



District of Columbia's Managed Care Biannual Performance Report

(January 2019 – June 2019)

Issued by:

Department of Health Care Finance

May 2020
Washington, DC

Presentation Outline

- Goals and Purpose of Managed Care Review**
- Summary Of Key Findings
- The Financial Performance of the District's MCOs
- The Administrative Performance of the District's Health Plans
- MCO Medical Spending and Beneficiary Utilization Patterns
- Care Coordination and Performance Against Program P4P Benchmarks
- Conclusions

Managed Care Represents DHCF's Largest Provider Expenditure

- ❑ Department of Health Care Finance's (DHCF) managed care program is the largest single expenditure in the agency's budget consisting of the Medicaid (including CHIP-funded Medicaid), Alliance and Immigrant Children's Program (ICP) publicly-funded health insurance programs.

- ❑ As of June 2019, 196,451 Medicaid beneficiaries and 15,720 Alliance enrollees were assigned to one of the four following Managed Care Organizations (MCOs):
 - Amerigroup DC, Inc. (Amerigroup)
 - AmeriHealth Caritas DC (AmeriHealth)
 - Trusted Health Plan (Trusted)
 - Health Services for Children With Special Needs (HSCSN)

- ❑ All four MCOs have continued to offer comprehensive benefits during the first half of 2019. Three of these MCOs – Amerigroup, AmeriHealth, and Trusted – operated under full risk-based contracts while HSCSN operated under a risk sharing arrangement with the District.

- ❑ The District spent roughly \$521 million* on MCO services in the first half of 2019. Eighty-three percent (\$434) million of this amount funded the full risk-based contracts signed by Amerigroup, AmeriHealth, and Trusted, while approximately 17 percent (\$87 million) funded the risk sharing contract with HSCSN.

History of The MCO Performance Review

- ❑ Following the award of the contracts for the three full risk-based plans in 2013, DHCF initiated the MCO performance review process as the first step towards reforming a troubled program.
- ❑ Prior to this award, DHCF's MCO 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 the comprehensive review process in 2014 to assess and evaluate the performance of its three full risk-based MCOs.
- ❑ In 2016, DHCF included the Child and Adolescent Supplemental Security Income Program, managed by HSCSN, as part of the MCO performance review.

Goals Of The Performance Review

□ There are three primary goals of this performance review:

1. Evaluate the degree to which DHCF's risk-based MCOs 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 MCOs 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 oversight activities and prioritize areas for enhanced monitoring and corrective action.

Focus Of The Performance Review

- ❑ This biannual report for the first half of 2019 addresses the following questions for each MCO:
 - What was the financial condition of the MCOs during the first half of 2019? Were the MCO revenues sufficient to cover claims and operating costs?
 - 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 percent Medical Loss Ratio (MLR) threshold 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 meet the MLR target established to anchor HSCSN's rates while otherwise containing cost? As a result what is the financial impact for DHCF?
 - What success -- as measured by performance against three established benchmarks -- did the full risk-based MCOs experience in coordinating care for its members thus far in 2019?

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Summary Of Key Findings

Troubling Financial Conditions Continue For Largest MCO In 2019

- ❑ Two of the three full risk-based MCOs are in good financial condition thus far in 2019. Each of the full risk-based MCOs reported risk-based capital (RBC) positions that are above the required level of 200 percent. While two of the MCOs posted profits ranging from 7 to 18 percent with ample reserves to meet incurred but unreported claims with liquid assets, these two MCOs continued to fall short of the threshold for premium spent on medical and quality improvement costs during the first half of 2019. Conversely, AmeriHealth was once again an exception – reporting growing trends in medical service costs and double-digit operating losses year-to-date in 2019.

AmeriHealth's Operating Losses

- AmeriHealth continued to experience notable growth in both net claims and total average monthly enrollment in 2019. During the 2018 contract year, the population previously enrolled in MedStar primarily shifted to Amerigroup. Subsequent to this initial population shift, a disproportionate share of the high-acuity, high-cost MedStar population ultimately transitioned to AmeriHealth from the other two full risk-based MCOs, leading to unforeseeable operating and financial challenges for AmeriHealth in 2018 and which have continued throughout 2019. Though the trends in enrollment and medical cost growth have slowed compared to rates observed in 2018, the significant disparity in overall costs and enrollment when compared to the other full risk-based MCOs are indicative of continued adverse selection observed within the managed care program. This has culminated in both operating losses and risk to the financial solvency of the District's largest MCO serving the 8 Medicaid population.

Summary Of Key Findings

(continued)

Amerigroup and Trusted's High Margins

- Amerigroup and Trusted continue to report high operating margins in 2019, though overall growth in profits have slowed compared to 2018 levels. The District implemented risk adjustment in May of 2019 which is partially responsible for the reductions in revenue relative to expenses observed in both MCOs' quarter two results. Amerigroup's reported medical expenses are showing growth across most service categories, driven primarily by the adult populations in both the District of Columbia Healthy Families Program (DCHFP) and Alliance programs. Trusted's per-member, per-month (PMPM) expenses for DCHFP and children are showing growth, driven by inpatient costs. However, Trusted's Alliance costs continue to decrease, and remain the lowest among the three full risk-based MCOs.

HSCSN's Improving Financial Position

- HSCSN's financial results for the first half of 2019 mirror that of the corresponding reporting period in 2018, with HSCSN reporting a marginal net operating loss driven by low to moderate cost growth in PMPM expenses when compared to prior years. The home health and behavioral health categories of service are showing large increases, offset by notable decreases in inpatient costs. HSCSN's financial experience is historically volatile, due to the small size and acute needs of the population enrolled in the plan. DHCF continues to closely monitor the MCO's operational and financial performance.

Summary Of Key Findings

(continued)

Administrative Performance

- ❑ Four areas are typically evaluated to assess MCOs' administrative performance – adequacy of provider network, timely payment of claims, appropriate management of the claims adjudication process, and successful execution of an encounter system. Data from this analysis indicates the MCOs are, on balance, properly managing these significant responsibilities:
 - The MCOs have maintained comprehensive and diverse provider networks to ensure access to a full range of services as well as robust systems to report patient encounters. However, some of the MCOs have struggled to contract with all District hospitals, which DHCF will focus on remediating through future Medicaid reform initiatives discussed later in this report.
 - All of the MCOs exceeded the District's timely payment requirement during the first half of 2019, ensuring the continuity of operations for their contracting providers.
 - District MCO's overall claims denial rate was five percent, which is consistent with prior period rates. However, nearly 12 percent of claims initially denied were later overturned – an unnecessary inefficiency in the claims management process. Trusted had the highest rate of denied claims later overturned, followed by Amerigroup. Trusted reported that the primary drivers of claims denied and later paid were due to following: absence of referring provider IDs, lack of documentation for coordination of benefits, and provider enrollment issues. Amerigroup reported that their primary drivers were improper coordination of benefits, inappropriate emergency room utilization without proper documentation of emergent diagnosis, and timing issues with retrospective eligibility requirements. Both MCOs reported that they are working collaboratively with providers to educate them on proper billing practices to resolve these operational concerns.

