



District of Columbia's Managed Care Quarterly Performance Report

(January 2016 – March 2016)

Department of Health Care Finance

August 2016
Washington DC

Presentation Outline

- Goals and Purpose of Managed Care Performance Review**
- 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
- Implementation of MCO Pay for Performance Plan

Managed Care Represents DHCF's Largest Provider Expenditure

- ❑ DHCF's managed care program is the largest single expenditure in the agency's budget consisting of the Medicaid and Alliance publicly-funded health insurance programs.
- ❑ As of March, 2016, more than 185,400 Medicaid beneficiaries and just over 12,400 Alliance enrollees are assigned to one of the four following Managed Care Organizations (MCO):
 - AmeriHealth Caritas DC (AmeriHealth)
 - MedStar Family Choice (MedStar)
 - Trusted Health Plan (Trusted)
 - Health Services for Children With Special Needs (HSCSN)
- ❑ All four health plans offer comprehensive benefits. Three of these health plans -- AmeriHealth, MedStar, and Trusted -- operate under full risk-based contracts while HSCSN works under a risk sharing arrangement with the District.
- ❑ The District spent more than \$984.3 million on MCO services in FY2015. A little more \$828.8 million of this amount funded the full risk-based contracts signed by AmeriHealth, MedStar, and Trusted, while approximately \$155 million funded the risk sharing contract with HSCSN.

DHCF Implements A Performance Review Of Its Managed Care Program

- ❑ The contracts for the three full risk-based plans were awarded in 2013 as the first step initiated by DHCF to reform a troubled program.
- ❑ Prior to this award, DHCF's managed care program was hampered by ambiguous contract language, financially unstable providers, and de minimis reporting requirements that made it difficult to assess the performance of the plans.
- ❑ Accordingly, 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 three full risk-based health plans.

Purpose Of The CASSIP Performance Review

- ❑ Initially, the Child and Adolescent Supplemental Security Income Program (CASSIP) program, managed by HSCSN, was not included in DHCF's review of the health plans.

- ❑ In 2015, HSCSN experienced sharp cost increases in certain areas that were previously unforeseen, including:
 - Pharmacy costs
 - Mental health costs
 - Hospital claims
 - Home Health costs

- ❑ DHCF now includes CASSIP program in this quarterly review in order to better understand cost fluctuations and to continue its commitment to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia.

Overview of CASSIP

- ❑ Overall, approximately 5,600 beneficiaries are voluntarily enrolled in CASSIP and assigned to Health Services for Children With Special Needs (HSCSN). Notably:
 - Two-thirds of children enrolled in the program have a mental health disorder as the primary diagnosis, with an estimated 10 percent diagnosed with an intellectual disability.
 - The majority of CASSIP enrollees suffer from co-morbidities that include both physical and behavioral/developmental disabilities.
 - HSCSN coordinates and manages medical, behavioral, dental, drug, long-term care and social benefits for enrollees between birth and 26 years of age through a network of more than 2,000 providers.

Goals Of The Performance Review

□ There are three primary goals of this performance review:

1. Evaluate the degree to which DHCF's three risk-based health plans and the single risk sharing plan 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 assessment of each MCO to help guide decisions regarding contract renewals of each health plan.

Focus Of The Performance Review

- ❑ This report primarily focuses on the period covering the first quarter of 2016 (1/1/16-3/31/16). The following questions are addressed for each MCO.
 - What was the financial condition of the MCOs during the first three months of 2016? Were the health plan revenues sufficient to cover claims and operating cost?
 - Did the MCOs successfully execute the administrative responsibilities required of a managed care plan – timely claims processing, robust member encounter systems, and appropriate use of claims denial procedures?
 - Did the full risk-based MCOs successfully meet the 85% threshold requirement for medical spending while otherwise containing cost? What service levels were achieved for primary care visits as well as mental health penetration rates for children and adults?
 - As a risk-sharing plan, did HSCSN exceed the 89% threshold requirement for medical spending? As a result what is the financial impact for DHCF?
 - What is the status of the District's pay-for-performance plan for the three full-risk MCOs?

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Summary Of Key Findings

(Continued)

- ❑ This report summarizes the 3-month performance in 2016 of the District's Medicaid managed care plans in five areas: financial condition, administrative performance, beneficiary service utilization, health plan medical spending, and the coordination of members' care.

Financial Conditions - Full Risk-Based Health Plans

- ❑ The strong financial performance observed for Trusted and AmeriHealth in 2015 has been sustained over the first three months of 2016. While MedStar ended 2015 in a positive financial position, the plan incurred a \$1.5 million operating loss for the first three months of 2016. Still, all three full risk-based health plans have Risk-Based Capital (RBC) positions that are above the required level of 200 percent.
- ❑ Significantly, the three full risk-based plans report sufficient liquidity to cover expenses for a significant number of days without having to use long-term assets. Moreover, each health plan had sufficient cash reserves to pay claims that have been incurred but were not submitted for payment during the 3-month period.

Summary Of Key Findings

(Continued)

Financial Conditions - Shared Risk Health Plan

- ❑ HSCSN generated an \$800,000 operating profit for the first three months of 2016, compared to the \$14 million loss incurred in 2015. Though these losses were later mitigated by the risk-sharing agreement that the plan has with DHCF, HSCSN's RBC thresholds still fall below the 200 percent standard and will be monitored by DHCF.
- ❑ HSCSN struggled with maintaining sufficient cash-flow to pay providers during the 3-month period in 2016 and has cash on hand sufficient to pay only 8 days worth of claims.
- ❑ DHCF addressed this issue by making a payment to HSCSN on the risk-corridor adjustments due for 2014 and 2015. In addition, DHCF revised HSCSN's capitation rates for the period of January 2016 through September 2016. This rate adjustment increases the overall rate by 9 percent from the current levels and, after considerable delay, was approved by CMS.
- ❑ HSCSN's allocation of its assets between short-term liquid and long-term does not support a position of solvency for the health plan and should be reexamined.

Summary Of Key Findings

(continued)

Administrative Performance- All Health Plans

- ❑ Overall, the three full-risk based health plans successfully executed the major administrative requirements of the program during the first three months of 2016. The provider networks continue to be strong and appropriately diverse to meet the varied medical needs of the enrollees in the plans. With the exception of HSCSN, claims were paid on time during the 1st Quarter of 2016 as required by the District's 30-day prompt payment rules.
- ❑ The process of submitting encounter claims has improved for all plans in general but Trusted continues to have issues with submitting accurate encounter data. In addition the accuracy rate for MedStar decreased during the first three months of CY2016.
- ❑ Some of the issues experienced by Trusted are related to rate adjustments for past periods and the resulting encounter submission errors. Once these issues are resolved, DHCF expects the accuracy rate for Trusted to be more in line with other health plans.

Summary Of Key Findings

(continued)

Medical Expenses: Full-Risk-Based Health Plans

- ❑ Two out of three full risk-based health plans -- Trusted and MedStar -- met the required spending level for medical expenses of 85 percent. While MedStar experienced a 4 percent reduction in its overall medical expenses compared to 2015, the plan continues to have the highest cost beneficiaries on a per-member-per-month basis - similar to 2015. AmeriHealth did not spend the required 85 percent on medical expenses, falling short by 2 percentage points.
- ❑ In terms of relative medical cost, Trusted experienced lower cost from last year for their adult Medicaid population while AmeriHealth and MedStar experienced 13 and 3 percent increases respectively. All three health plans experienced increases in cost for children with Trusted showing the highest increase of 19 percent.
- ❑ Both AmeriHealth and Trusted successfully aligned beneficiary cost with their enrollees' risk levels during the first three months of 2016. MedStar, however, continued with what is now a two year struggle to address this problem, showing higher cost for lower risk beneficiaries. This is attributed to MedStar's rapid rate of beneficiary enrollment growth, much higher cost than the other plans for the more expensive forms of care - inpatient, outpatient, and pharmacy services – and a substantially higher rate of inpatient admissions.

Summary Of Key Findings

(continued)

Medical Expenses: Full-Risk-Based Health Plans (continued)

- ❑ The physician visit rates for adults and children were generally positive during the first three months of 2016 for the three full risk-based health plans. Nearly 8 of 10 children who receive Medicaid benefits visited a physician with AmeriHealth having the highest visit rate.
- ❑ For adults, the visit rate was lower at 60 percent on average but steady for all plans except Trusted which had the lowest level at 50 percent. As previously reported, Trusted's adult physician visit rate (historically a problem) worsened and DHCF's Managed Care Division has been directed to initiate a review and recommend any needed corrective actions by October 31, 2016.
- ❑ Health care costs for Alliance beneficiaries increased for all three health plans when compared to 2015 for the same period. The increase was moderate for MedStar (3 percent) but the other two plans absorbed double digit expense growth from the same period in 2015.

Summary Of Key Findings

(continued)

Medical Expenses: Shared Risk Health Plan

- ❑ HSCSN's 91 percent spending level on medical expenses exceeded the 89 percent risk sharing threshold for the first three months of 2016, putting pressure on the operating margins for the plan. Still, this is an improvement compared to the 99 percent spending level HSCSN experienced in 2015 and must be continually managed by the plan to avoid future losses. DHCF will continue to monitor the plan's spending level on medical expenses as well as staff efforts to control cost.
- ❑ HSCSN's overall medical expenses on a per-member basis, increased by 15 percent from levels witnessed in the 1st Quarter of 2015. Increases in inpatient, outpatient, physician and pharmacy contributed significantly to the overall increase.
- ❑ HSCSN maintained a positive physician visit rate during the first three months of 2016. Nearly 85 percent of beneficiaries visited a physician during this time period -- the highest among all plans -- and consistent with the level the plan has been able to maintain over the past year.

Summary Of Key Findings

(continued)

Care Coordination

- ❑ The care coordination challenges that plagued the District's three full-risk health plans in 2014 and 2015 have been well documented -- members' use of the emergency room for routine care, the repeated occurrences of potentially avoidable hospital admissions, the problem of hospital readmissions -- and remain stubborn challenges.
- ❑ Due to changes in the rate review process by CMS, DHCF was forced to delay its plans to implement a pay-for performance program. Originally scheduled to start January 1, 2106, DHCF moved the start date to October 1, 2016.
- ❑ Now approved by CMS, this program will require the health plans to show measurable improvements against benchmarks for specific patient outcome measures or face the loss of up to 2 percent of their capitated payment - potentially \$16 million.
- ❑ For HSCSN, this health plan faces significant challenges with care coordination and its struggles are aggravated by the high cost nature of its population. This combination creates significant stress on the health plan's finances and must be addressed to ensure the long-term viability of the operation.

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There Are Several Key Metrics That Speak To The Financial Health Of Managed Care Plans

- ❑ DHCF focuses on four key metrics when evaluating the financial stability of health plans:
 - Medical loss ratio (MLR) – represents the portion of total revenue used by the MCOs to fund medical expenses, including expenses for cost containment
 - Administrative loss ratio (ALR) – represents the portion of total revenue used by the MCOs to fund both claims processing and general administrative expenses
 - Operating Margin (OM) – also referred to as profit margin and is defined as the sum of MLR and ALR subtracted from 100 percent. A positive OM indicates a financial gain while a negative indicates a loss. Mercer’s benchmark of the operating margin needed to sustain a strong financial position is approximately 2-4 percent annually over a 3-5 year time horizon
 - Risk-based Capital (RBC) – represents a measure of the financial solvency of managed care plans and reflects the proportion of the required minimum capital that is maintained by a managed care plan as of the annual filing

Generally, Observed Differences In Health Plan Operating Margins Can Be Traced To A Few Key Factors

- ❑ Assuming adequacy in the base capitated payment rate, there are typically three important factors that impact whether a health plan will experience positive operating margins:
 - **Risk-adjusted payment rates.** With DHCF's payment model, health plans whose enrollees evince greater medical risk in the form of disease prevalence, receive higher risk scores and greater payments. MCOs with lower risk enrollees receive reduced rates. Thus, plans that properly align membership risk and utilization can gain a considerable advantage over others that do not
 - **Provider contract rates.** Plans that negotiate contract rates that are adequate to build a solid network but lower than their competitors can realize significant higher surpluses
 - **Patient utilization management.** Relative differences across plans in the degree to which their enrollees unnecessarily access high end care as an alternative to less expensive treatment will drive variations in operating margins

Some Strategies Can Increase Operating Margins But Are Not Reflective Of A Properly Operated Health Plan

- ❑ Traditional concerns that patient care is being sacrificed are often expressed when health plans report significant operating margins. Accordingly:
 - DHCF routinely tracks the MCOs' performance against the 85% Medical Loss Ratio (MLR) requirement for full the risk based plans and 89.6% for the shared risk plan.
 - MCOs that fall short of this standard face detailed scrutiny and possible financial penalties if warranted.

- ❑ Health plans can also artificially (and temporarily) inflate operating margins by repeatedly denying claims that should be paid.
 - DHCF released its latest report on the health plan's management of the denied claims process in April 2016 covering all of 2015. This report does not include denied claims results for 2016. DHCF intends to include these results in the six month review which will be released in October 2016.

The Medicaid Enrollee Growth In MedStar Continues To Out Pace The Rate Of Growth Observed For All Other Plans Since The Program Was Reshaped in July 2013

MCO	Medicaid July 2013 Enrollment	Medicaid March 2016 Enrollment	Net Change (%)
AmeriHealth	91,585	98,237	7%
MedStar	32,536	47,000	44%
Trusted	26,204	29,999	14%
HSCSN	5,595	5,604	1%

Source: Department of Health Care Finance Medicaid Management Information System (MMIS).
HSCSN members include well child members.

