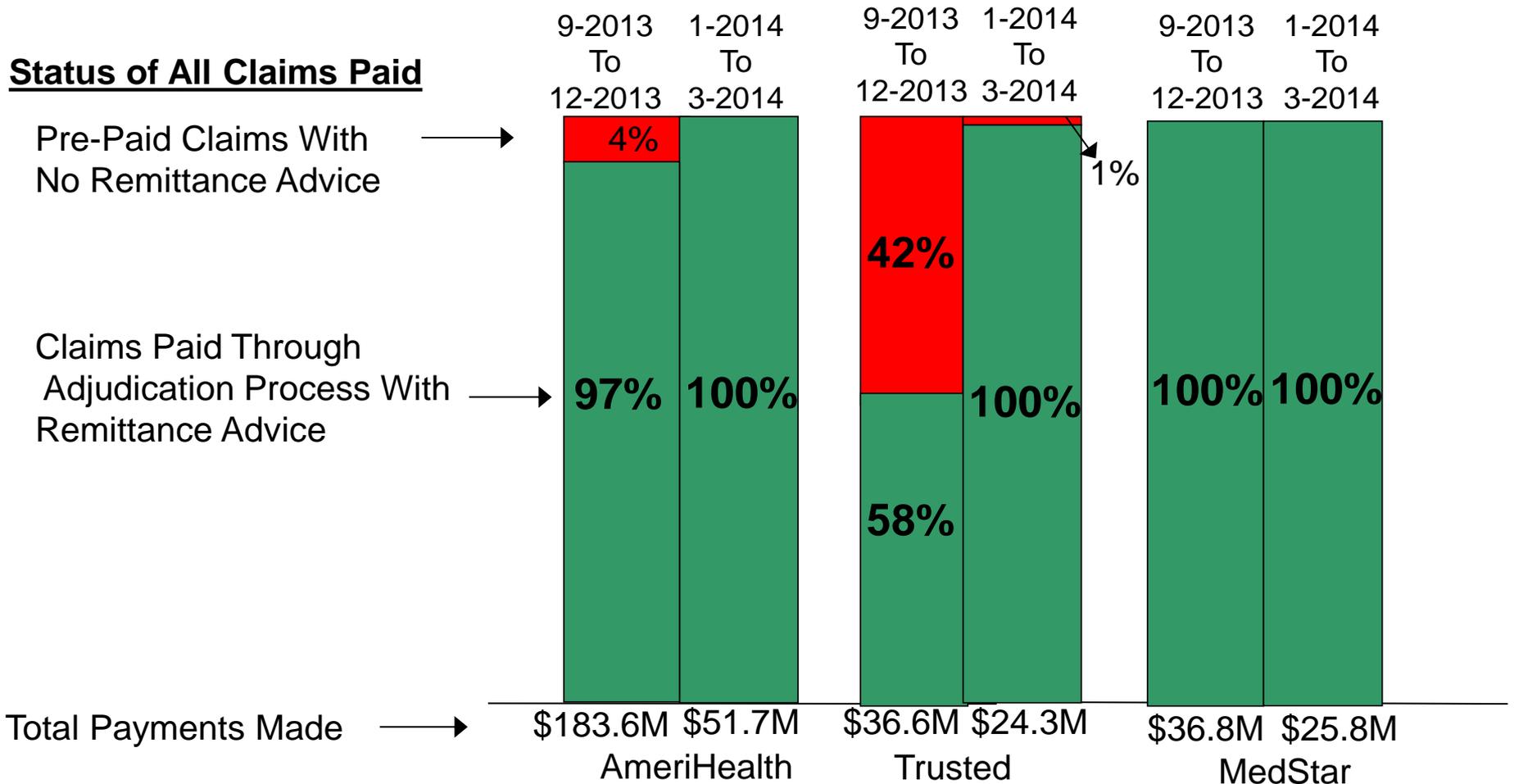
The Health Plans Were Generally In Compliance With The District's Timely Claims Payment Requirement During The Period From January 2014 Through March 2014

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement



In The Period From January to March 2014, Each Managed Care Plan Processed And Paid Virtually All Claims Through The Normal Adjudication Process With The Appropriate Remittance Advices

MCO Compliance Rate For Payments Made To Providers,



Progress Continues Around The Health Plans' Efforts To Build Reliable Encounter Systems But Work Remains

Number of Recorded Encounters And Accuracy Transfer Rate, July 2013-March 2014

MCO	Average Monthly Enrollment	Total Encounters	Total Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	102,342	927,805	9.1	*86%
MedStar	35,027	285,747	8.2	92%
Trusted	26,813	159,007	5.9	83%

Note: *The figure for AmeriHealth was determined by averaging their accuracy rate from the period of July to December 2013 with the rate for January to March 2014

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	102,342	46	8,041 (7.8%)	1795 (22.3%)
MedStar FP	35,027	14	1212 (3.4%)	591 (48.7%)
Trusted	26,813	6	3469 (12.9%)	926 (26.6%)