Summary Of Key Findings

(continued)

Medical Expenses

- ❑ Only one of the three full risk-based MCOs spent at least the required 85 percent of MCO revenue on beneficiary Medicaid and Alliance medical expenses while generally avoiding spikes in their PMPM costs during the first half of 2019. As reported in 2018, Amerigroup fell short of this requirement, due to a greater portion healthier (i.e., low acuity) members in the MCO's population than what was anticipated during rate development, which was not adjusted for due to the absence of risk adjustment during the corresponding reporting period. Amerigroup contracted with a third party to audit their MLR in 2019, which resulted in no errors on the part of Amerigroup. Trusted also fell short of this requirement, and reported that the primary driver was a re-estimation of prior period unpaid claims expenses which artificially reduced medical expenses for the current reporting period. Notwithstanding, medical expenses for Amerigroup and Trusted are showing growth in the first half of 2019, with observed growth for Medicaid adults and children at four and seven percent across all full risk-based MCOs from 2018 to 2019.
- ❑ The growth in PMPM cost for the Alliance program was flat at one percent for the first two quarters of 2019, a sharp decrease from the 13 percent growth in 2018. Past Alliance spending growth was attributed to the transition of pharmacy benefits into the managed care program in 2016. While enrollment growth is stable, the Alliance population is becoming slightly older with more complex medical problems. This has driven increased spending in pharmacy, outpatient, and inpatient hospital costs. Though the preliminary growth rate for the Alliance population in 2019 has appeared to slow from the 13 percent in 2018, the inherent short runout period for this analysis results in a high degree of uncertainty for reported reserve estimates and future results may vary.
- ❑ AmeriHealth's total Alliance PMPM costs remain disproportionately higher than the other MCOs, driven primarily by the plan's disproportionate share of Alliance enrollees and their use of inpatient, outpatient, and pharmacy services. AmeriHealth attributes the increase in pharmacy spend due to both pharmacy cost and utilization increases for specialty drugs. Specifically, oncology drugs are a major source of disparity for Alliance enrollees, with AmeriHealth spending roughly four times as much on a PMPM basis compared to the other MCOs. For both the DCHFP and Alliance populations, AmeriHealth continues to experience significantly higher pharmacy, inpatient, outpatient and physician medical service utilization driven primarily by enrollees with the following conditions: rheumatoid arthritis, diabetes and asthma. Beginning with the exit of MedStar in late 2017, the challenges experienced by the other two full risk-based MCOs in securing contracts with some of the key District hospitals, continue to drive enrollment of a disproportionate share of high-utilizers to AmeriHealth.
- ❑ DHCf plans to mitigate these financial pressures by implementing the following rate adjustments in FY20: Adopting a new risk-adjustment model (CDPS+Rx) which better aligns disease conditions and the use of pharmaceuticals with future healthcare costs, increasing the frequency of risk score review with quarterly updates for eligibility changes, performing a one-time DCHFP pharmacy adjustment and an Alliance experience adjustment, and incorporating a one-time trend and base-cost adjustment to AmeriHealth's base rates. DHCf is including new requirements in the MCO Request for Proposal (RFP) for FY21 – e.g., universal contracting for key providers – that are designed to mitigate the adverse selection experienced by AmeriHealth, so that in future contract periods the additional contracting adjustments are not necessary.

Summary Of Key Findings

(continued)

Mental Health Service Utilization

- ❑ The outpatient mental health MCO beneficiary utilization rates for 2019 Q1-Q2 were higher compared to 2018 Q1-Q2. Specifically, MCO beneficiaries utilizing Mental Health Rehabilitative Services (MHRS) represented 6 percent and 3 percent of the total adult and child population in 2019, an increase from the 5 percent and 2 percent of the total Medicaid adult and child population in 2018.* Similarly, utilization for any outpatient mental health services increased from 10 percent and 8 percent of the total adult and child population in 2018, to 11 percent and 9 percent during the same time period in 2019. This could potentially be the result of the Department of Behavioral Health (DBH) focusing on increasing access and availability of all mental health services and removing barriers for beneficiaries. As a result, there are ten new core service agencies (CSA) enrolled in the provider network and DBH expanded access by providing four new access points for beneficiaries to get qualified mental health services. In addition, DHCF released guidance in 2018 that further clarified the scope of services MCOs must cover that are not carved out of Mental Health Rehabilitative Services (MHRS), coupled with the ongoing implementation of the Federally Qualified Health Center (FQHC) behavioral health services under the new Alternative Payment Methodology (APM) rate – all of which may have resulted in increased utilization of these services.
- ❑ Total MCO spending on behavioral health services increased 5 percent and 14 percent PMPM for Medicaid adults and children from 2018 to 2019.* Additionally, the District has observed consistent growth in PMPM spend on MCO behavioral health services over the past five and a half years.

Physician Visit Rates

- ❑ On average, MCO-enrolled adult and children's physician visit rates and well-child visits (WCV) increased in 2019 Q1-Q2 for nearly all plans except for Trusted adults, which observed slight decreases in physician visit rates. Amerigroup anticipated that newly implemented medical record review processes in 2018 would improve rates, and its physician visit rates may reflect that. Trusted attributes the decline in PCP and well-child visits to a loss in eligible membership since 2018 and the termination of their contract with George Washington (GW) Hospital which covers a significant amount of beneficiaries. Trusted has implemented a no-show project with Howard University Hospital to target improved engagement with beneficiaries regarding primary care appointment adherence. DHCF will work with the MCOs, pediatric providers and agency stakeholders to continue to increase awareness of the importance of periodic preventative visits for all Medicaid beneficiaries.

Summary Of Key Findings

(continued)

Care Coordination

- ❑ The care coordination challenges that plagued the District's three full risk-based MCOs from 2014 through 2016 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, but with some improvement.
- ❑ For the most recent annual data period for 2019, the MCOs have spent approximately \$45 million on patient care that may have been avoided through the use of more aggressive care coordination strategies. These amounts are slightly below FY2018 reported results; however, the MCOs have opportunities for continued improvement in implementing effective care coordination interventions in the future.
- ❑ With CMS approval, DHCF implemented the MCO pay-for-performance (P4P) program in 2017. When comparing the most recent annual data period for 2019 to the baseline targets, AmeriHealth and Trusted currently meet or surpass the minimum requirements on all three quality measures, with Amerigroup falling short on the non-emergent use of the emergency room performance measure.
- ❑ DHCF postponed the P4P withhold in FY2019 due to changes in the payment rates for the MCOs; however, DHCF will continue to monitor and work collaboratively with the MCOs on interventions to improve the underlying quality measures for this program.

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There Are Several Key Metrics That Speak To The Financial Health Of MCOs

- ❑ DHCF focuses on four key metrics when evaluating the financial stability of MCOs:
 - 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 an MCO will experience positive operating margins:
 - **Risk-adjusted payment rates.** Risk adjustment ensures financial viability and operational sustainability for MCOs whose membership represent a disproportionate share of high-acuity, high-cost beneficiaries. With DHCF's payment model, MCOs 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 based on enrollee disease prevalence with utilization of appropriate services based on the acute needs of their population, can gain a considerable advantage over others that do not. For May 1, 2019 through September 30, 2019 of the 2019 contract year, risk adjustment was implemented using an adjusted District-specific version of the Medicaid Rx model and was applied to the actuarially sound capitation rates established during annual rate setting.
 - **Provider contract rates.** Plans that negotiate contract rates that are adequate to build a solid network but lower than their competitors can realize significantly 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. In addition, differences in the application of medical necessity requirements may directly impact utilization and incurred costs observed between MCOs.

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 MCOs report significant operating margins. Accordingly:
 - DHCF routinely tracks the MCOs' performance against the 85 percent Medical Loss Ratio (MLR) requirement for the full risk-based plans and an MLR target established during rate setting for the shared-risk plan.
 - MCOs that fall short of this standard face detailed scrutiny and possible financial penalties if warranted.
- ❑ MCOs can also artificially (and temporarily) inflate operating margins by repeatedly denying claims that should be paid.
 - DHCF monitored and reported on the MCOs' management of the denied claims process starting in 2016. This report provides a comparative analysis for the first half of 2019 and the corresponding period in 2018.

Though The Enrollment Growth Rate Has Slowed For AmeriHealth Compared To 2018, The MCO Continues To Serve A Significantly Disproportionate Share Of The Managed Care Population

MCO	Medicaid & Alliance October 2018 Enrollment	Medicaid & Alliance June 2019 Enrollment	Net Change (%)
Amerigroup	47,041	46,564	(1)
AmeriHealth	121,000	125,716	4
Trusted	34,599	34,835	0.7

Source: Enrollment data extracted from DHCF's Medicaid Management Information System (MMIS).