When Alliance Members Are Included, The Numbers Do Not Significantly Change

MCO	Medicaid & Alliance July 2013 Enrollment	Medicaid & Alliance March 2016 Enrollment	Net Change
AmeriHealth	98,019	104,172	6%
MedStar	35,911	50,335	40%
Trusted	28,803	32,726	14%
HSCSN	--	--	--

Source: Department of Health Care Finance Medicaid Management Information System (MMIS).
HSCSN does not have alliance members. HSCSN members include well child members.

The Quarterly Revenue For Three Of The Four Health Plans Was Sufficient To Cover Both Claims And Administrative Cost During Q1 Of CY2016

MCO Revenue and Expense Data for January 2016 to March 2016

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

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	\$117.1M	\$97.7M	\$10.2M	\$9.3M
MedStar	\$57.8M	\$56.1M	\$3.3M	(\$1.5M)
Trusted	\$34.9M	\$29.6M	\$3.5M	\$1.8M
HSCSN	\$43.8M	\$39.8M	\$3.2M	\$.8M

Notes: *MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue.
 **Total claims include incurred but not reported amounts for YTD as of March 31 2016, net of reinsurance recoveries.
 ***Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

Estimated Risk-Based Capital Measures Provide A Reliable Indicator Of MCO Solvency

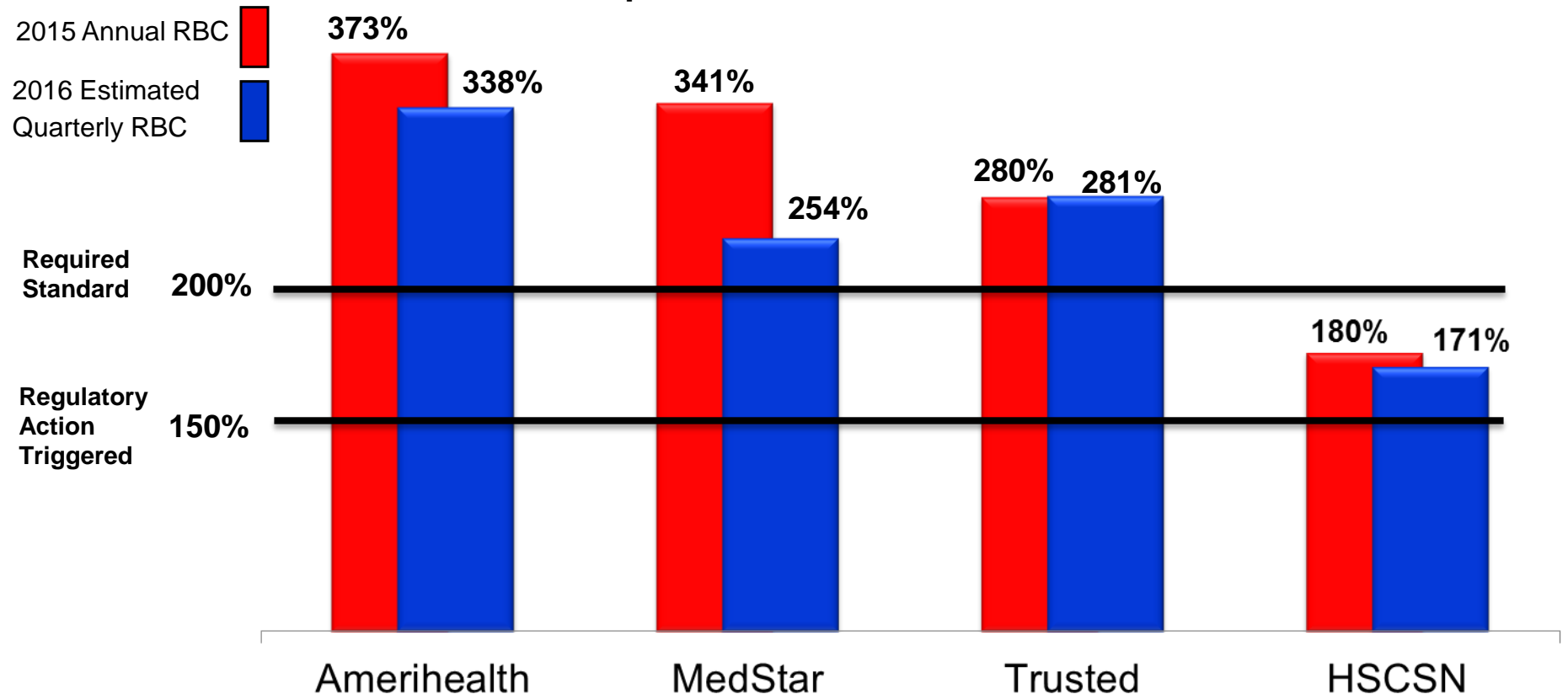
- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims.
- ❑ MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) that is provided to the Department of Insurance, Securities and Banking (DISB) for review.
- ❑ Health plans with RBC levels that fall below 200% face greater scrutiny from DISB and DHCF (as described on the next slide) to ensure that they raise their capital level above 200% RBC.
- ❑ This report compares the annual RBC measures reported by the plans in their official 2015 financial statement filed with DISB to a more recent 3-month proxy measure for 2016 calculated by Mercer Consulting.

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 percent or more of Authorized Control Level.
 2. **Company Action Level** - Total Adjusted Capital of 150 to 200 percent 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 percent 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 percent 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 percent 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).

All Three Full Risk-Based Health Plans Maintained Risk Based Capital Levels That Exceed The Required Threshold While HSCSN -- The Shared Risk Plan -- Fell Short Of The Required Level

Estimated 2016 Quarterly Risk-Based Capital For Managed Care Plans Compared To 2015 Annual Level



Note: There are no District Risk-Based Capital reporting requirements for HSCSN.

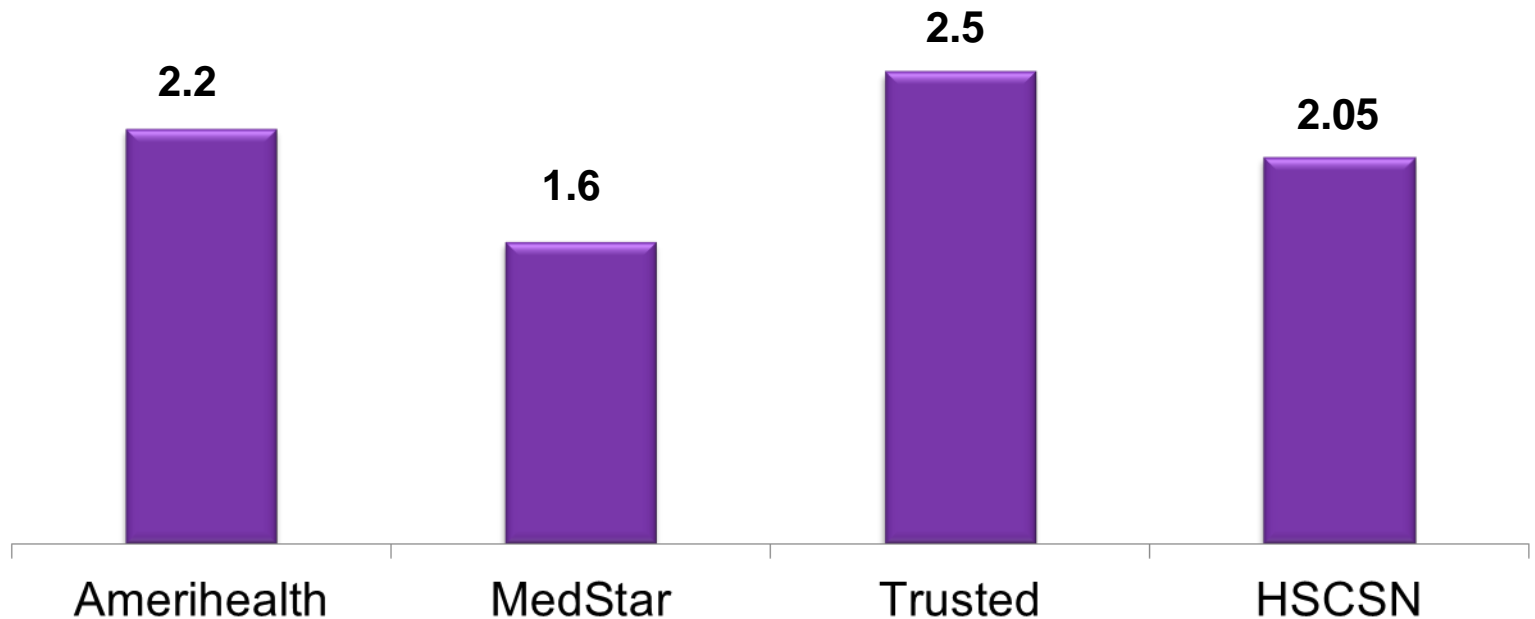
Source: Reported figures are from the MCO's annual 2015 and quarterly 2016 financial statements filed with DISB for the full risk MCOs and self reported financials for shared risk MCO.

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 and health 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 this report, DHCF reports the reserves MCO's have available to satisfy incurred but not reported claims. This analysis is based on calculations provided by Mercer using data on the monthly claim's experience for each plan to calculate the reserves on hand.
- ❑ We also provide an analysis of the number of days the health plans can operate without accessing long-term assets. This is described as a Defensive Interval Ratio which is, in essence, a liquidity measure -- the degree to which the MCOs can survive on liquid assets without having to make use of either investments from the market or by selling long term assets.

All Four Health Plans Have A Sufficient Number Of Months In Reserve For Estimated Incurred But Not Reported Claims

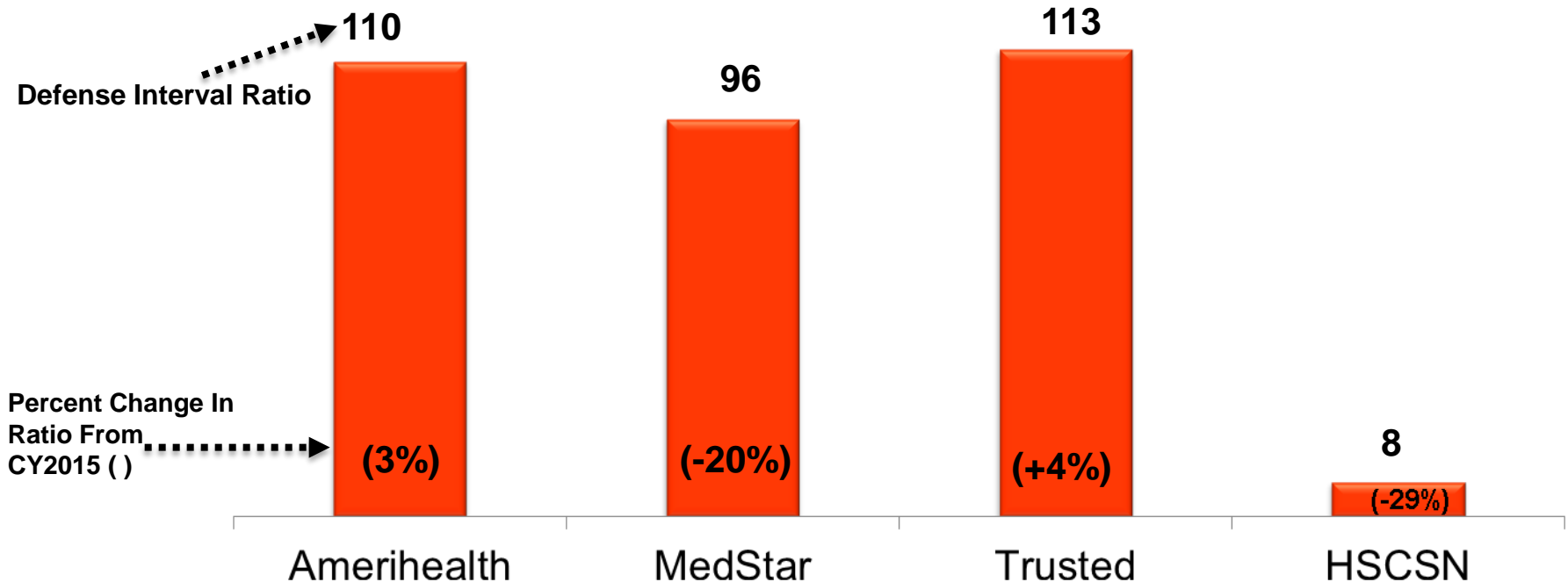
Estimated Number Of Months Reserves Compared To Average Monthly Incurred Claims For The Period Covering January 2016 to March 2016



Source: IBNR is based on amount reported on the MCO's quarterly filings for the three full risk-based plans and self reported financials for the shared risk plan.

The Overall Liquidity Measures Remain Favorable For All Three Full Risk-Based Health Plans Despite Declines From 2015 But, The Ratio For HSCSN Is Not Adequate And Creates Insolvency Concerns

Days In A Year That MCOs Can Operate On Existing Cash Without Having To Access Long-Term Assets For The Period Covering January 2016 to March 2016



Note: Mercer calculated the Defensive Interval Ratio as cash and equivalents divided by daily operating expenses (91.25 days per quarter) for the period from January to March 2016 measured in days.