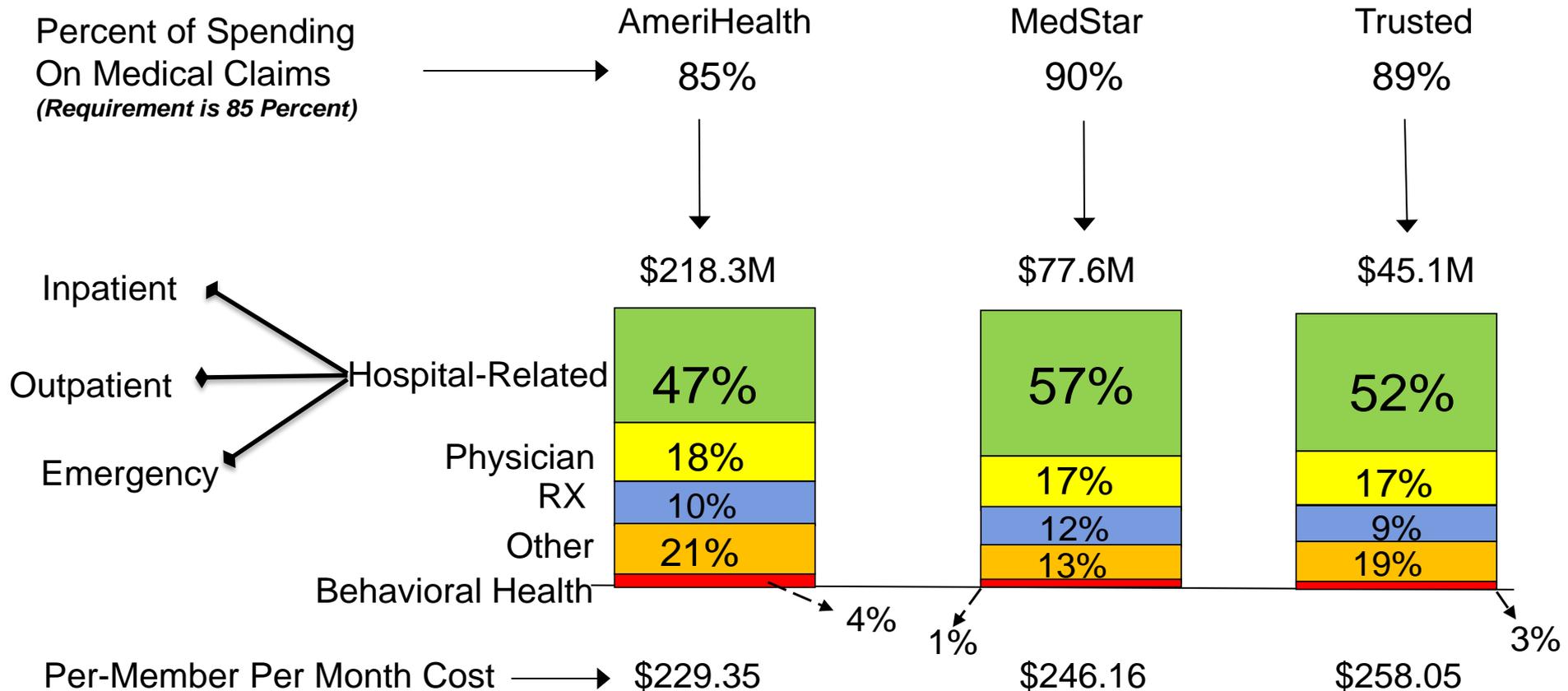
Source: This information is self reported by the MCOs as of March 2014