Due To Utilization Exceeding Expectations, AmeriHealth Reported A Loss For The First Half Of 2019; DHCF Has Put In Place Remediation Efforts Through Implementation Of New Risk Adjustment Models And Cost-Experience Adjustments In FY20

MCO Revenue and Expense Data for January to June 2019

$$\text{Revenue}^1 - \text{Claims}^2 - \text{Administrative Cost}^3 = \text{Operating Margin (Loss)}$$

MCO	Revenue	Claims	Administrative Cost	Operating Margin (Loss)
Amerigroup	\$95.9M	\$72.3M	\$6.1M	\$17.5M
AmeriHealth	\$269.1M	\$272.1M	\$23.6M	\$(26.6)M
Trusted	\$69.5M	\$52.9M	\$11.9M	\$4.7M
HSCSN	\$86.6M	\$78.7M	\$9.9M	\$(2)M

- Notes: 1. Total Capitation Revenue excluding HIPF payments and DC Exchange/Premium tax revenue based on the MLR letters and calculations provided by the MCOs. For HSCSN, capitation revenue excludes DC Exchange/Premium tax revenue and Risk Share.
 2. Total incurred claims (including IBNR) and cost containment expenses as of June 30, 2019, net of reinsurance recoveries.
 3. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses as reported in the DISB and HIPF payments and DC Exchange/Premium taxes as reported in MLR report/calculation provided by the MCOs. For HSCSN, administrative expenses are reported based on MCO submitted balance sheet and income statement.

Source: MCO Quarterly Statement filed by the MCOs with the Department of Insurance, Securities, and Banking (DISB) and self reported financials for HSCSN.

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

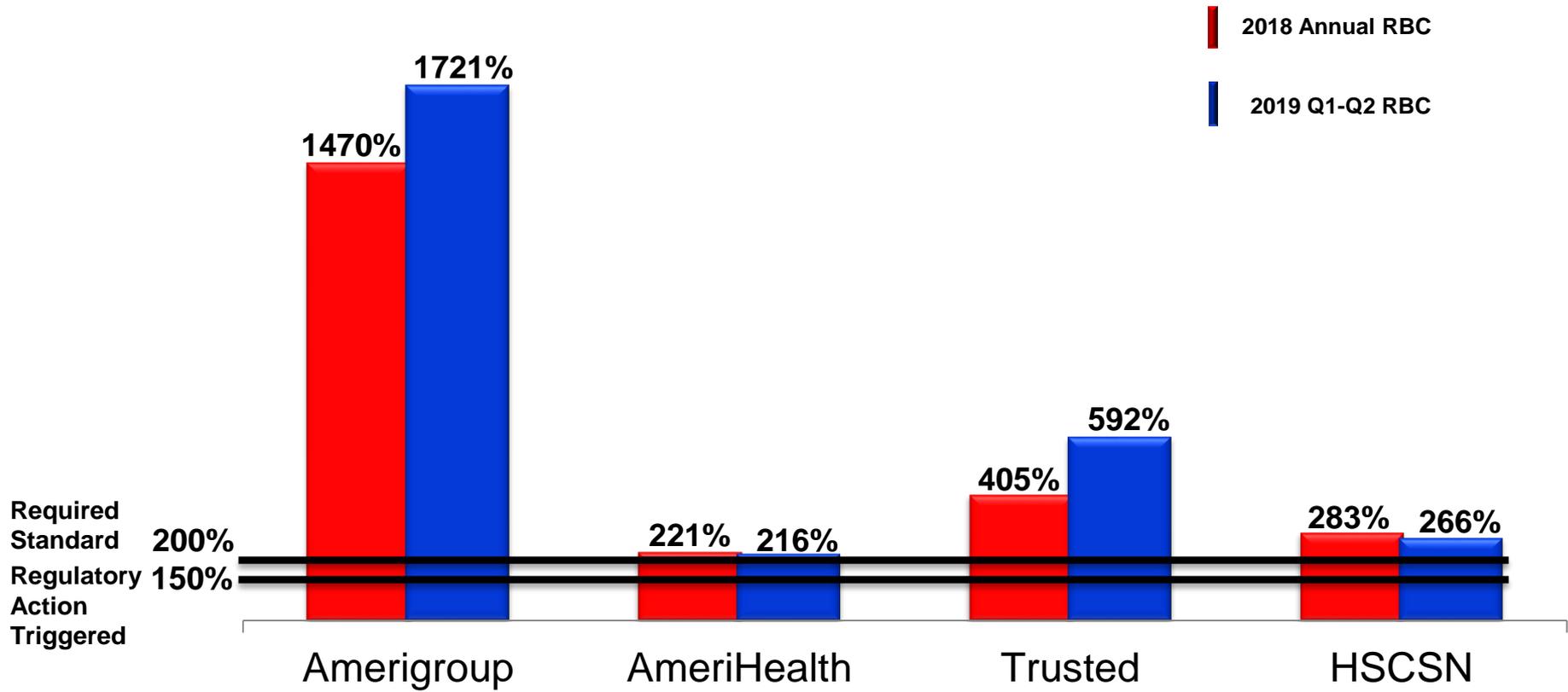
- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether an MCO has the assets to pay claims.
- ❑ MCOs conduct this complicated calculation annually for each MCO using end-of-year financial data (as well as some information that is not publicly disclosed) that is provided to the Department of Insurance, Securities and Banking (DISB) for review.
- ❑ MCOs with RBC levels that fall below 200 percent face greater scrutiny from DISB and DHCF (as described on the next slide) to ensure that they raise their capital level above 200 percent RBC.
- ❑ This report compares the annual RBC measures reported by the MCOs in their official 2018 financial statements filed with DISB to more recent 6-month proxy measure for 2019 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 MCOs Maintained Risk-Based Capital Levels That Exceeded Recommended Standards For The First Half Of 2019

Proxy Q1 & Q2 2019 Risk-Based Capital For MCOs Compared To 2018 Annual Level



Notes: HSCSN is not subject to DISB Risk-Based Capital reporting requirements. The reported numbers are calculated and included in this report for monitoring and informational purposes.

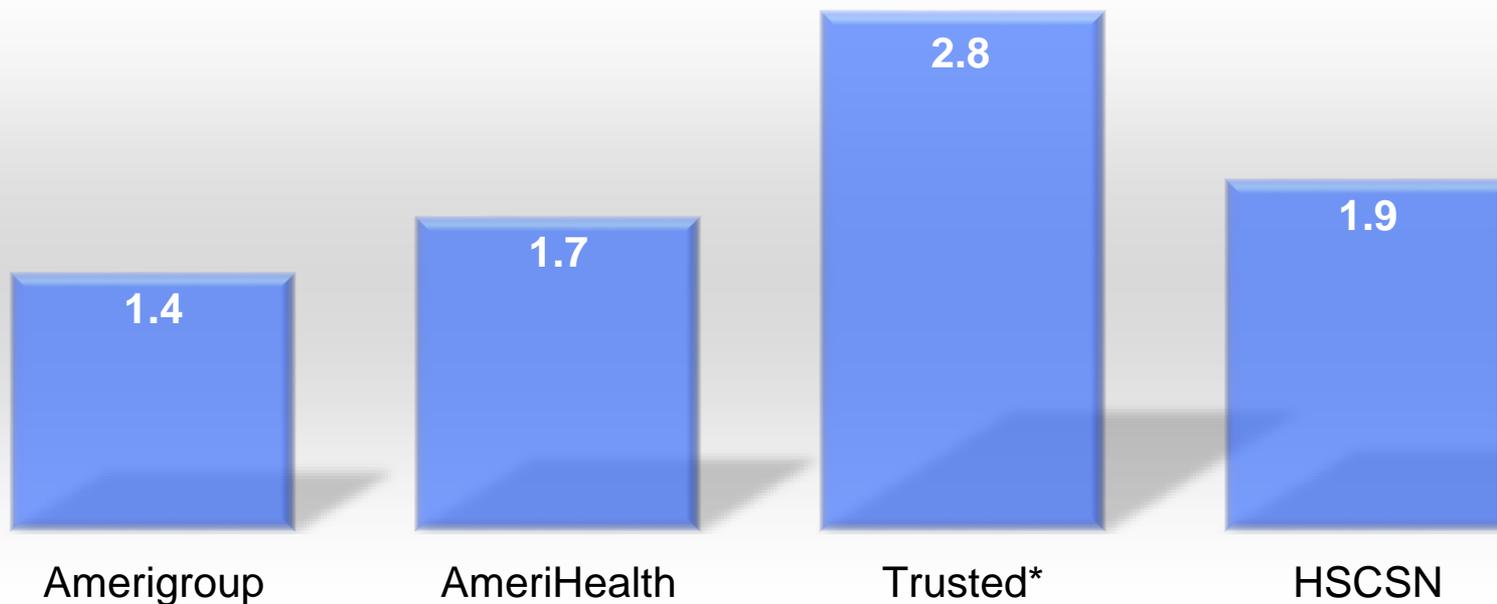
Source: Reported figures are from the full risk-based MCO's annual 2018 financial statements reported to DISB and self-reported financials for the shared risk MCO, and calculated proxy amounts provided by Mercer for the 2019 reporting period.