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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 enrollees with special or chronic health care issues and ensure that these enrollees each receives access to appropriate care, while managing the delivery of health care services for all enrollees

Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

- ❑ The five-year MCO contracts contain specific provisions to ensure Medicaid and Alliance enrollees have reasonable access to care. The health plans must have:
 - 1 primary care physician for every 1,500 enrollees
 - 1 primary care physician with pediatric training for children through age 20 for every 1,000 enrollees
 - 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 enrollees' residence

- ❑ For pharmacies, each plan must have:
 - 2 pharmacies within 2 miles of the enrollees' 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 Four Health Plans Continue To Operate With Sufficient Networks Ensuring Patient Access To Care

The Number of Providers In The MCO Networks Compared to Contract Requirements as of January 2016

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	34	561	48	712	64	340
MedStar FP	21	691	16	395	22	446
Trusted	13	427	10	660	14	439
HSCSN	--	846	--	44	--	177

Source: This information is self-reported and attested by the MCOs as of March 31, 2016 and verified by Department of Health Care Finance and the Enrollment Broker through a sampling of providers. The age of enrollment at HSCSN is 0-26 years; the report does not include a break-out by adults and children for HSCSN. Future reports will include this information

Accuracy Issues In The Submission Of Encounters Remain For Trusted While MedStar's Performance Weakened As Well

Number of Recorded Encounters An Accuracy Transfer Rate, January 2016 to March 2016

MCO	Average Monthly Enrollment	Total Encounters	Average Encounters Per Enrollee	Accuracy Rate March 2016	Accuracy Rate Year Ending 2015
AmeriHealth	103,227	390,333	3.78	98%	92%
MedStar	49,098	232,786	4.74	89%	97%
Trusted	32,125	93,427	2.90	84%	89%
HSCSN	5,598	86,543	15.45	95%	97%

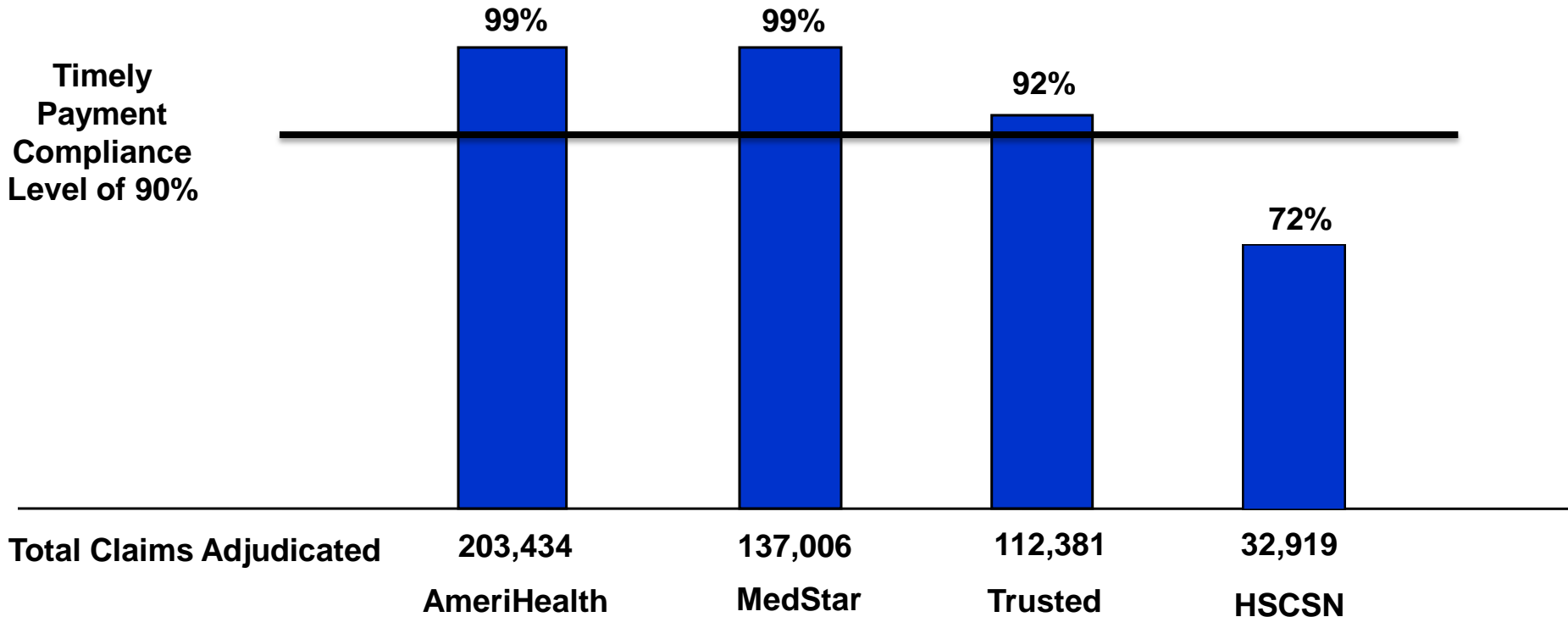
Source: Department Of Health Care Finance Medicaid Management System as of March 2016

Timely Payment Of Health Care Claims Is Core Requirement For The District's Managed Care Plans

- ❑ Claims processing is a central administrative function that health plans must effectively execute to avoid payment problems for providers.
- ❑ Through electronic claims processing, the District's three managed care organizations are required to pay or deny clean claims within 30 days to satisfy timely filing requirements.
- ❑ Like most health plans, the District's MCOs employ a series of automated edit checks on all claims submitted for payment by healthcare providers in the Medicaid and Alliance programs.
- ❑ Included among the numerous potential problems this system of edit checks is designed to eliminate are:
 - Duplicate or overpayments
 - Payments to out-of-network or otherwise ineligible providers
 - Payments for services delivered to non-eligible patients

While Three Of The Four Health Plans Met The District's Timely Payment Requirement During The 1st Quarter Of 2016 HSCSN Was Unable To Do So Because of Delays In Federal Approval Of The Plan's Adjusted Rates

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement, January 2016 to March 2016

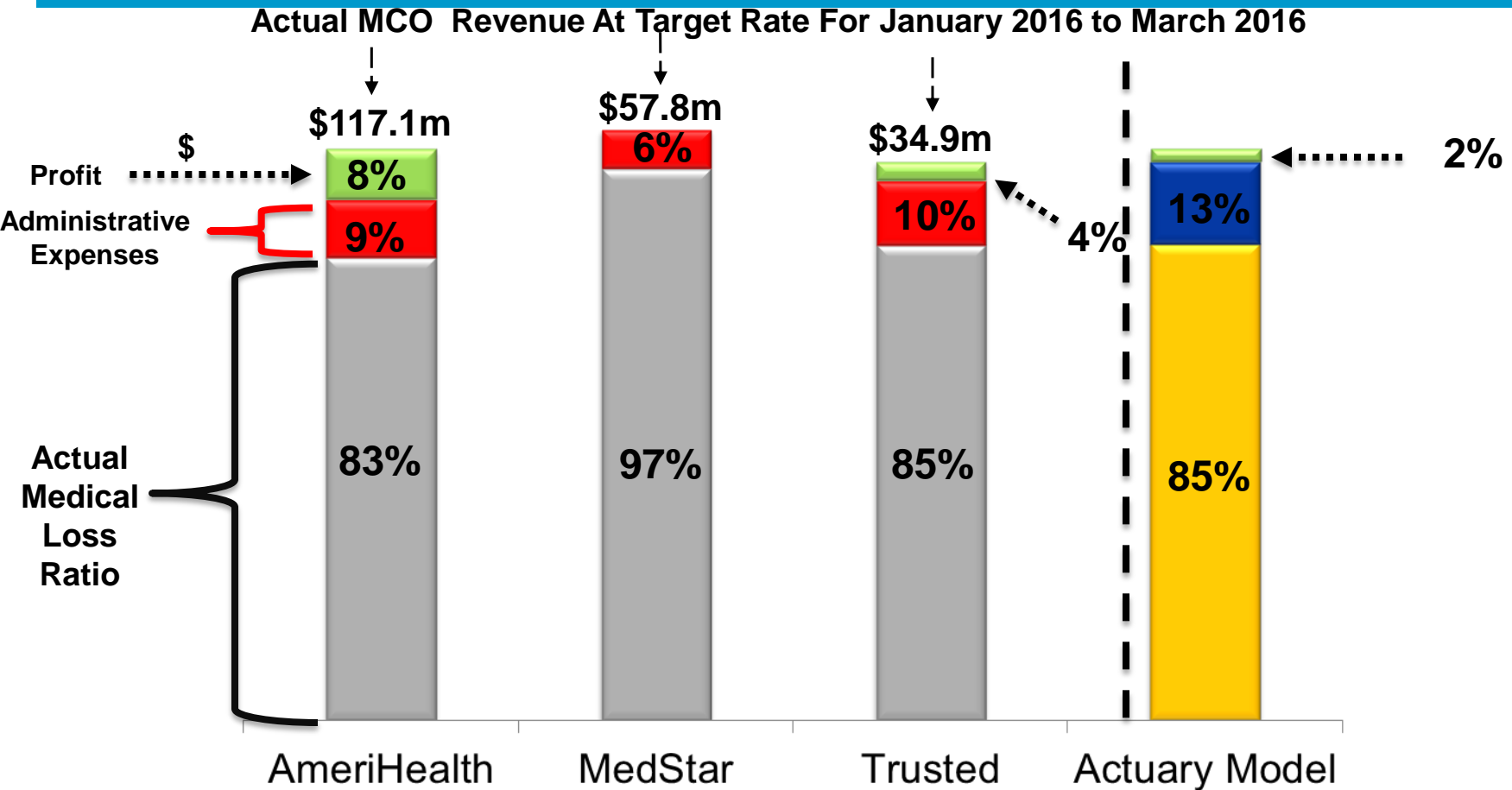


Source: Data reported by MCOs on the Department of Health Care Finance's Claims Payment Report,

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Of The Three Full Risk Health Plans, Trusted Overall Performance Tracks Closest To The Actuary's Model On Which Rates Are Based



Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings and self reported quarterly filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking for the three full risk MCOs and self reported Quarterly statements for shared risk plan, HSCSN

DHCF Has A Risk Sharing Arrangement With HSCSN In Which The Government Shares in The Plan's Profit And Losses

- ❑ DHCF and HSCSN entered into a risk sharing arrangement to limit the financial gains and losses under the contract through the application of risk corridors.
 - The arrangement sets risk corridors around a Medical Loss Ratio of 89 percent. Thus if the health plan experiences cost below the 89 percent threshold, the District shares in the financial gain.
 - Conversely, if HSCSN incurs cost above the 89 percent threshold, the District absorbs a portion of the cost.

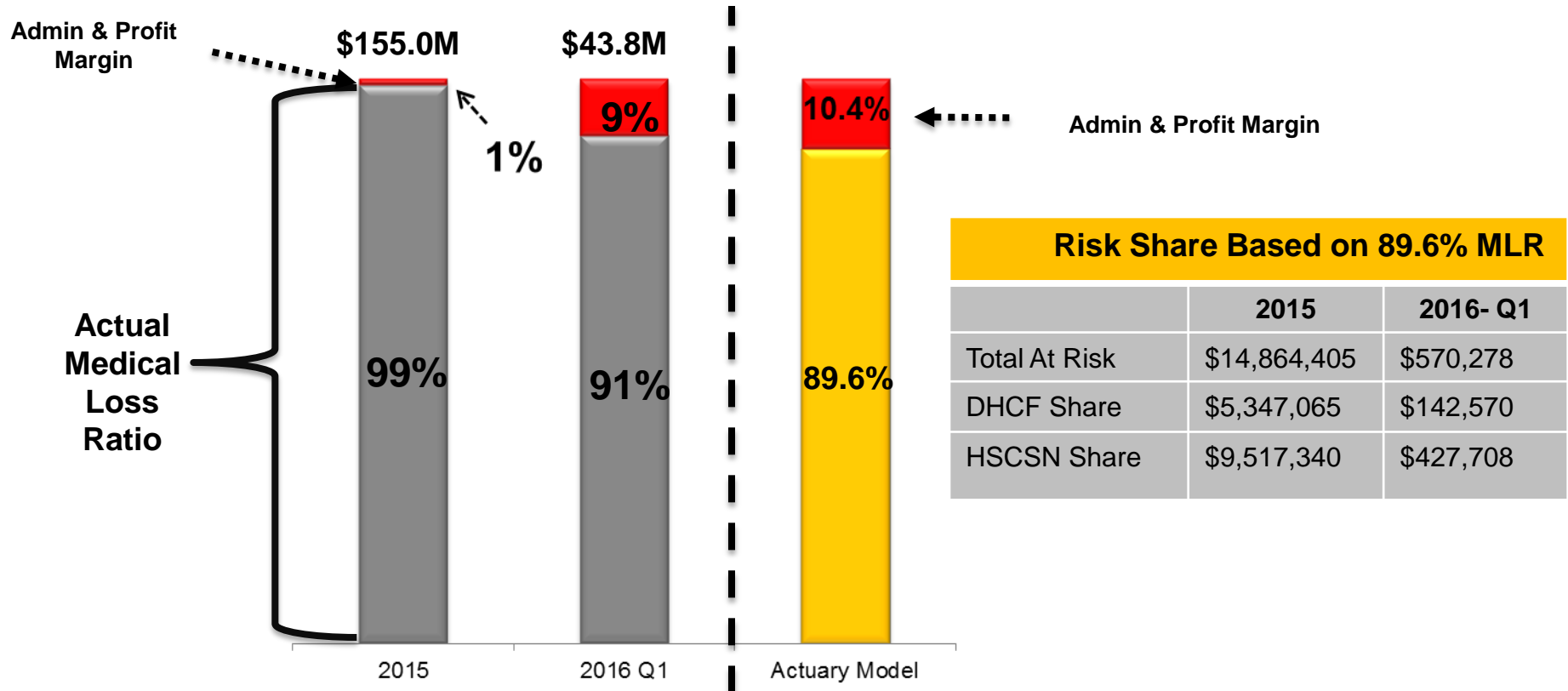
- ❑ The Table below shows the risk corridors for this contract and how financial gains or losses are shared between the HSCSN and the District

Risk Corridors	District's Share	Contractor Share
<75%	0%	100%
>75-80%	75%	25%
>80-85%	50%	50%
>85-95%	25%	75%
95-100%	50%	50%
>100-105%	75%	25%
>105%	100%	0%

- ❑ For this first quarter of this period, HSCSN medical expenses as a percent of its revenue (91 percent) exceeded its Medical by Loss Ratio of 89%, meaning the District was forced to absorb 50 percent of the cost incurred above the 89 percent threshold

After Large Losses In 2015, HSCSN Spent Slightly Above The 89 Percent Risk Sharing Threshold On The Actuary Model For The First Three Months of 2016.