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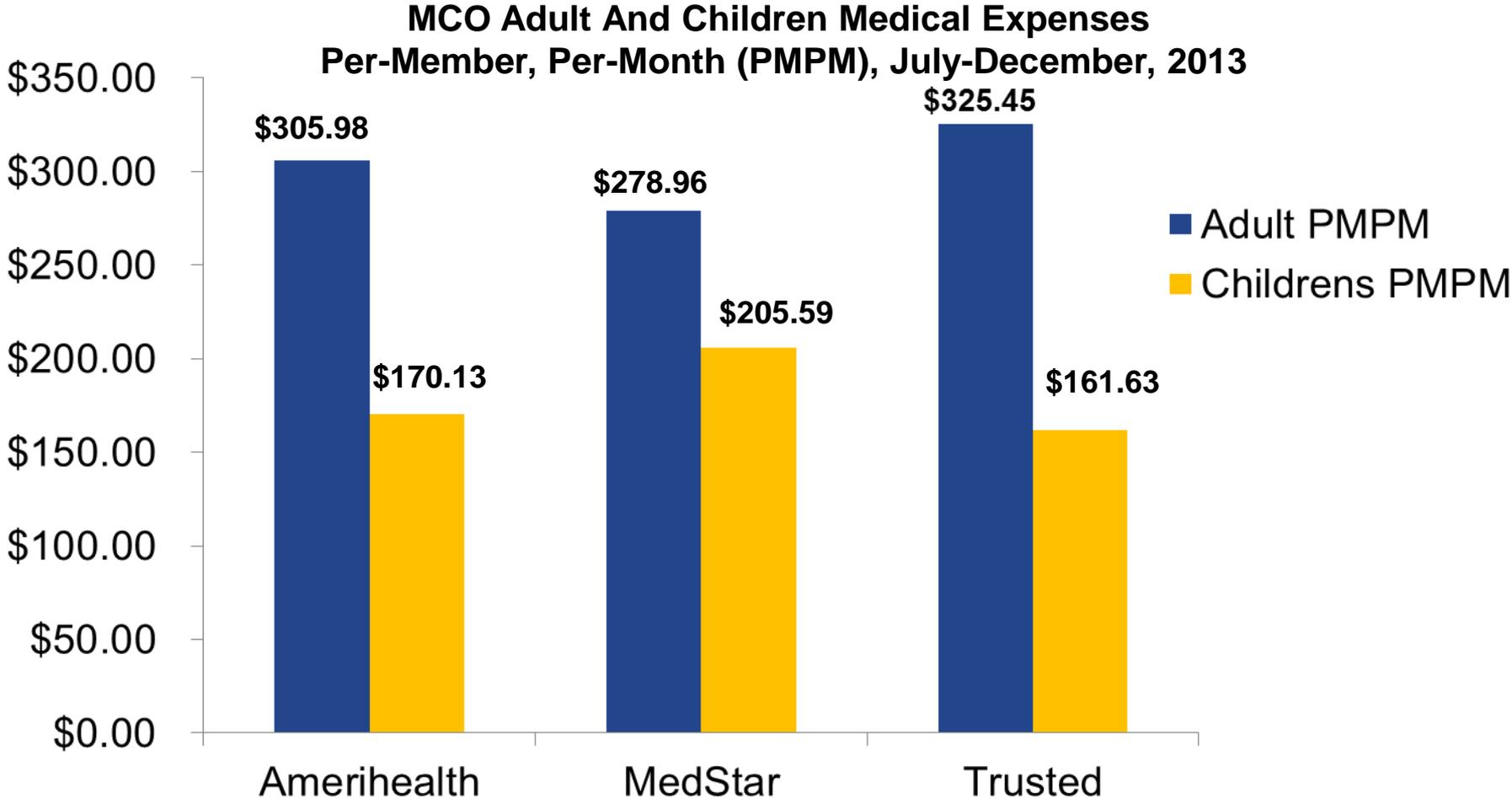
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MCOs Continue To Meet Medical Loss Spending Requirements And Most Of The Cost Are Attributed To Hospital-Based Care

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



Also Previous Large Differences That Existed Across Health Plans In Medicaid Per-Member Per-Month Expenses For Adults And Children Have Moderated