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 MCOs 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 monthly claim's experience for each plan to calculate the reserves on hand.
- ❑ We also provide an analysis of the number of days the MCOs 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 to June 2019

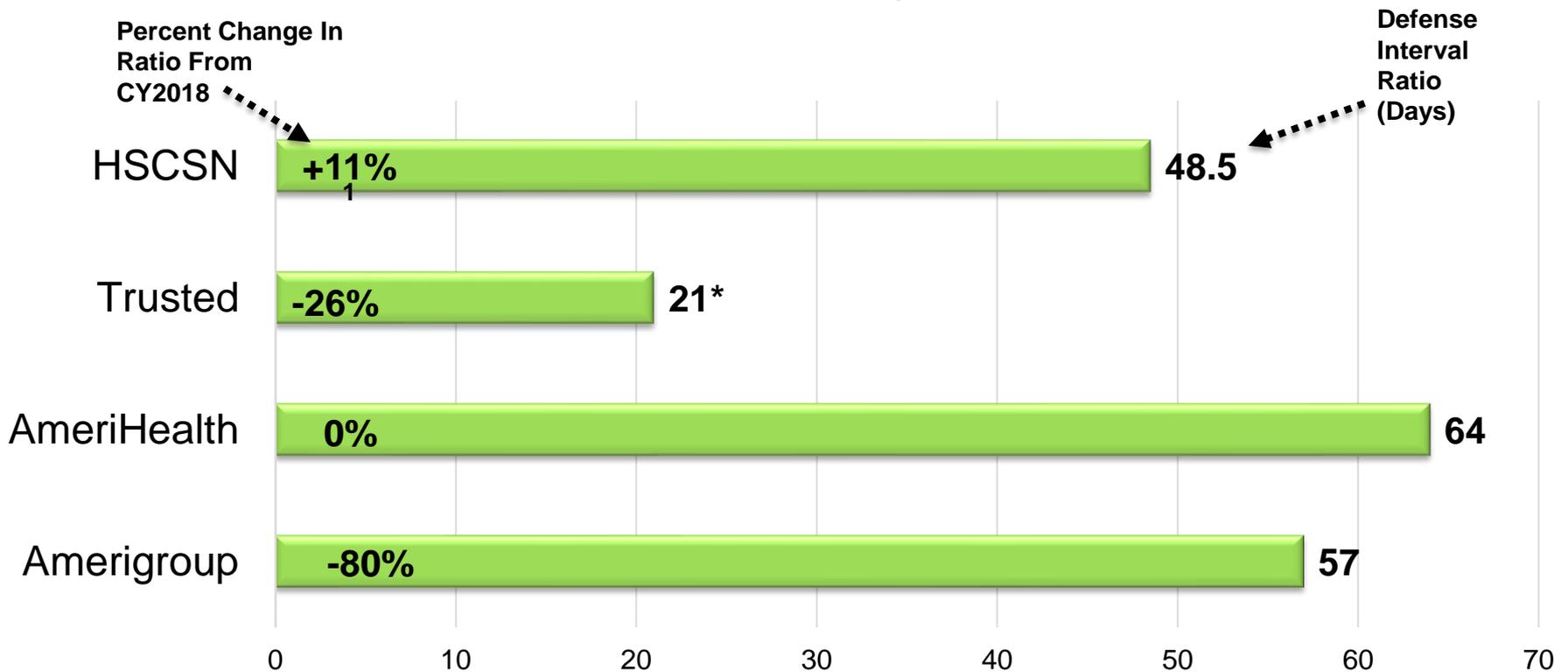


Notes: *Trusted has a longer claims runout period than the other MCOs, which impacts derived IBNR amounts. The reported results rely heavily on IBNR assumptions and final actual results could differ from current estimates.

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

Three Of The Four MCOs Met The Standard Liquidity Benchmark For The First Half Of 2019, While Trusted Reported Adequate Alternative Liquid Investments For Covering Claims

Days In A Year That MCOs Can Operate On Existing Cash Without Having To Access Long-Term Assets For The Period Covering January to June 2019



Notes: *Trusted officials report that the company has over \$43M in bonds with varying maturity dates, which could be liquidated if necessary to pay claims.

Source: Mercer calculated the Defensive Interval Ratio as cash and cash equivalents divided by daily operating expenses for the period from January to June 2019.

AmeriHealth's Operating Losses Continue To Grow In 2019, Though The MCO Maintained Healthy Capital And Liquidity Levels

Summary Of MCOs' Financial Condition For The Period Covering January to June 2019

Financial Metric	Amerigroup	AmeriHealth	Trusted	HSCSN
Reserves for estimated incurred but not reported claims in months	1.4	1.7	2.8	1.9
Risk-based capital (RBC) position	1721%	216%	592%	266%
Defensive interval ratio (liquidity) in operating days on existing cash	57	64	21	49
Operating margin (loss) in millions	\$17.50	\$(26.60)	\$4.70	\$(2.00)
Operating margin (loss) % of revenue	18.2%	-9.9%	6.8%	-2.3%
Medical Loss Ratio	75%	101%	76%	91%

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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 MCO 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 MCOs 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

The MCOs Continue To Maintain Accurate Encounter Data File Submissions

Number of Recorded Encounters And Accuracy Transfer Rate, January to June 2019

MCO	Total Submitted Encounters*	Accuracy Rate For Encounter Transfers
Amerigroup	217,351	99%
AmeriHealth	967,831	99%
Trusted	184,135	89%
HSCSN	177,606	97%

Note: *Gross count can include originals, voids and resubmissions. Reported numbers are currently abnormally high due to correction and resubmission of historical encounters to support the FQHC Wrap process. The District expects this number to remain higher than normal for one to two more reporting periods.

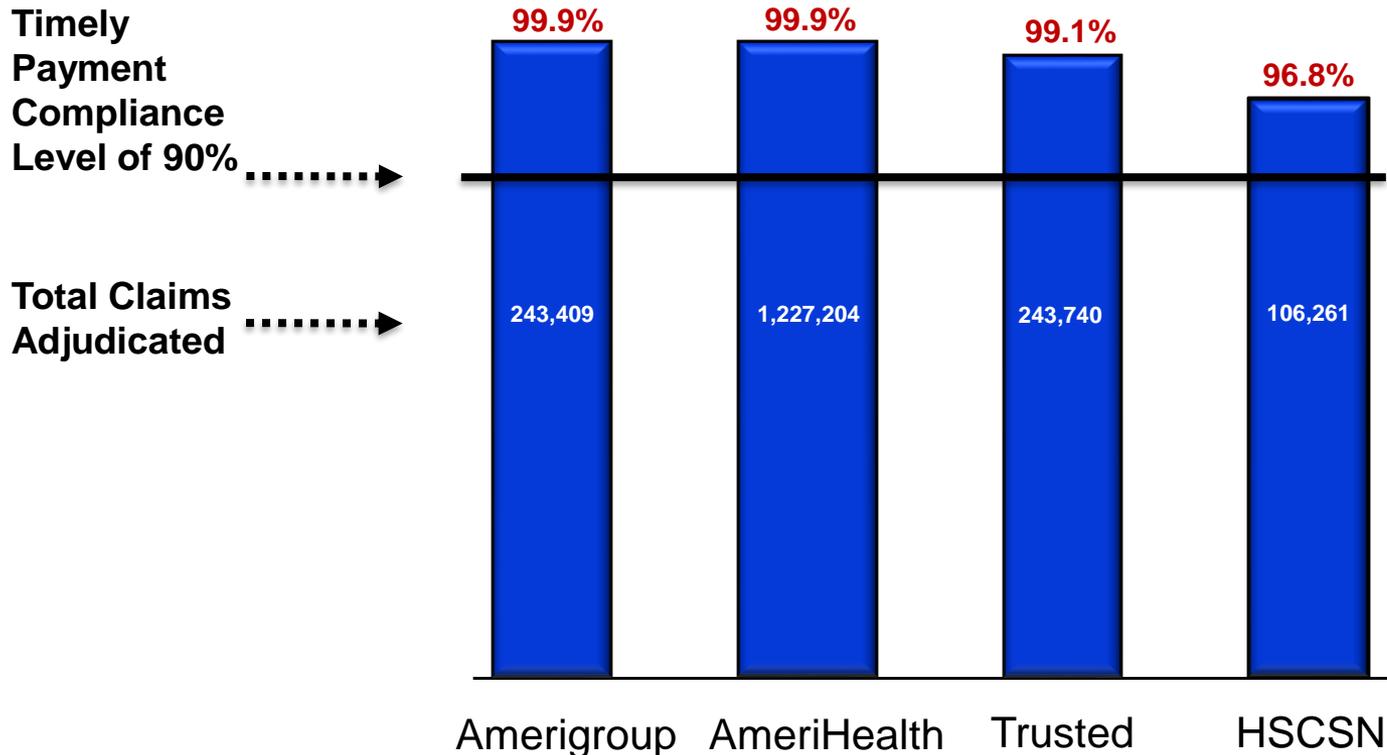
Source: Department of Health Care Finance MMIS each month January through June 2019.