HSCSN Revenue And Claims Cost For 2015 and January 2016 to March 2016

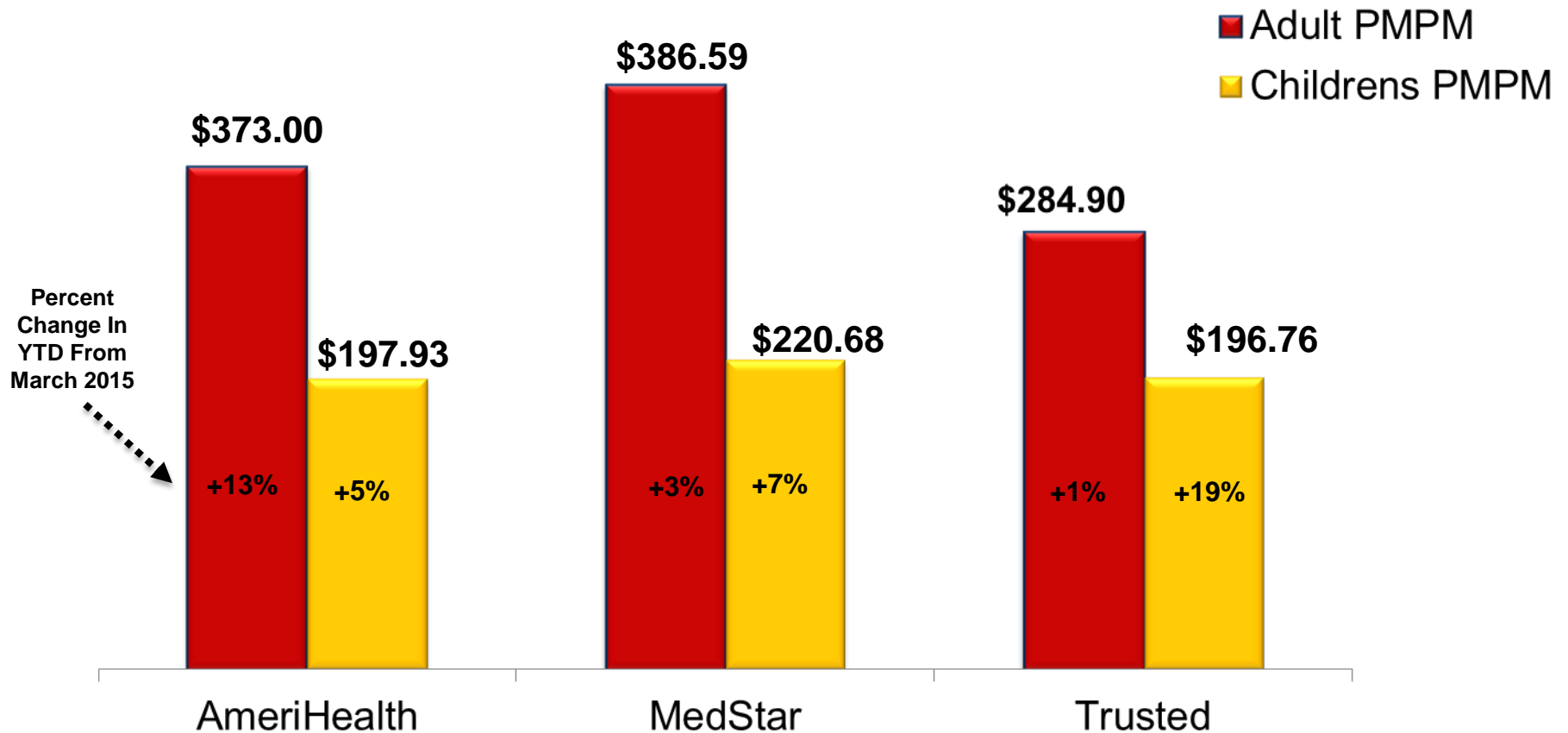


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Source: Self reported quarterly statements .

There Is Significant Variance Across Plans And Noticeable Expense Growth For Adults in Two Health Plans And For Children Across All Three MCOs

Medicaid Adult And Children Medical Expenses Per-Member, Per-Month, January 1, 2016 to March 31, 2016



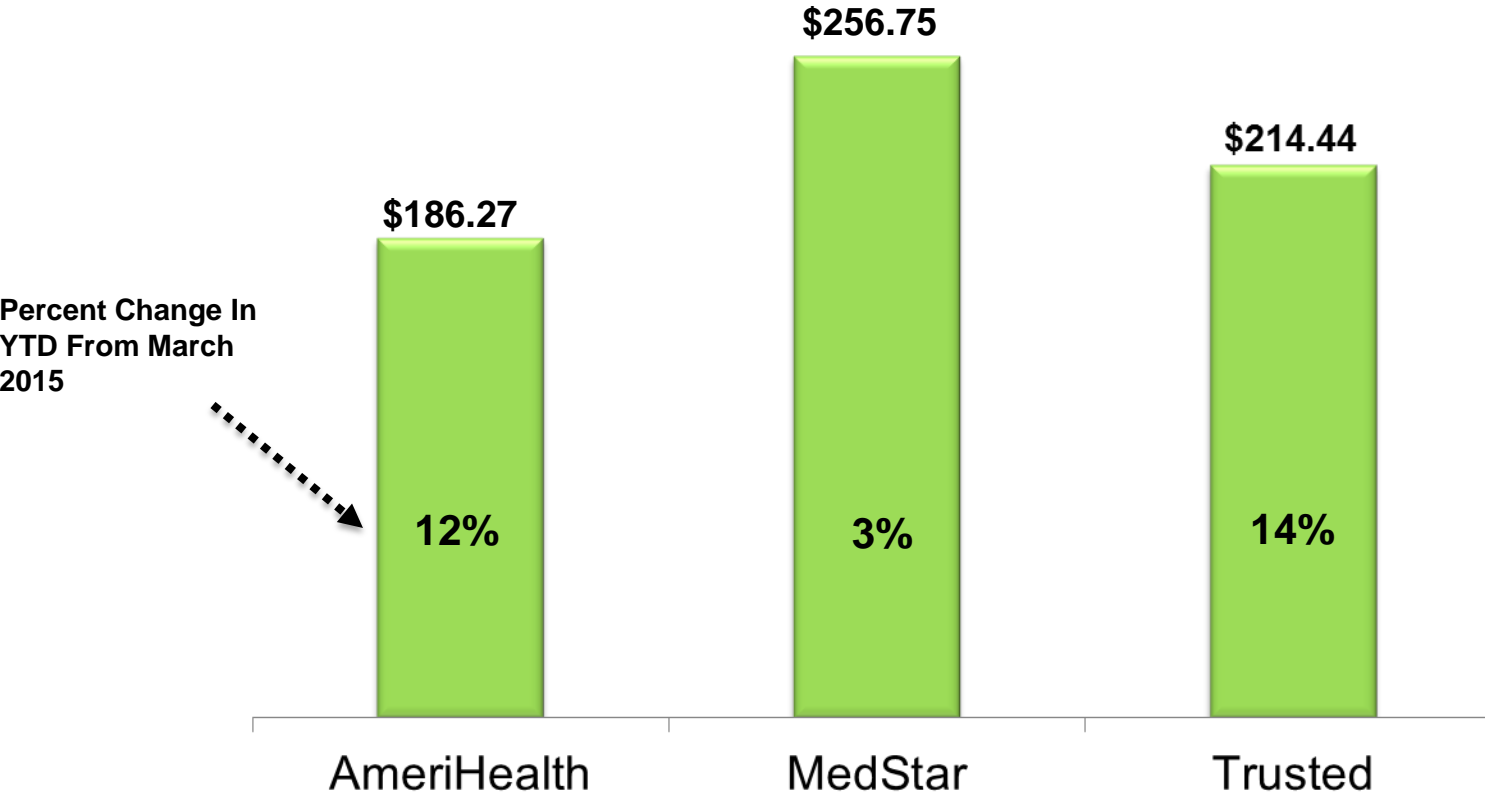
Notes: Expenses incurred from January 1, 2016 to March 31, 2016 and paid as of May 31, 2016. The expenses do not reflect adjustments to account for IBNR claims.

Children defined as person up to age 21 in this analysis for the three full risk MCOS and 26 for HSCSN

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

Similar Variation In Expenses Are Witnessed For Adults In Alliance With Two Of The Three Plans Showing Double Digit Growth

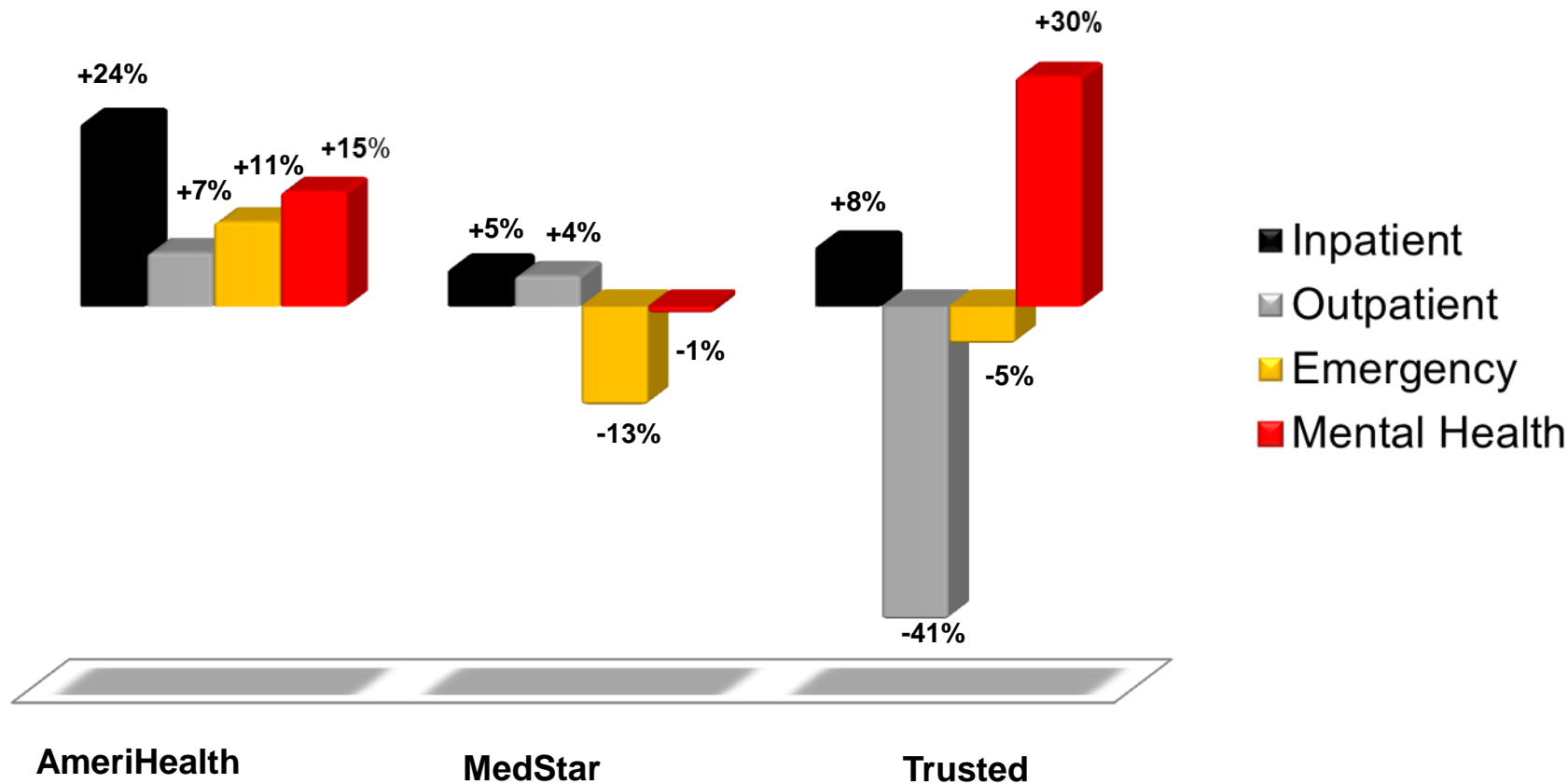
Alliance Adult Medical Expenses Per-Member, Per-Month, January 1, 2016 to March 31, 2016



Notes: Expenses incurred from January 1, 2016 to March 31, 2016 and paid as of May 31, 2016. The expenses do not reflect adjustments to account for IBNR claims. 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.