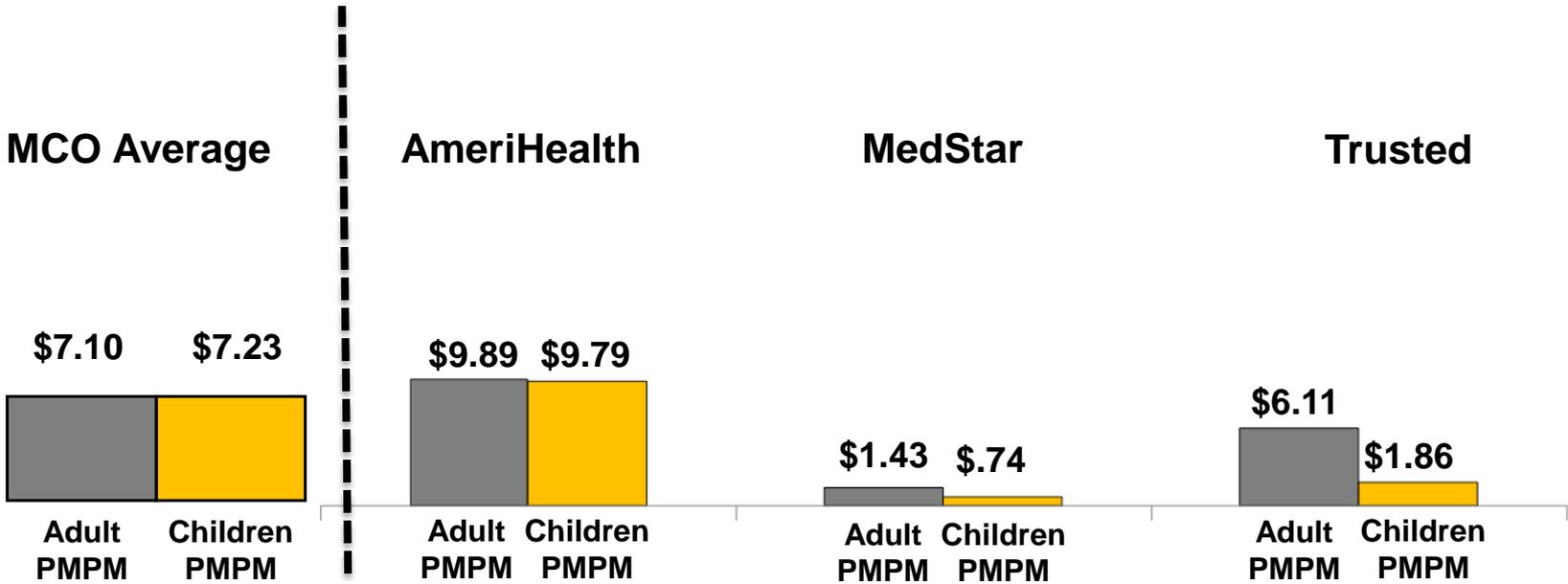


Notes: Expenses incurred from July 1, 2013 to December 31, 2013 and paid as of January 31, 2014. The expenses do not reflect adjustments to account for INBR claims. 37
Children defined as person up to age 21 in this analysis.

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

MCO Spending On Behavioral Health Has Grown Primarily Due To The Efforts Of AmeriHealth But There Is Considerable Room For Improvement, Especially For Children

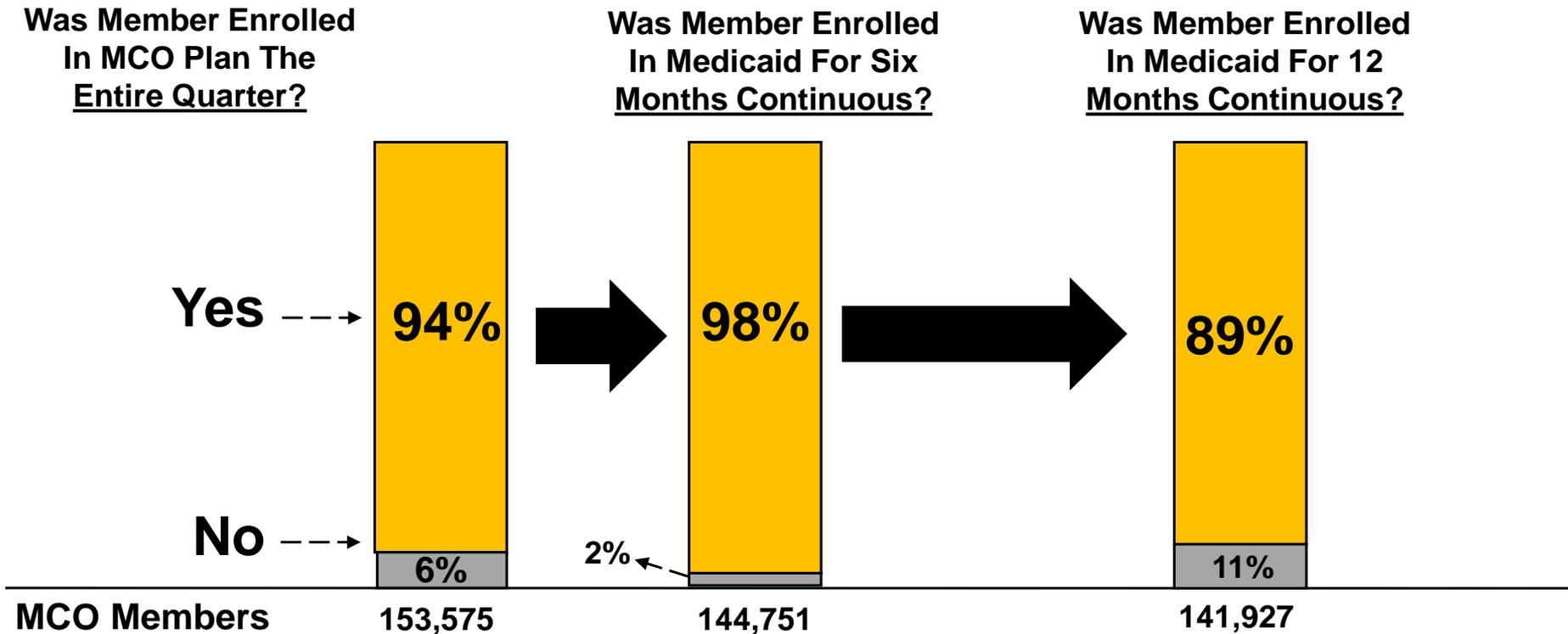
The Per-Member Per-Month MCO Expenses For Behavioral Health Services, July 1, 2013 to December 31, 2013