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

- ❑ Claims processing is a central administrative function that MCOs must effectively execute to avoid payment problems for providers.
- ❑ Through electronic claims processing, the District's managed care organizations are required to pay or deny clean claims within 30 days to satisfy timely filing requirements.
- ❑ Like most MCOs, 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

Each of the MCOs Exceeded The District's Timely Payment Requirement In Q1 Through Q2 Of 2019

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement, January to June 2019



Claims Adjudication Review Focuses On Whether MCOs Are Acting In Good Faith

- ❑ Because the District's 30-day timely payment requirement does not apply to claims that are initially denied, some providers expressed concern that managed care plans were unjustifiably denying a high rate of claims as a cash management strategy.
- ❑ Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the MCOs' networks, and potentially cause access to care issues.
- ❑ This report addresses this issue by reporting on the incidence of denied claims in the managed care program and the reasons for the denials for the period covering calendar year 2019 Q1 and Q2. Additionally, outcomes for claims that were initially denied but subsequently approved and repaid are also examined.

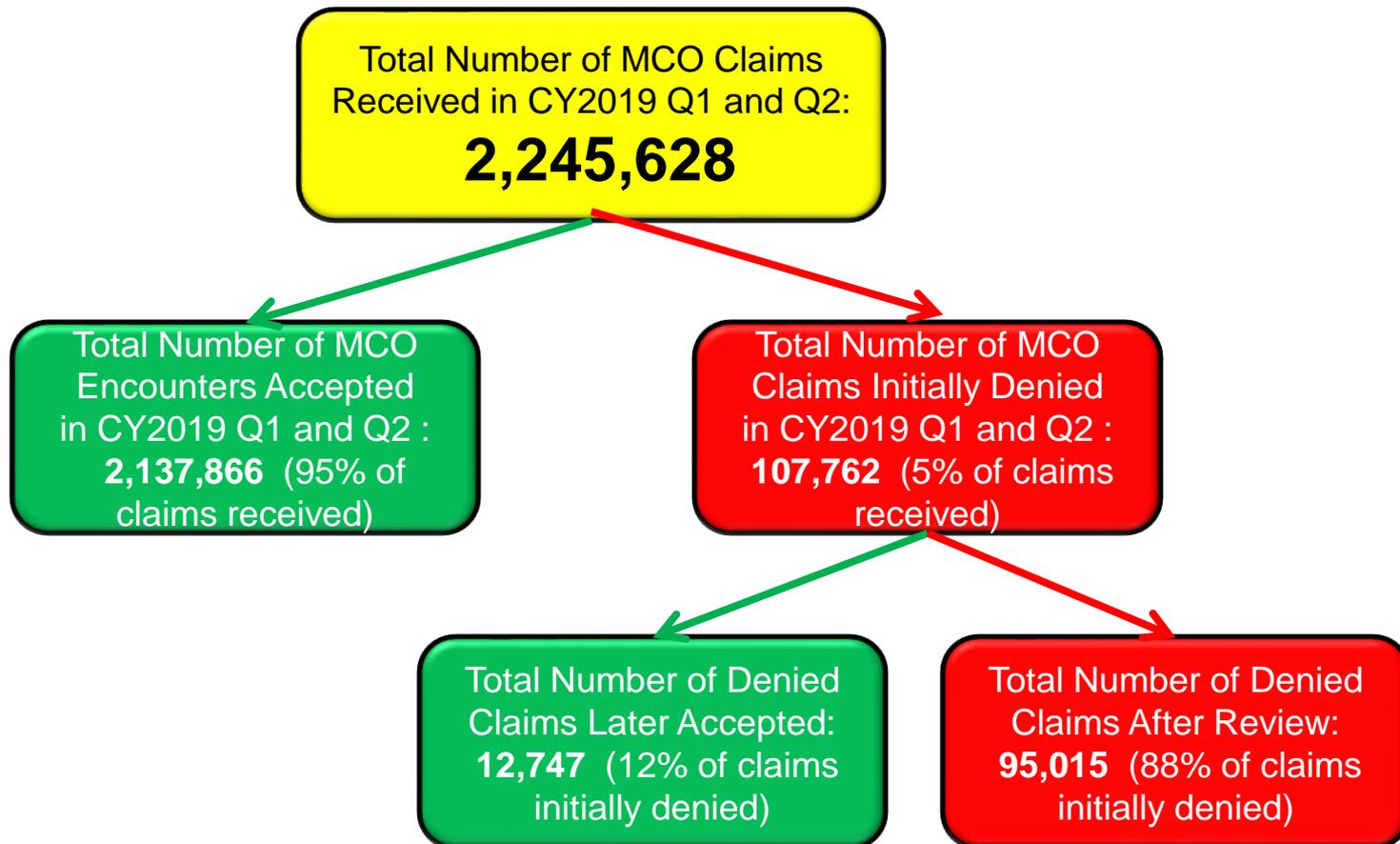
Methodology For Denied Claims Review

□ The key steps executed for this analysis were as follows:

- First, all MCO denied claims with dates of service between January 1, 2019 and June 30, 2019 were obtained from the District's four MCOs and established as the master dataset. This data extraction yielded 107,820 claims. Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), denied pharmacy claims were then excluded, yielding a final count of approximately 107,762 denied claims.
- Second, this master dataset was used to categorize provider types to match DHCF naming schemes and search for all claims with missing identifiers.
- Third, using DHCF's MMIS, all paid patient encounters with dates of service between January 1, 2019 and June 30, 2019 were extracted, yielding over two million records.
- Fourth, the dataset containing denied MCO claims (Step 1) was then merged with the dataset containing accepted encounters from MMIS (Step 2), using the beneficiaries' Medicaid ID, first date of service, last date of service, and billing provider NPI as the matching variables. This established in the same dataset, claims that were paid, denied, and those that were initially denied but paid at a later date.