Relative To The 1st Quarter Of 2015, Sharp Swings Were Witnessed In Adult Inpatient Spending For AmeriHealth, Outpatient Cost For MedStar, And Mental Health Expenses For Trusted

Percent Change in Expenses In 1st Quarter 2016 Compared To 1st Quarter 2015

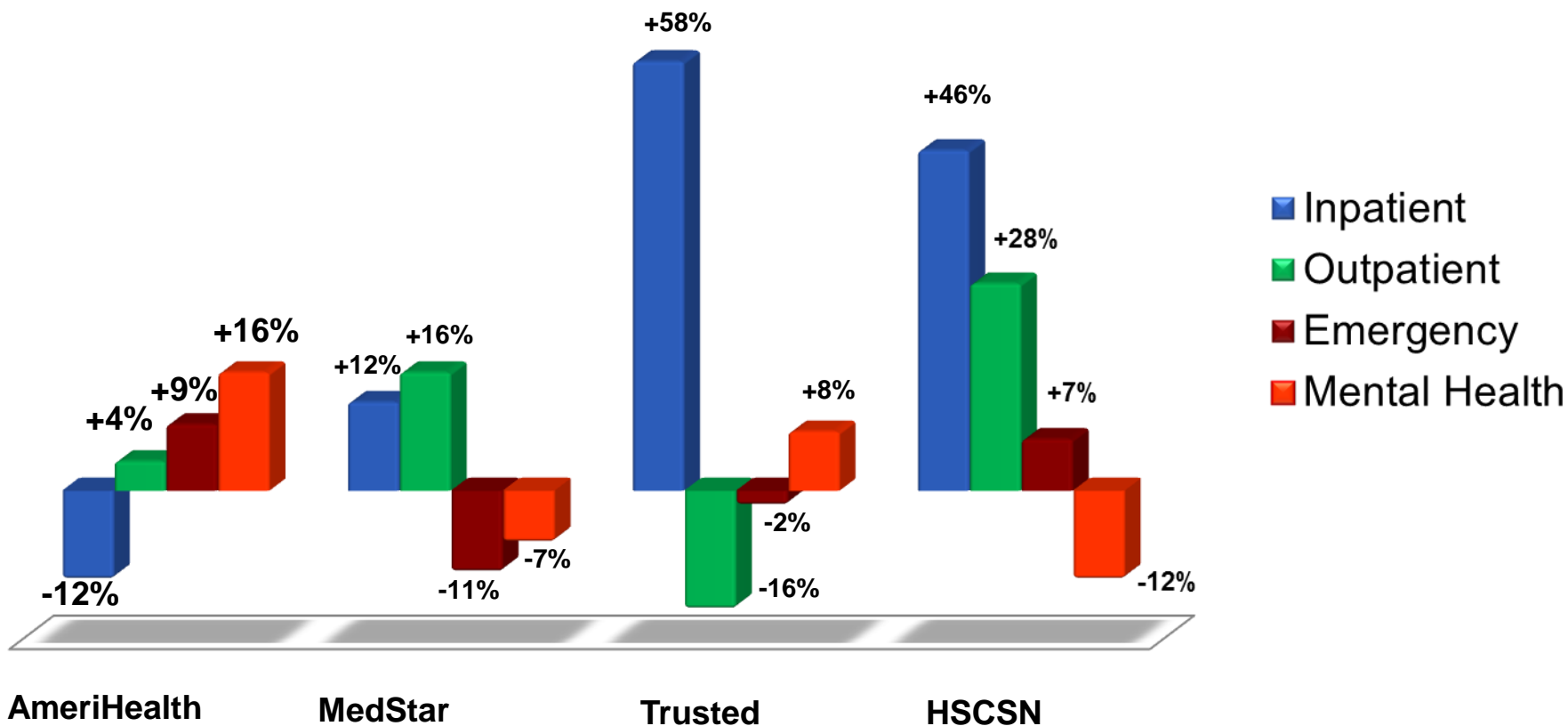


Note: *The expenses do not reflect adjustments to account for IBNR

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

For Children, The Growth In Inpatient Cost From The First Quarter Of 2015 Was Substantial For Trusted, HSCSN And, To A Lesser Degree, MedStar

Percent Change in Expenses In 1st Quarter 2016 Compared To 1st Quarter 2015



Notes: The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOSs and 26 for HSCSN.

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

MedStar Has Continuing Challenges In Its Efforts To Align Enrollee Medical Costs With Their Assigned Risk Scores

Ranking On Enrollee Risk Scores As Of April 2016

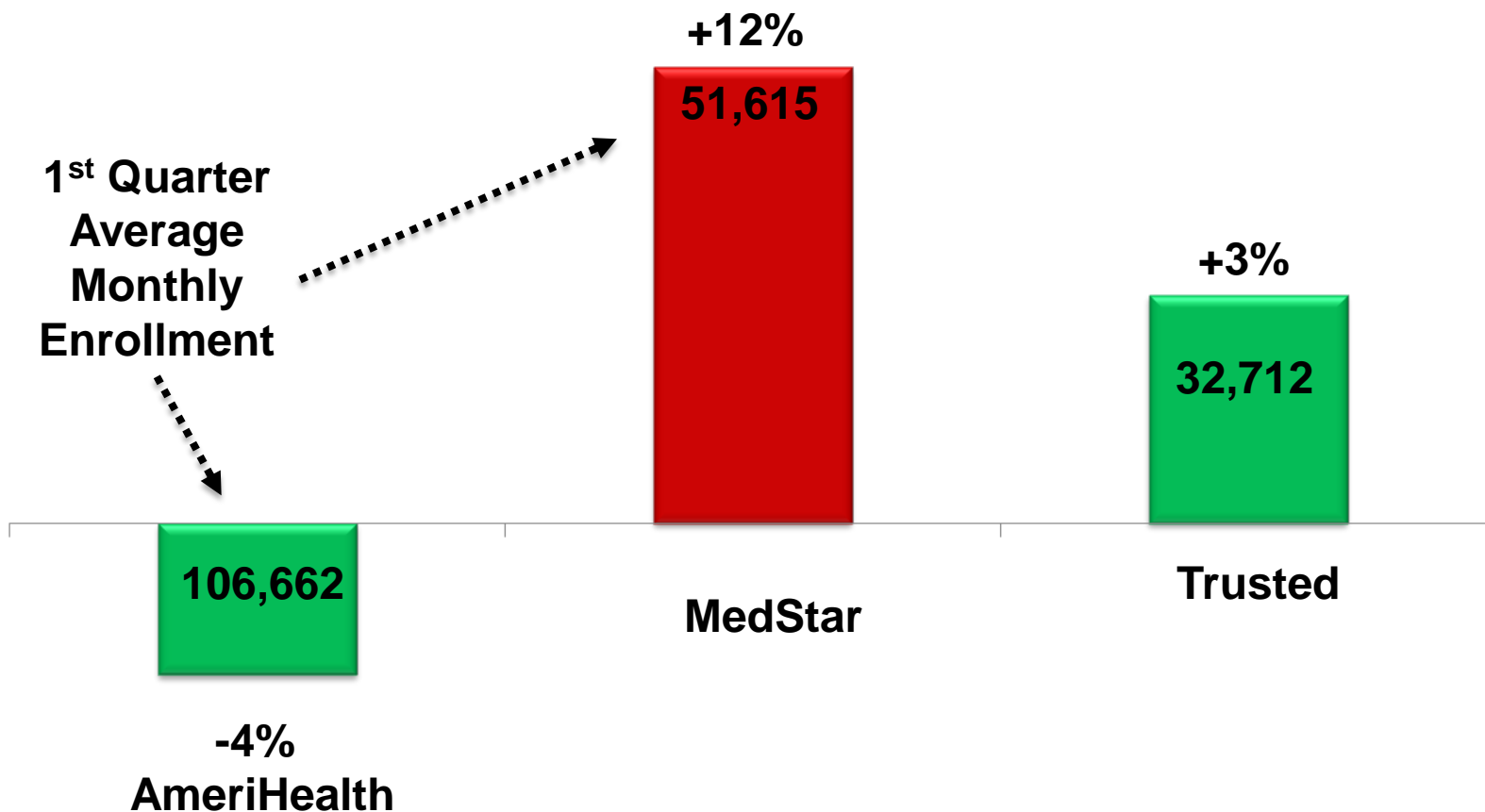
		Low	Medium	High
Ranking On Medical Cost	Low	*Trusted - Adults		
		Trusted - Children		
	Medium			AmeriHealth - Children
				AmeriHealth - Adults
	High		MedStar - Adults	
			MedStar - Children	

Notes: Expenses incurred from January 1 2016 to March 30 2016 and paid as of May 31 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis. Health plans' risk scores are derived from pharmacy data. *A large volume of claims denied by Trusted using new procedures have likely impacted Trusted ranking as a low-cost plan for adults on Medicaid.

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

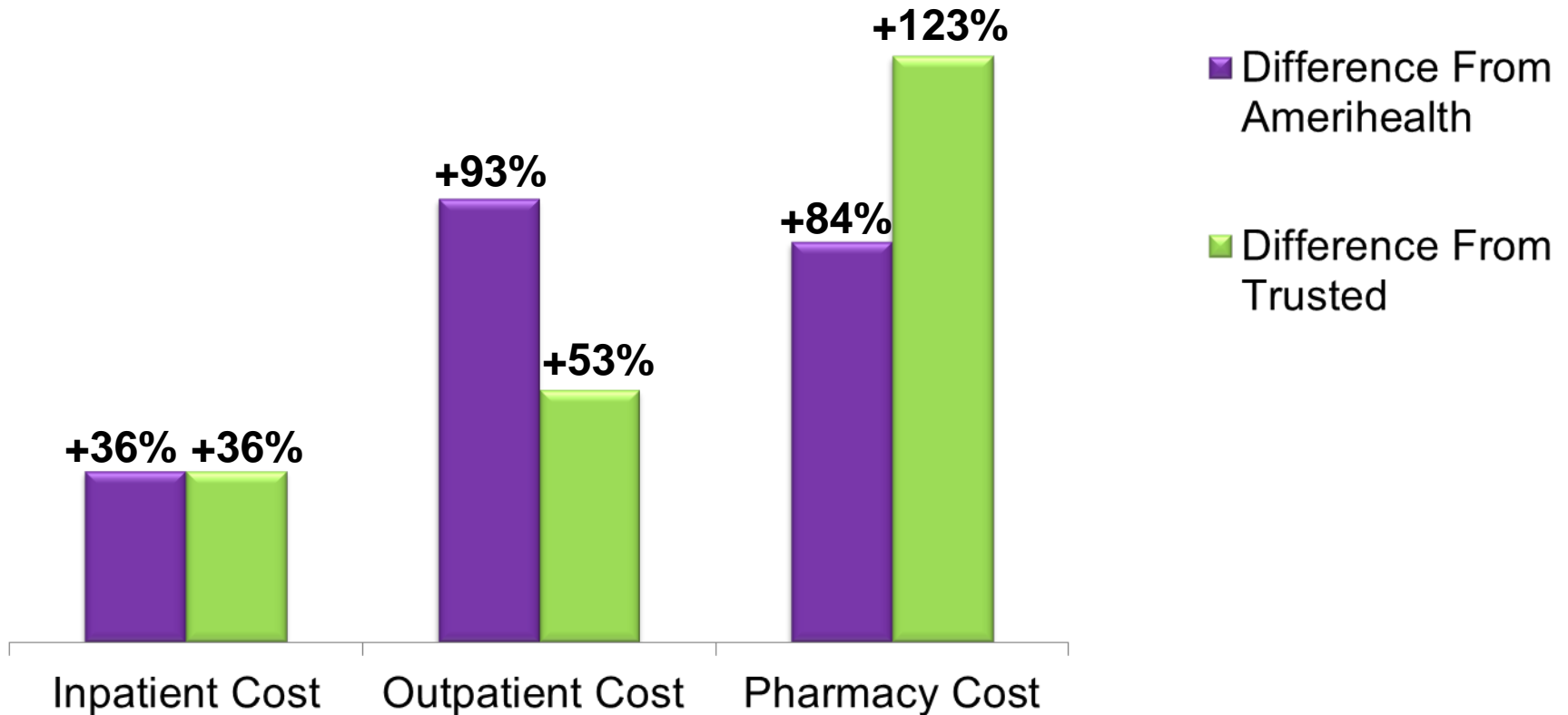
Why? Relative To The 1st Quarter Of 2015, MedStar Experienced More Enrollment Growth Than Both AmeriHealth – Whose Enrollment Declined – And Trusted

Change In Enrollment Levels From 1st Quarter 2015 to 1st Quarter 2016



MedStar's 1st Quarter 2016 Costs For Three Major Services Were Also Substantially Higher Than The Other MCOs