Notes: Expenses incurred from July 1, 2013 to December 31, 2013 and paid as of January 31, 2014. The expenses do not reflect adjustments to account for INBR claims. Children defined as person up to age 21 in this analysis. MedStar reports that the mental health expenditure for its plan is underreported.
 Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

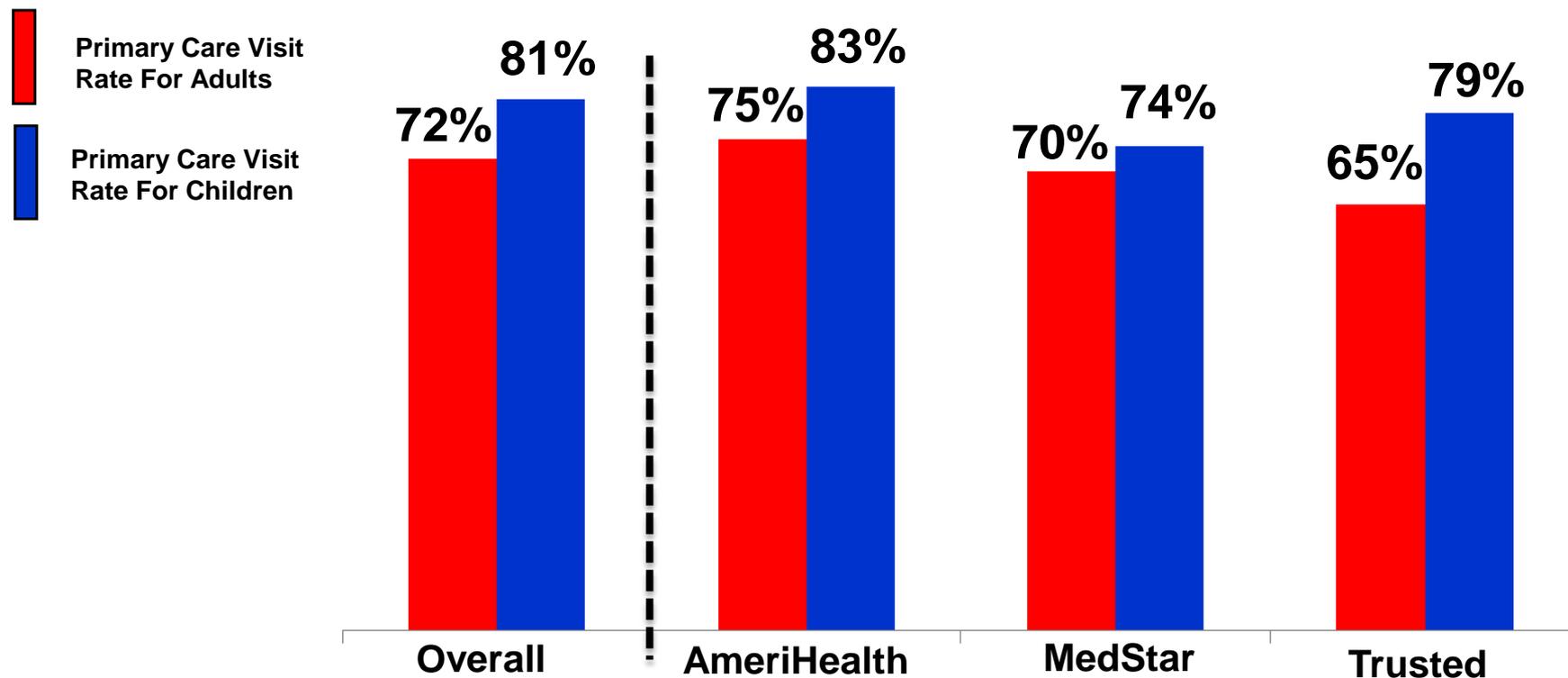
The Enrollment Patterns For Members In The Three MCOs Continue To Be Largely Static Which Greatly Improves Care Coordination Opportunities For The Health Plans

Eligibility And Plan Membership Patterns For Beneficiaries Who Were Enrolled In Managed Care During The Period Of October 1, 2013 Through December 31, 2013



The Primary Care Visit Rate For Members In Each Managed Care Plan Remains High.....

Primary Care Visit Rates For Members Who Were Enrolled In Managed Care During The Period Of October 1, 2013 Through December 31, 2013 And Had 12 Months Of Continuous Eligibility