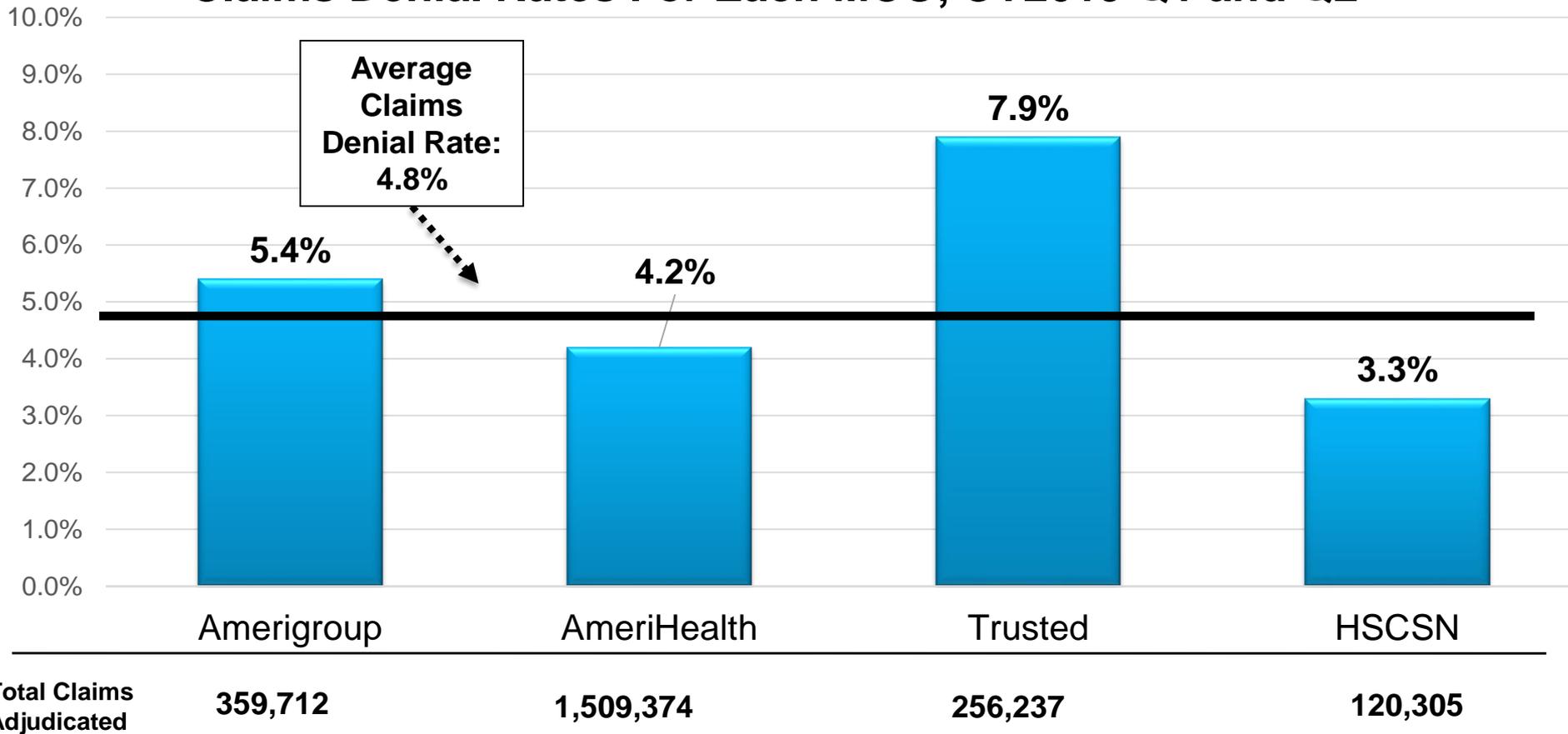
Five percent of MCO Claims Were Denied In CY2019 Q1 and Q2, Similar To 2018 Results

*Total number of denied claims after review represented five percent of all claims processed



Trusted and Amerigroup Denial Rates Were Above the MCO Average

Claims Denial Rates For Each MCO, CY2019 Q1 and Q2

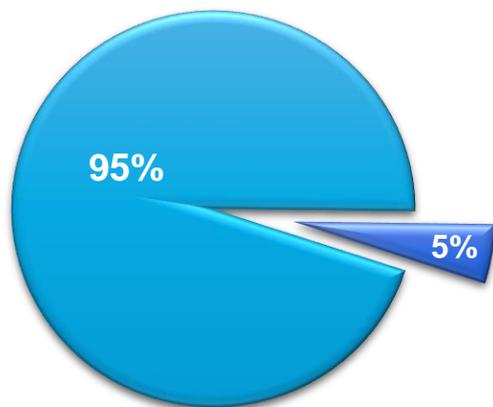


Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.
 Source: Patient encounters with January 1-June 30, 2019 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period

MCO Denials Were Mostly Related To Service Coverage And Improper Billing

MCO Claims Denial Rate, CY2019 Q1 and Q2

■ Claims Paid ■ Claims Denied



N = 2,245,628

Four Most Common Denial Reasons	Number of Denied Claims	Percent of Total Denied Claims
Service coverage issue*	29,060	25%
Billing process deficiencies**	60,100	52%
Duplicate claim	10,230	9%
Member not eligible	10,880	9%

N = 116,226 total denial reasons**

Notes:

*This includes claims missing prior authorization, services not being covered, or exceeded units.

**This includes claims not submitted to primary payor/carrier, or claims with incomplete billing provider information.

Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims. In addition, results shown here should be viewed with caution because the denial codes reported by plans are not standardized, which may lead findings to differ over time due to changes in plan coding practices and/or the manual process used by DHCF for grouping claims into the categories shown here.

Source: Patient encounters with January 1-June 30, 2019 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

Across All Provider Types, The Rate Of Denied Claims Is Down Compared To 2018

Claims Denial Rate By Select Provider Types, CY2019 Q1 and Q2 Compared to CY2018 Q1 and Q2

Select Provider Type	Number of Denied Claims		Number of Total Claims		Claims Denial Rate	
	2018	2019	2018	2019	2018	2019
Nurse Practitioner	3,918	1,504	6,935	5,794	56%	26%
Community Clinics* (excluding FQHCs)	2,003	411	7,693	5,473	26%	8%
Mental Health Rehabilitation Services (MHRS) providers	4,105	585	16,162	14,776	25%	4%
Free Standing Mental Health Centers	4,974	2,193	25,067	18,191	20%	12%
Home Health Agency	1,726	986	9,064	7,084	19%	14%

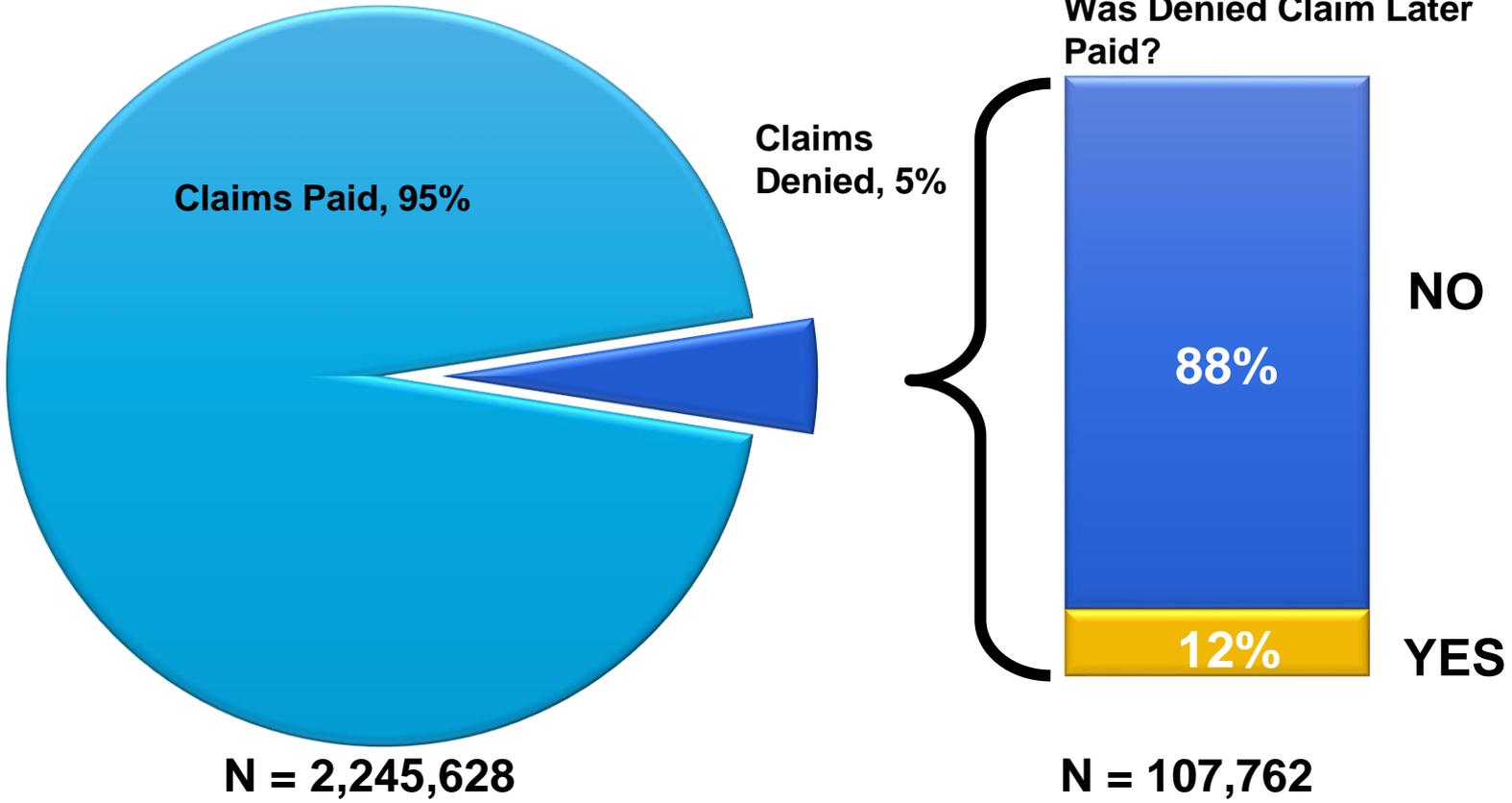
Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims

*Community Clinics are identified in MMIS as Private Clinics, and typically offer primary care services.