MedStar's Cost Differences Relative To AmeriHealth And Trusted, 2015

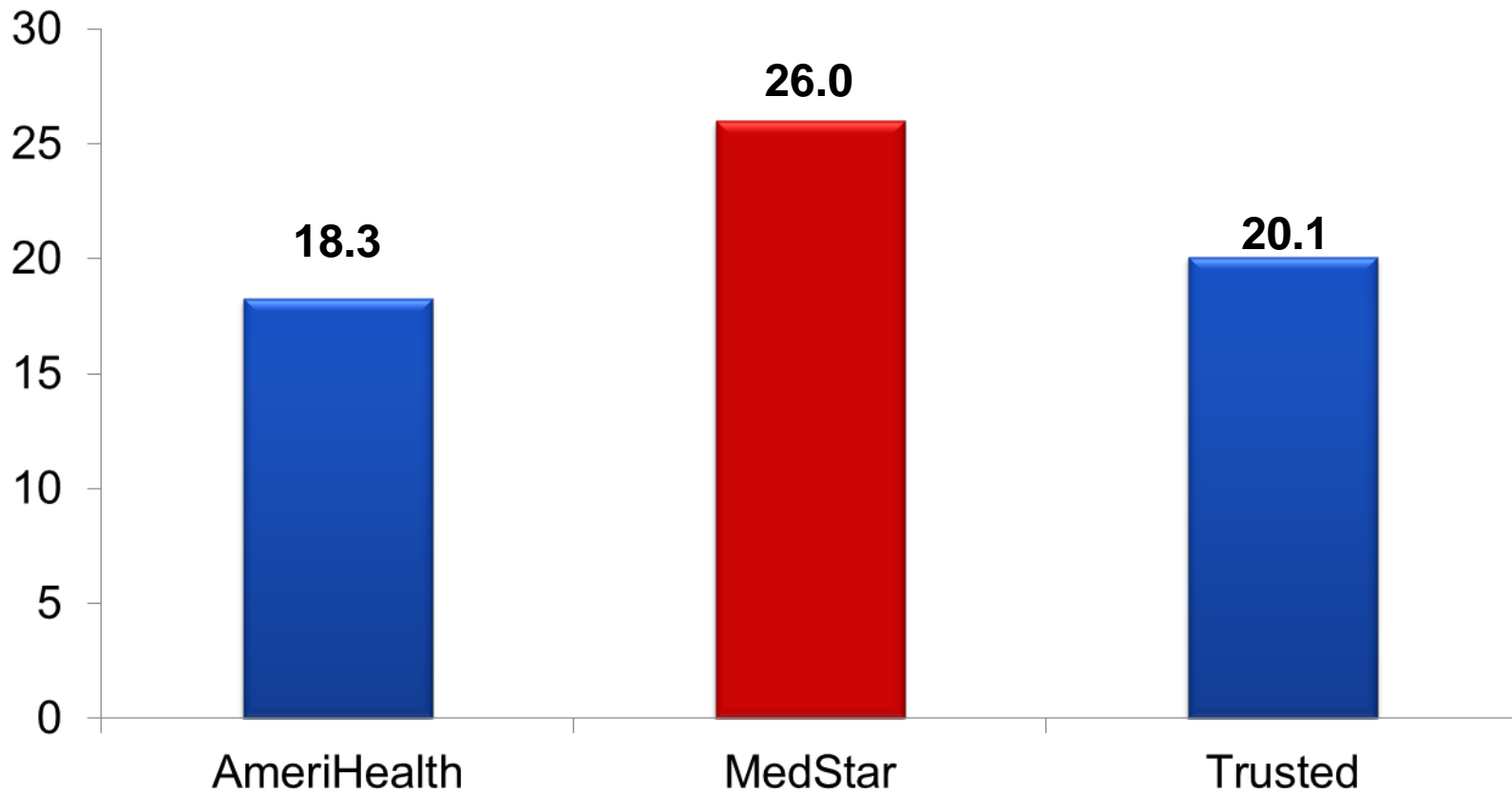


Notes: Expenses incurred from January 1 2016 to March 30, 2016 and paid as of May 31, 2016.

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

Finally, Continuing A Historical Trend, MedStar's Higher Inpatient Cost In The 1st Quarter Of 2016 Was Fueled By A Larger Rate Of Inpatient Admissions Than Observed For The Other Plans

Total Number Of Inpatient Admissions In 1st Quarter 2016 Per 1000 Members

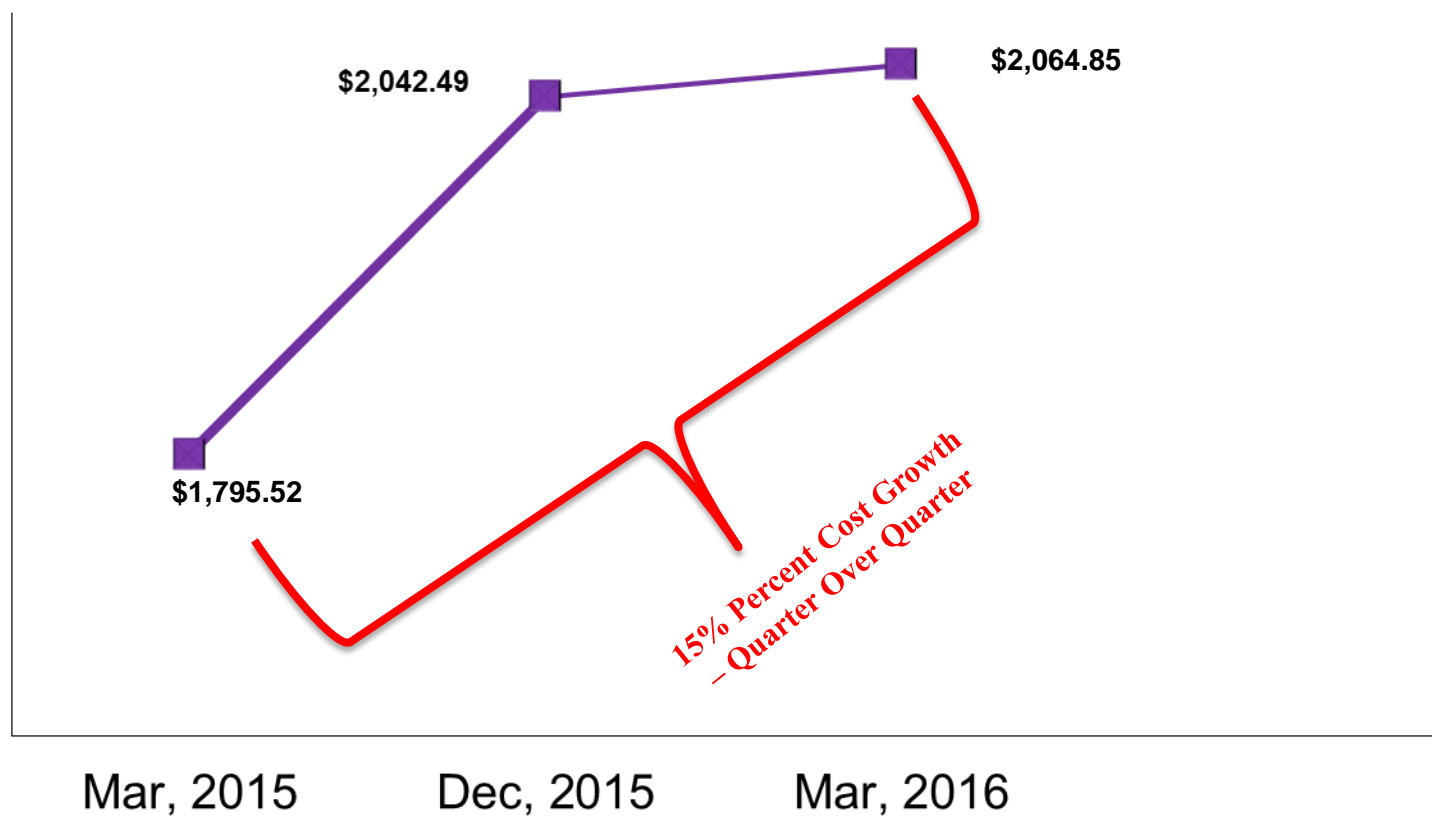


Notes: The current frequency of Index Admissions analysis for the period January 2016 to March 2016 includes encounters that are stamped by DHCF's MMIS both "Paid and Denied" encounters

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

For HSCSN, Per-Member, Per-Month Medical Expenses For Children In CASSIP Showed a 15 Percent Growth During The First Three Months of CY2016 Compared To Same Period in 2015

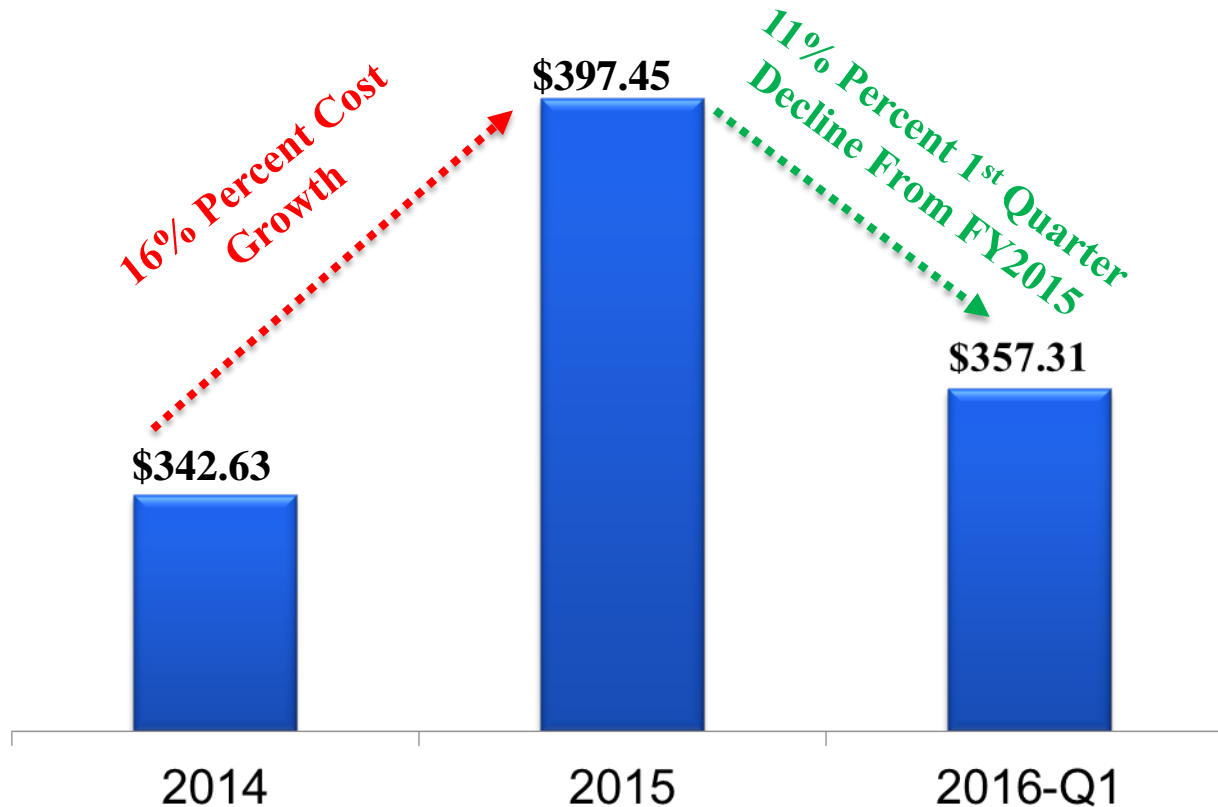
Medicaid Children Medical Expenses Per-Member, Per-Month, March 1, 2015 to March 31, 2016



Notes: Expenses incurred from January 1, 2016 to March 31, 2016 and paid as of April 30, 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOs and 26 for HSCSN. Source: Enrollment and expense data is based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

HSCSN 2015 Home Health Cost Increases – Which Were A Factor In The Health Plans Financial Struggles That Year – Have Moderated In The 1st Quarter Of 2016

HSCSN Home Health Per-Member Per-Month Expenses From 2014 through 2016

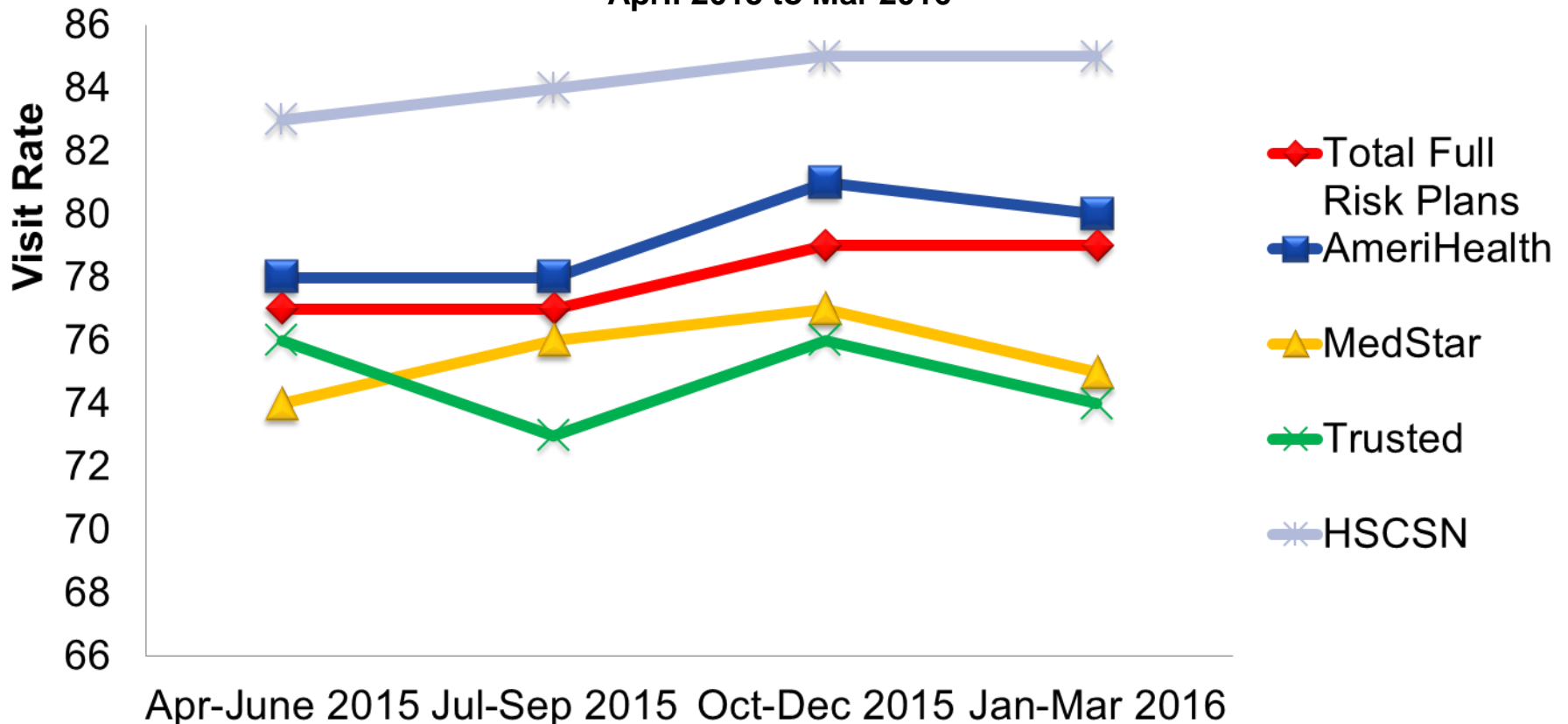


Notes: Expenses incurred from January 1, 2016 to March 31, 2016 and paid as of May 31, 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOs and 26 for HSCSN