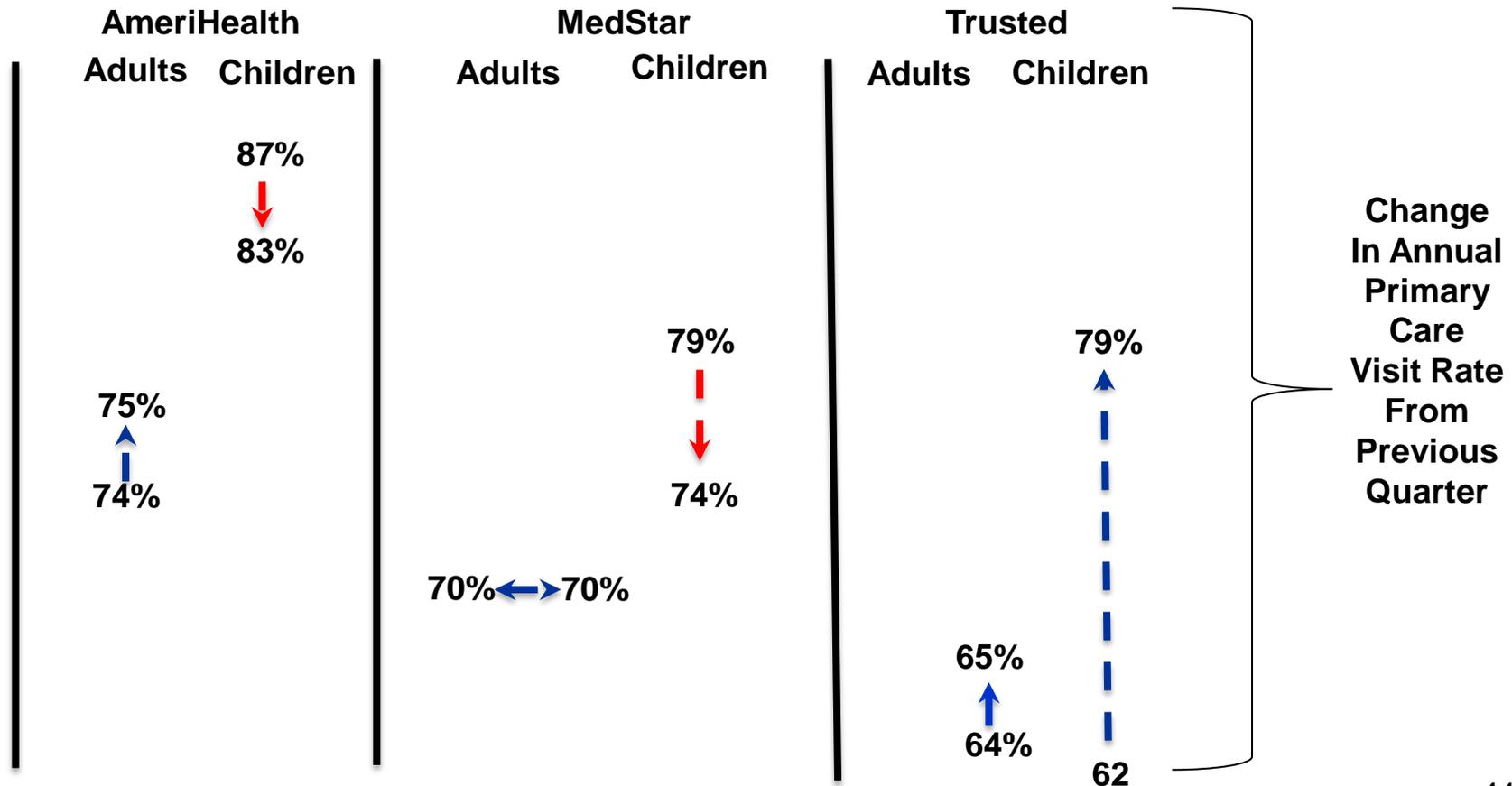


Note: Only members who were enrolled with the health plan for three months continuously during the period of October –December 2013 and had 12 months of continuous Medicaid participation as of December 31 2013 are included in this analysis. Dates of service for primary care visit are December 2012 through December 2013.

Source Encounter data submitted by MCOs to DHCF.

However Two Health Plans -- AmeriHealth And MedStar -- Witnessed Slight Declines In The Annual Primary Care Visits For Children From The Previous Reporting Period