Source: Patient encounters with January 1-June 30, 2019 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

Over 12 Percent Of Claims Initially Denied in CY2019 Q1 and Q2 Were Later Overturned And Paid, Similar To Prior Reporting Periods

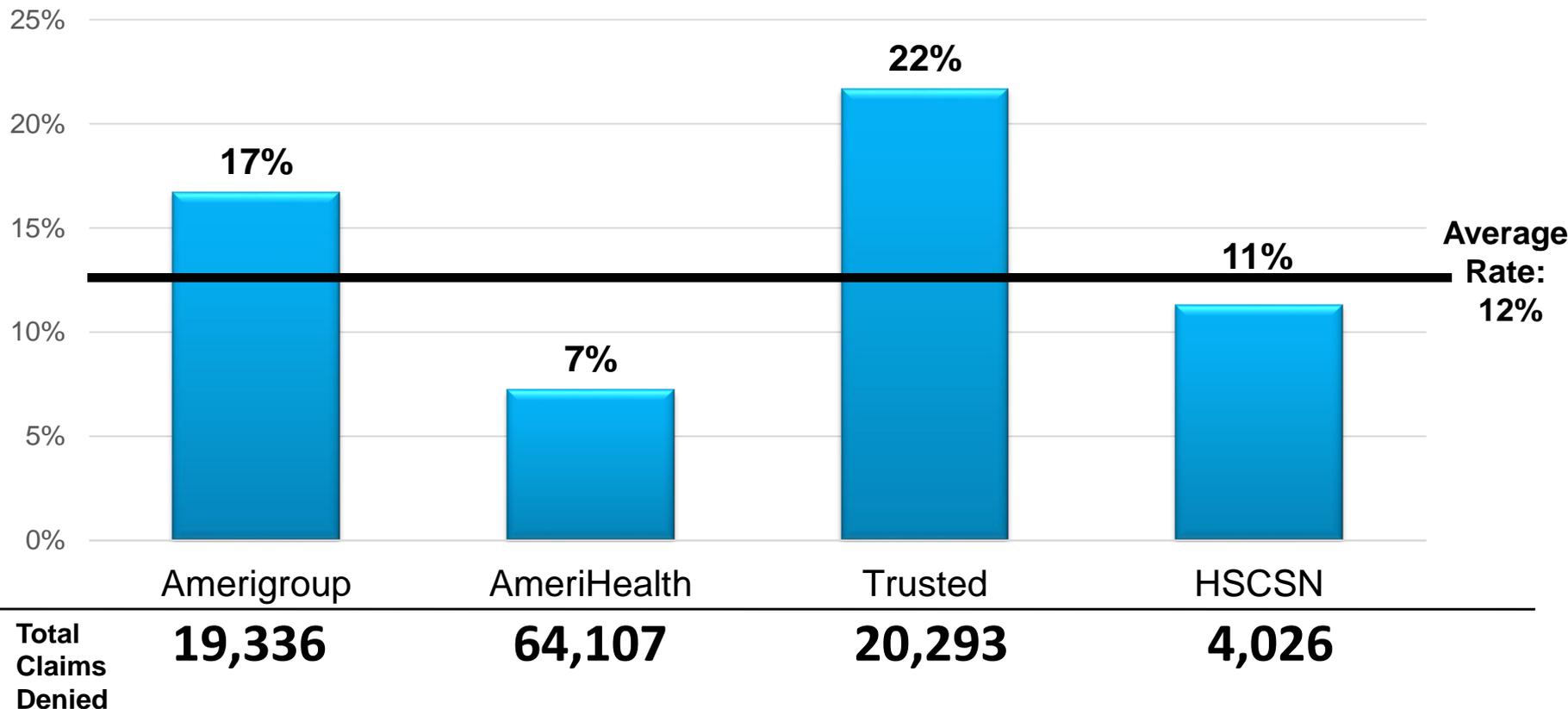
MCO Claims Denial Rate, CY2019 Q1 and Q2



Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.
Source: Patient encounters with January 1-June 30, 2019 dates of service from DHCF, Medicaid Management Information System (MMIS) merged with MCO files containing denied claims for the same period.

Trusted Had The Highest Percentage of Denied Claims Overturned After Appeal

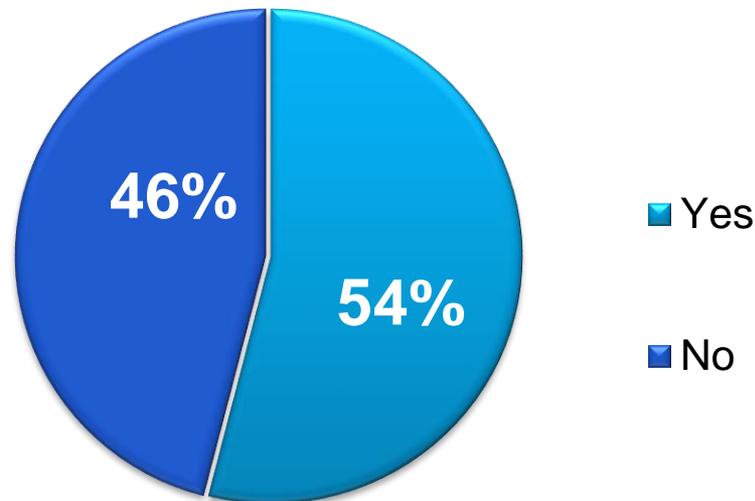
MCO Rates of Payment For Originally Denied Claims, CY2019 Q1 and Q2



Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.
 Source: Patient encounters with January 1-June 30, 2019 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

More Than 5 Out of 10 Of All Appealed Denied Claims Approved After An Appeal Were Paid Within 30 Days