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

The First Quarter Physician Visit Rate For Children Exceeded 70 Percent For All Three Full Risk-Based Health Plans While HSCSN Successfully Maintained A Level Above 80 Percent

Medicaid Quarterly Physician Care Visit Rates For Children Who Were Enrolled In Managed Care, April 2015 to Mar 2016

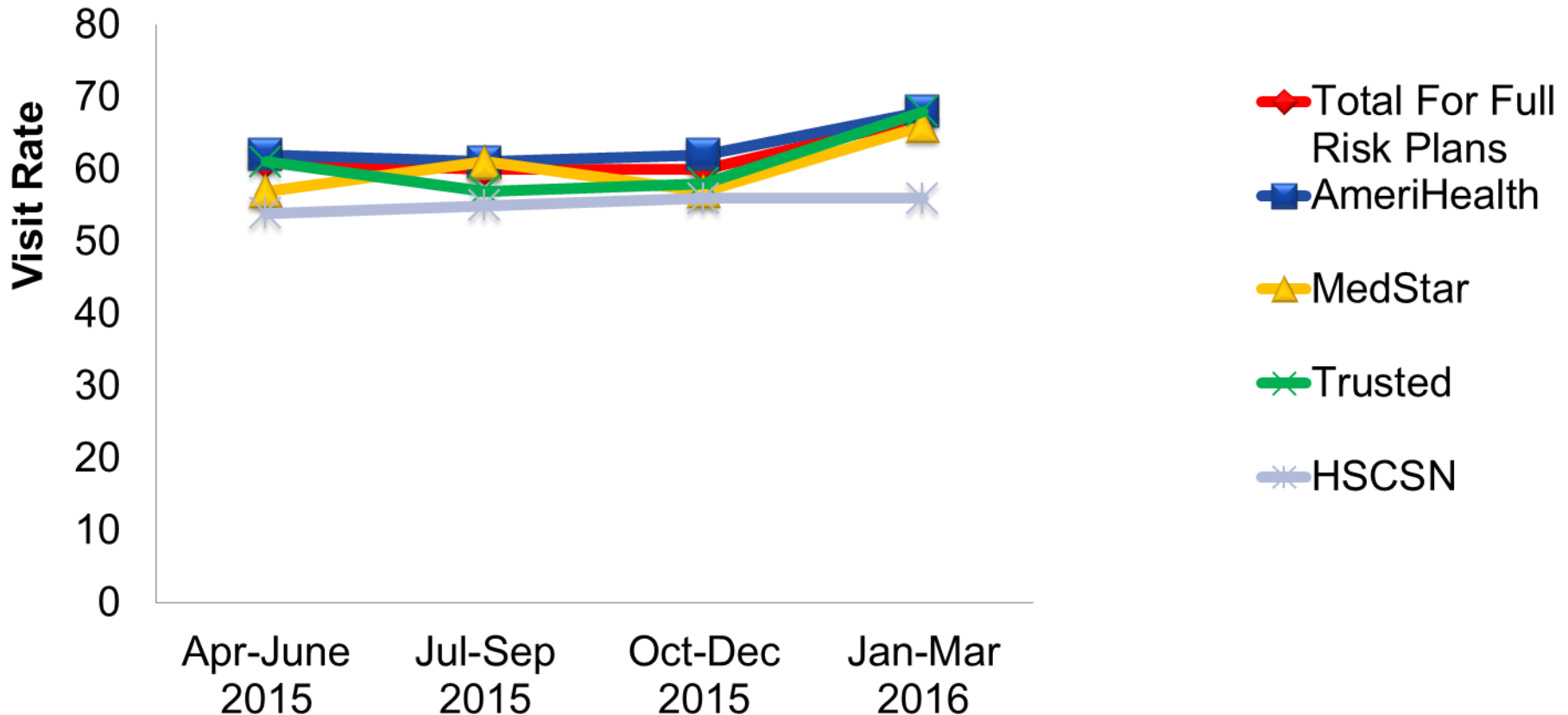


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The Physician Visit Rate For Children With An Added Well-Child Component Improved To Approximately 68% From The End Of 2015 But HSCSN's Performance Lags

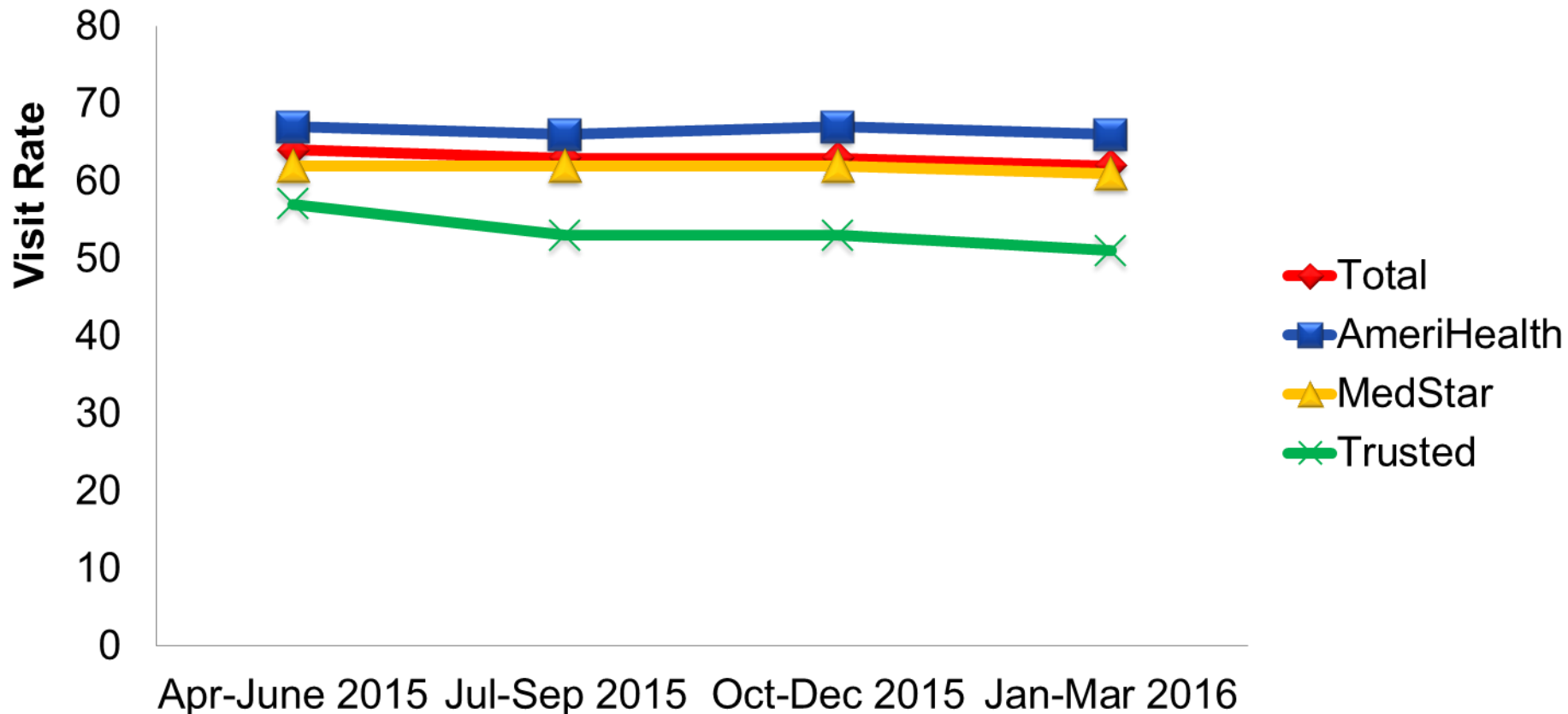
Medicaid Quarterly Physician Care and Well Child Visit Rates For Children Who Were Enrolled In Managed Care, April 2015 to March 2016



Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis..

Trusted's Medicaid Physician Visit Rate For Adults Continues To Decline And Is Significantly Below Levels Achieved By AmeriHealth And MedStar

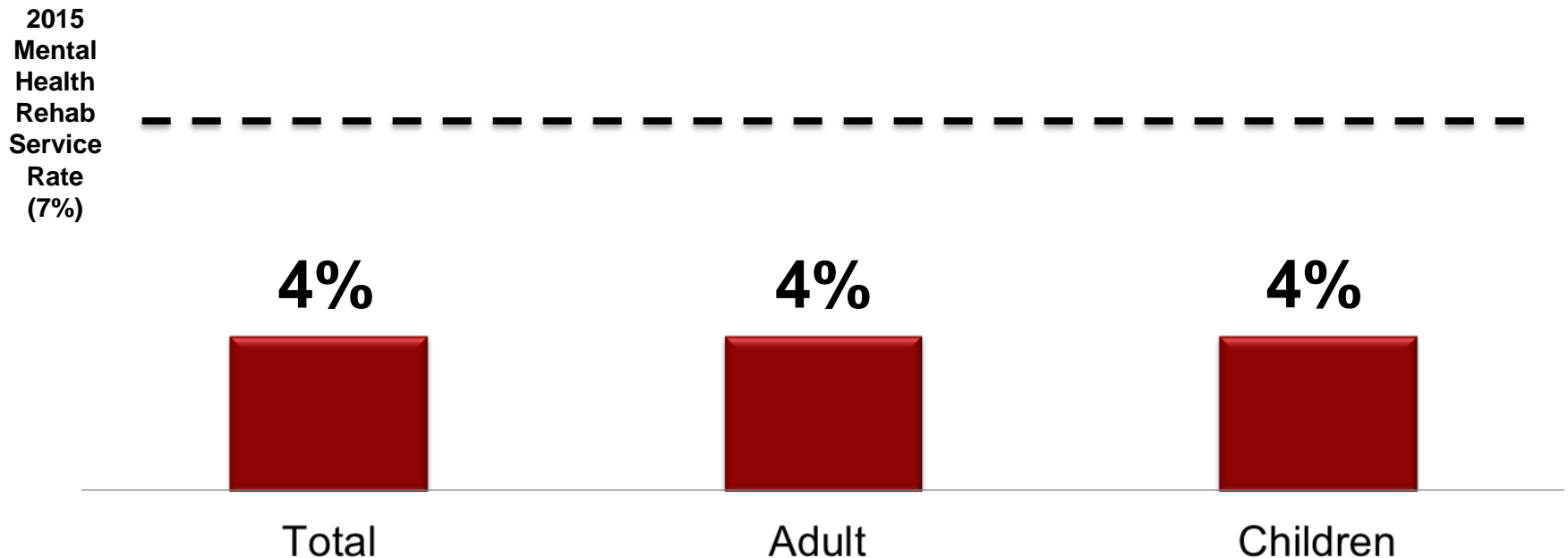
Medicaid Quarterly Physician Care Visit Rates For Adults Who Were Enrolled In Managed Care, April 2015 to March 2016



Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis..