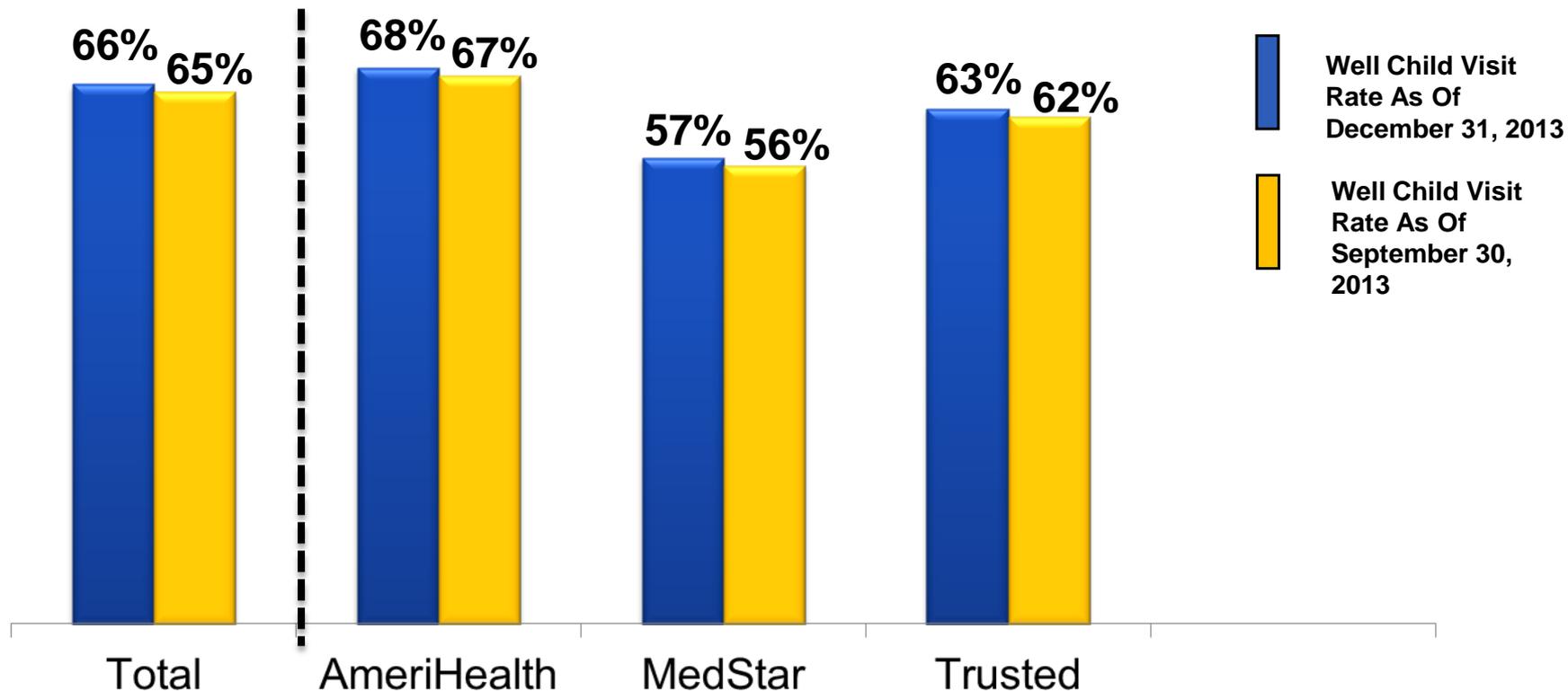
Change In Annual Primary Care Visit Rate For Members With 12 Months Of Service, By Health Plan



Note: Only members who were enrolled with the health plan for three months continuously during the period of October –December 2013 and had 12 months of continuous Medicaid participation as of December 31 2013 are included in this analysis. Source for analysis is MCO Encounter Data

The “Well Child Visit” Rate Is Largely Unchanged From The Levels Observed In The Previous Quarter

Change In Well Child Visit Rate By Health Plan For Members With 12 Months Of Continuous Medicaid Eligibility



Note: Only members who were enrolled with the health plan for three months continuously during the period of October –December 2013 and had 12 months of continuous Medicaid participation as of December 31 2013 are included in this analysis. Dates of service for primary care visit are December 2012 through December 2013. Source for analysis is MCO Encounter Data. 42

Progress Continues With DHCF Efforts To Improve Children's Access To Comprehensive Care

- ❑ DHCF continues with efforts to integrate primary care with developmental, behavioral, and oral health for children

- ❑ Since the last MCO quarterly report:
 - The Mayor's funding for this initiative has been secured

 - Meetings with providers continue as a means to finalize changes to the EPSDT billing manual

 - A billing plan for the "well child" visits has been established in concept to incentivize primary care providers to document and bill the Medicaid program separately for each component of the visit

 - DHCF staff continue to work with the managed care plans in preparation for the launch of this program in FY2015