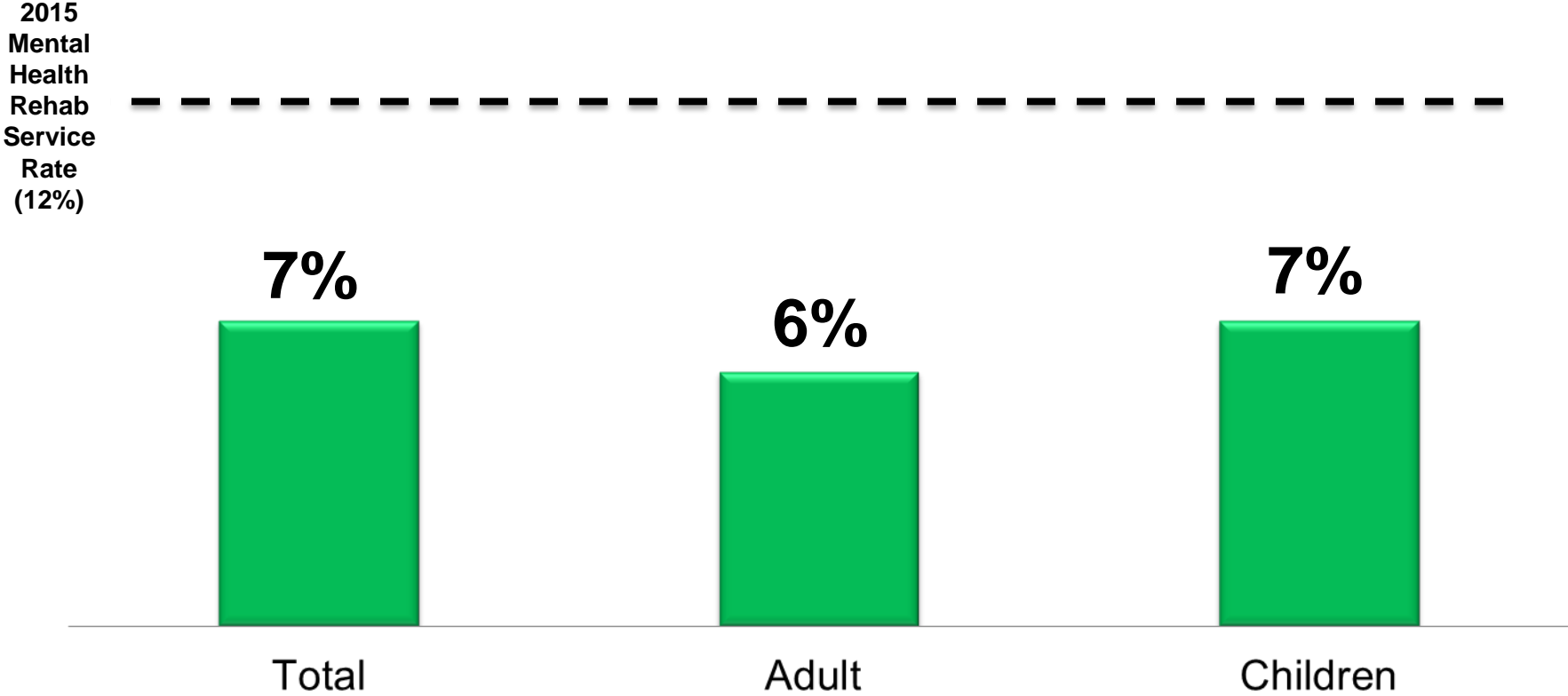
Understandably After One Quarter, The Utilization Rate For Medicaid-Funded Mental Health Rehabilitation Services Significantly Below Last Year's Rate

Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans January 2016 to March 2016



A Similar Finding Is Revealed When Analyzing The MCO Penetration For Beneficiaries Who Received Any Mental Health Services

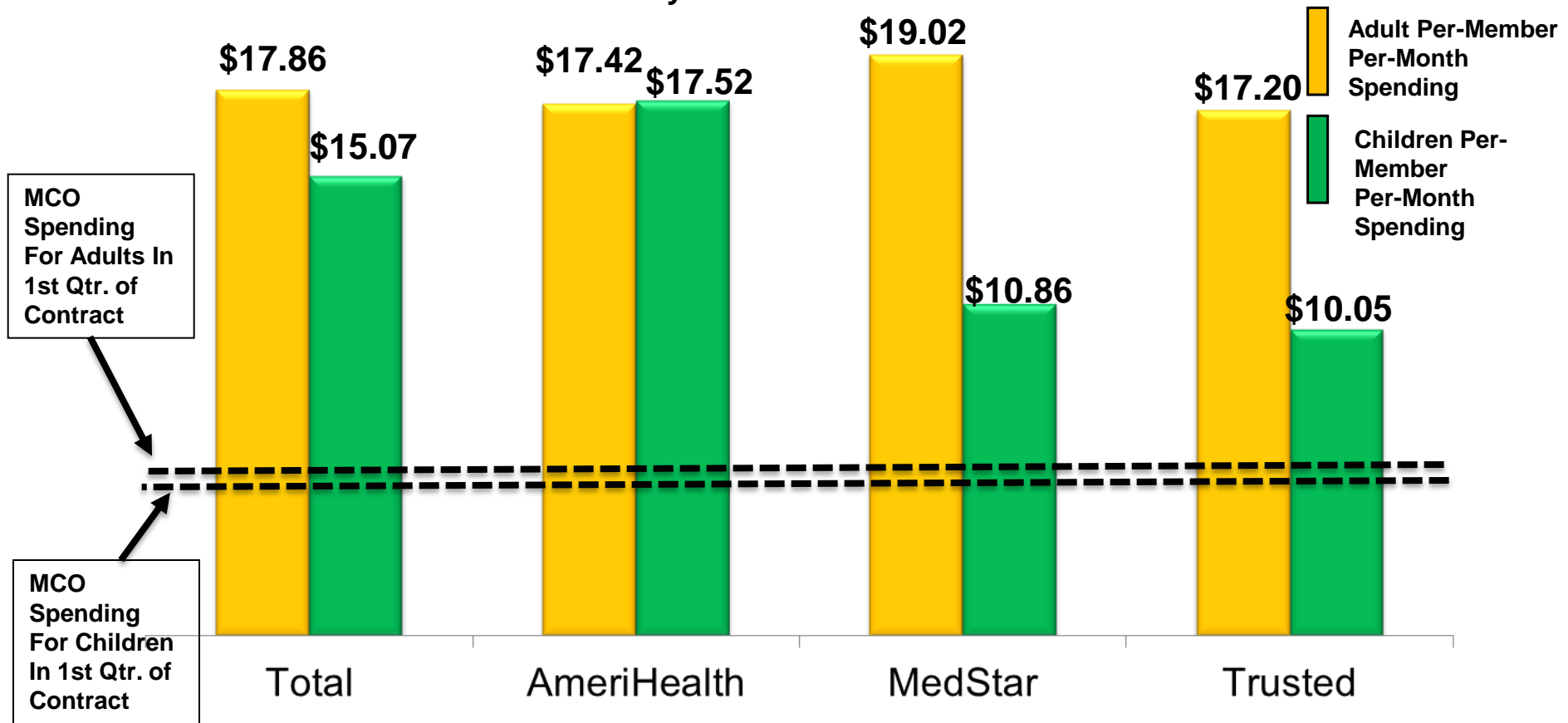
Percent of MCO Members Receiving Any Mental Health Services Through The Health Plans January 2016 to March 2016



Note: The data presented above are based on MCO capitated payments for the 1st Quarter of 2016.
Source: Encounter data submitted by MCOs to DHCF.

Since The 1st Quarter Of The Managed Care Contract (October to December 2013) -- On A Per-Member Per-Month Basis -- MCO Spending On Medicaid-Funded Mental Health Services For Both Children And Adults Has Grown Significantly For All Full Risk Health Plans

The Per-Member Per-Month MCO Expenses For Behavioral Health Services, January 2016 to March 2016



Notes: The expenses do not reflect adjustments to account for IBNR claims. 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.

Presentation Outline

- Goals and Purpose of Managed Care Performance Review
- 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
- Implementation of MCO Pay for Performance Plan

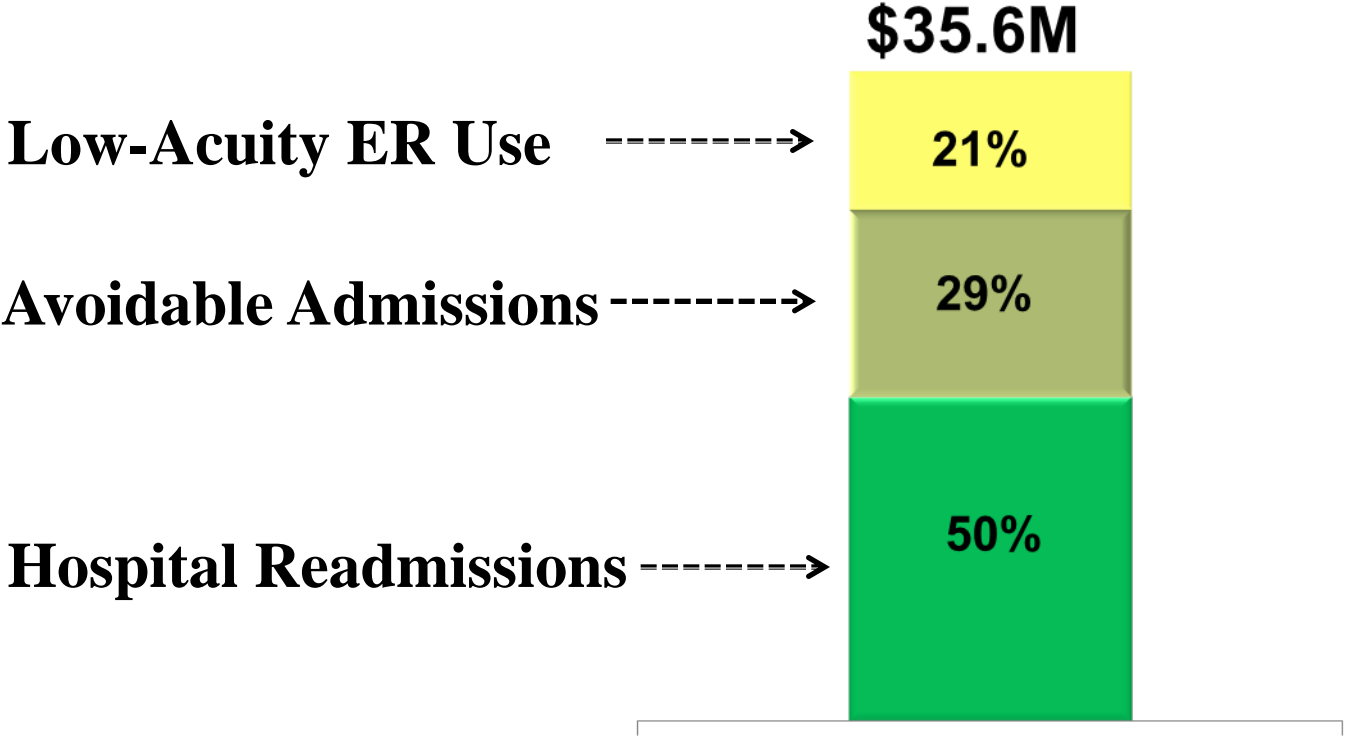
DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The Health Plans To Coordinate Enrollee Care

- ❑ 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.
- ❑ With more than one year's worth of data, DHCF can now more closely examine the following performance indicators for each 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 and preventative care
 - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days -- hospitalization

More Than \$36 Million In Managed Care Expenses in 2015 Were Potentially Avoidable

Managed Care Expenses Due To Lack of Care Coordination, 2015

Patient Metrics



Notes: The LANE dollars are adjusted for the duration of enrollment and percent credibility factors are applied to each diagnosis based on professional judgment.

Source: MCO Encounter data reported by the health plans to DHCF.

DHCF To Launch Pay-For-Performance Program As An Incentive For MCOs To Address Care Coordination Problems

- ❑ Beginning in October 2016, DHCF's three full-risk MCOs will be required to meet performance goals in order to receive their full capitated payment rate.

- ❑ These performance goals will require the MCOs to reduce the incidence of the following three patient outcomes:
 - 1) Potentially preventable admissions (PPA),
 - 2) Low acuity non-emergent (LANE) visits, and
 - 3) 30-day hospital readmissions for all-causes

Program Structure Is Based On Cash Withhold

- ❑ The program will be funded through a two-percent (2%) withhold of each MCO's actuarially sound capitation payments for the corresponding period.
- ❑ The 2% withhold is the profit margin for each MCO that is factored into the base per-member, per-month payment rate. The withhold will begin October 1, 2016 through September 30, 2017.
- ❑ The baseline period used for the program is April 1, 2015 through March 31, 2016 and the MCOs may be eligible to receive a portion, or all of the withheld capitation payments based on performance against the three outcome measures.

Weighting And Scoring System For Pay-For-Performance

- ❑ A scoring system will be used to determine the distribution of payment incentives for the MCOs:

- ❑ LANE and PPAs will be weighted at 33% of the capitation withhold. The MCOs have an opportunity to earn back the full 33% based on performance as follows:
 - 5% reduction in LANE Emergency Department (ED) utilization and PPAs from the baseline will result in the MCO earning 100% of the 33% withhold attributed to each of these measures
 - 3.5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 75% of the of the 33% withhold attributed to these measures
 - 2% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 50% of the 33% withhold attributed to these measures
 - If reduction in LANE utilization and PPAs are less than 2% from the baseline, the MCOs does not earn any portion of the 33% withhold attributed to the relevant measure

Weighting And Scoring System For Pay-For-Performance (continued)

- ❑ The scoring system is the same for the third measure -- All-Cause Hospital Readmissions -- but this outcome is weighted at 34% of the capitation withhold.
- ❑ The MCOs can earn back 50%, 75% or 100% of the 34% withhold attributed to the measure by demonstrating reductions at 2%, 3.5% and 5% respectively.
- ❑ DHCF will rely on claims data to measure the MCOs performance in this system. Since a run-out period must be allowed to ensure a more complete picture of claims activity, payments will likely occur 4 to 6 months after the measurement period closes.