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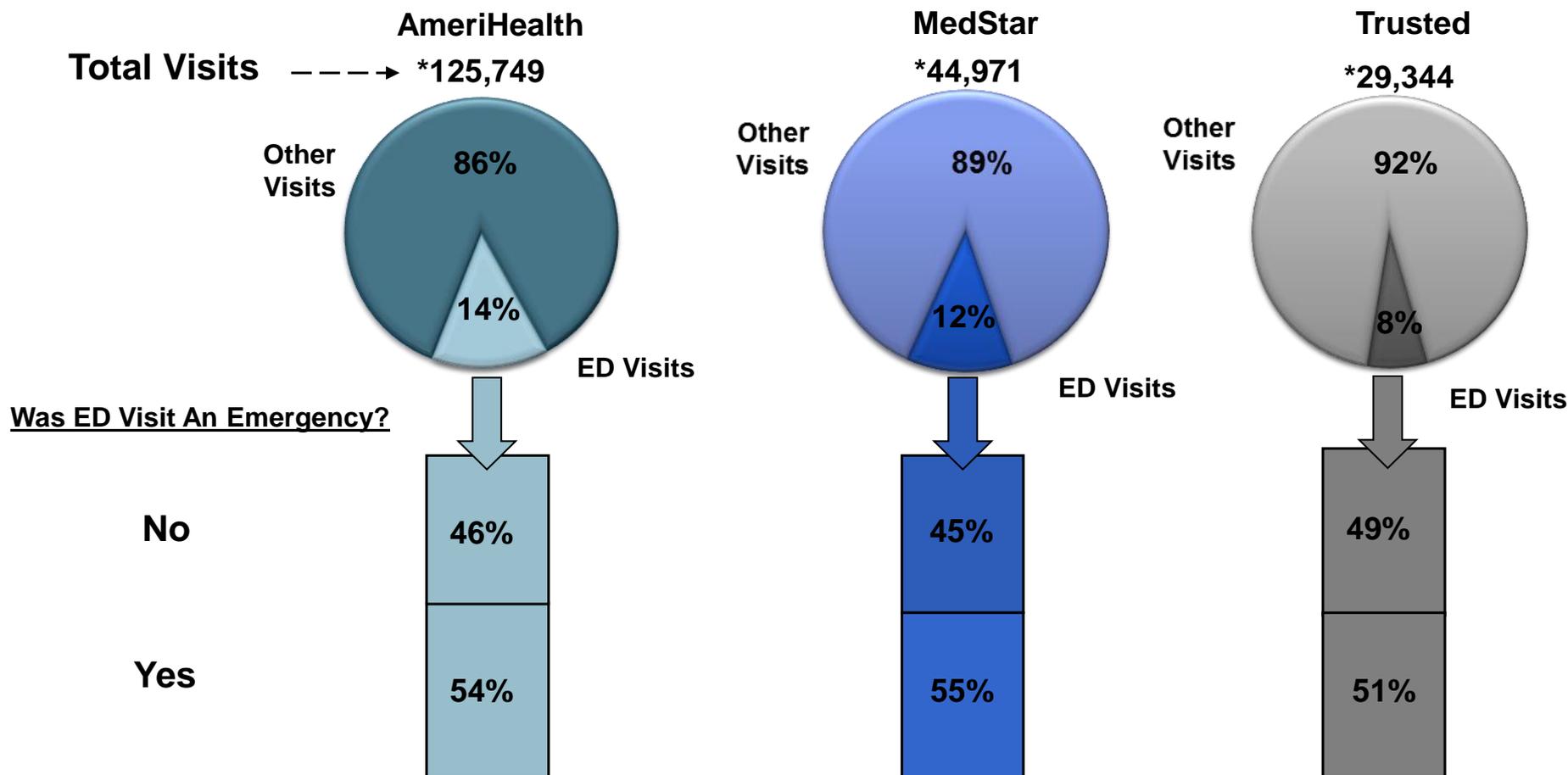
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As The MCO Program Matures, DHCF Will Closely Evaluate Efforts By The Health Plans To Coordinate Beneficiary Care

- ❑ Achieving high value in health care for Medicaid and Alliance beneficiaries is a preeminent goal of DHCF's managed care program
- ❑ The District's three managed care plans are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management
- ❑ As one component in a set of performance measures, DHCF will regularly focus upon the following outcomes in its evaluation of the District's three health plans:
 - Emergency room utilization for non-emergency conditions
 - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary care and preventative
 - Hospital readmissions for the same diagnosis which prompted a previous and recent hospitalization
- ❑ When sufficient data are accumulated -- likely by the first report in 2015 -- DHCF will assess the degree to which the health plans are limiting low acuity hospital admissions and reducing patient readmissions within 30 days for same diagnosis. In this report we continue the examination of hospital emergency room use

The Rate At Which Beneficiaries Continue To Use The Emergency Room For Non-Emergency Care Remains Unacceptably High Across The Three Health Plans

Type And Frequency Of Emergency Dept. Visits For MCO Members, October to December, 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.

Status Of Action Items From Previous Report

- ❑ At the conclusion of the first quarterly report, DHCF indicated that a number of policy actions would be implemented in the coming months to improve the managed care program. The status of these actions are as follows:
 - Contract language to institute enrollment cap for plans that do not meet quarterly and estimated Risk-based Capital levels has been drafted and will be submitted to the health plans for execution in July 2014 once the legal review process is completed
 - Contract language to strengthen language that caps enrollment for non-compliance with timely payment requirement has been drafted and will be submitted to the health plans for execution in July 2014 once the legal review process is completed
 - Contract language clarifying Medical Loss Ratio program requirements as well as consequences for non-compliance, including failure to provide required reports has been drafted and will be submitted to the health plans for execution in July 2014 once the legal review process is completed
- ❑ More developmental is necessary to clarify language on staffing requirements with respect to the number of case managers and other key personnel based on plan membership size as well as defining allowable administrative costs