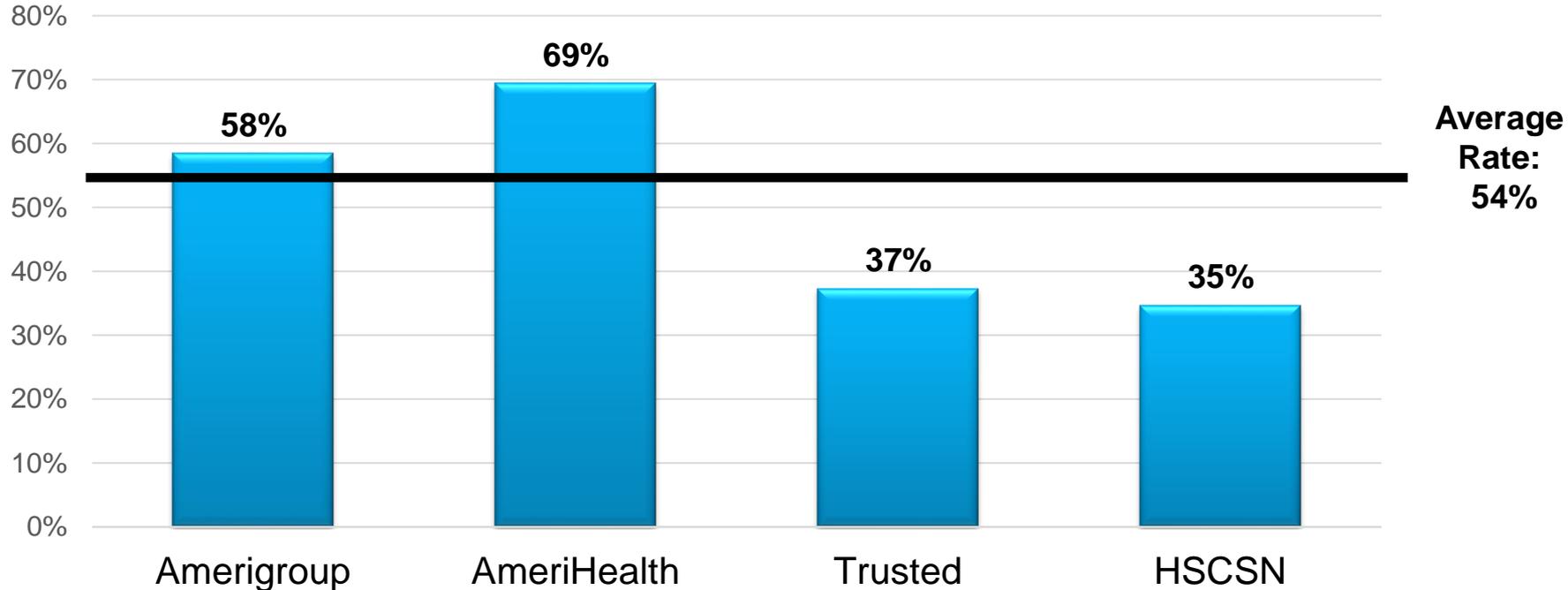
Percentage Of MCO Claims Approved After Appeal That Were Paid Within 30 Days, CY2019 Q1 and Q2



N = 12,747

Payment Of Claims Within 30 Days After Initial Denial Varies By MCO, With Higher Rates For AmeriHealth and Amerigroup

MCO Rates of Payment Within 30 Days For Originally Denied Claims, CY2019 Q1 and Q2



Total Claims Paid After Initial Denial

3,238

4,648

4,405

456

Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims.
 Source: Patient encounters with January 1-June 30, 2019 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

Average Number of Days From Initial Denial To Payment Decreased For Several Provider Types From CY2018 To CY2019 Q1 And Q2

Average Number Of Days To Payment For Appealed Claims, CY2019 Q1 and Q2 Compared To 2018

Select Provider Types	CY2018	CY2019 Q1 & Q2
Home Health Agencies	34	19
Nurse Midwives	47	15
Psychiatric Residential Treatment Facilities	54	95
Federally Qualified Health Centers	56	36
Free Standing Mental Health Clinics	24	33

Denial Rates Have Decreased By More Than Half Since 2015; Timely Payment of Claims Approved After Initial Denial Has Increased in CY 2019 Q1-Q2

A Comparison of Outcomes from 2015 – 2019 to date

<u>Outcome</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019 Q1/Q2</u>
Total Claims Processed	4.06M	4.23M	4.1M	4.2M	2.2M
Claims Denied (%)	14%	12%	8%	5%	5%
Highest Denial Rate By Plan	22% (Trusted)	19% (MedStar)	13% (MedStar)	8% (Trusted)	8% (Trusted)
Denied Claims Later Approved	6%	7%	11%	11%	12%
Denied Claims Later Approved And Paid Within 30 Days	43%	46%	42%	43%	54%

AmeriHealth Reported The Lowest Denial Rates And Denied Claims Later Approved, While Reporting The Highest Rate Of Timely Payment For Originally Denied Claims

Summary Of MCOs' Administrative Performance For The Period Covering January To June 2019

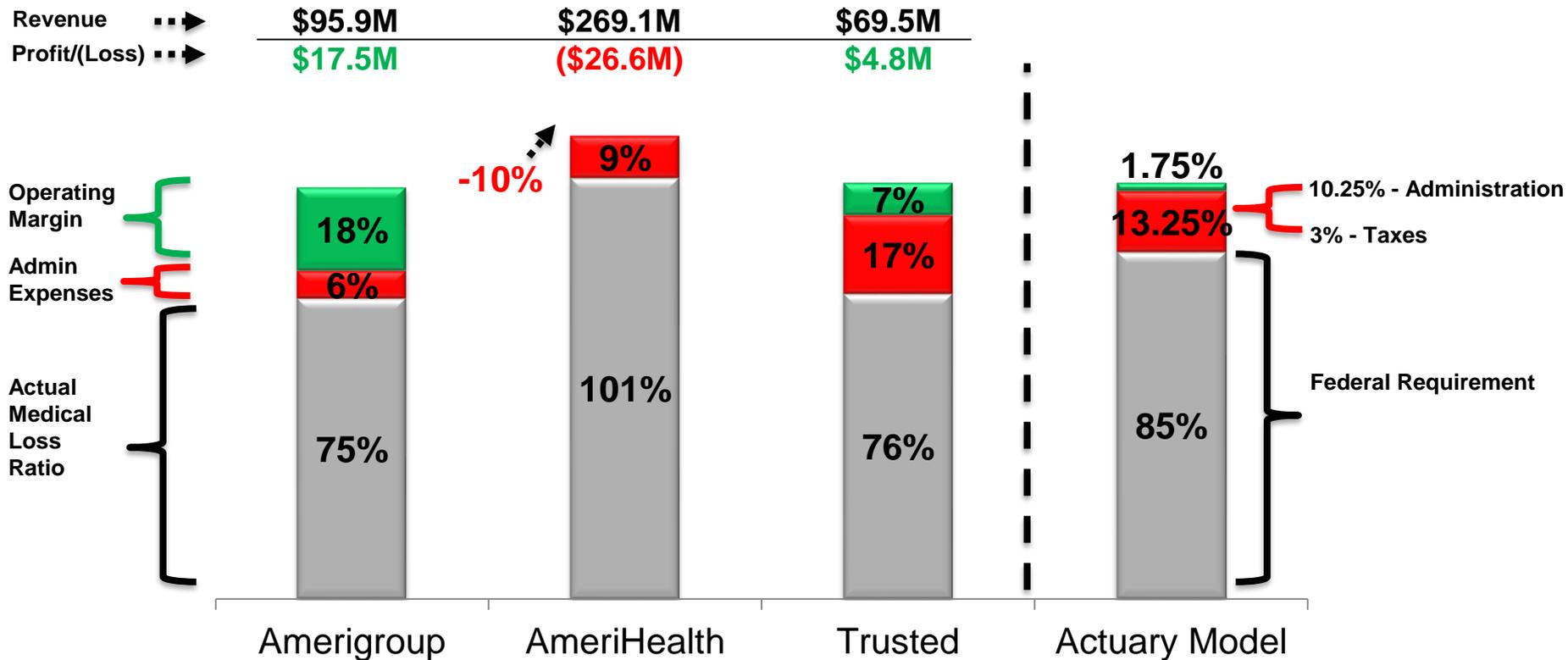
Administrative Metric	Amerigroup	AmeriHealth	Trusted	HSCSN
Accuracy rate for encounter transfers	99%	99%	89%	97%
Claims paid within 30 days	99.9%	99.9%	99.1%	96.8%
Claims denial rate	5.4%	4.2%	7.9%	3.3%
Percentage of denied claims overturned after appeal	17%	7%	22%	11%
Payment of claims within 30 days after initial denial	58%	69%	37%	35%

Presentation Outline

- Goals and Purpose of Managed Care Review
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- The Administrative Performance of the District's Health Plans
- MCO Medical Spending and Beneficiary Utilization Patterns**
- Care Coordination and Performance Against Program P4P Benchmarks
- Conclusions

The Notable Gap In Medical Service Costs For AmeriHealth Compared To The Other Full Risk MCOs Observed In 2018 Continued In The First Half Of 2019

Actual MCO Revenue for January 2019 to June 2019



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 as reported in MLR report/calculation provided by the MCOs. Total annual incurred claims (including IBNR) and cost containment expenses as of June 30, 2019, net of reinsurance recoveries.
 Source: MCO Quarterly Statements filed by the MCOs with the Department of Insurance, Securities, and Banking for the three full risk-based MCOs.

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

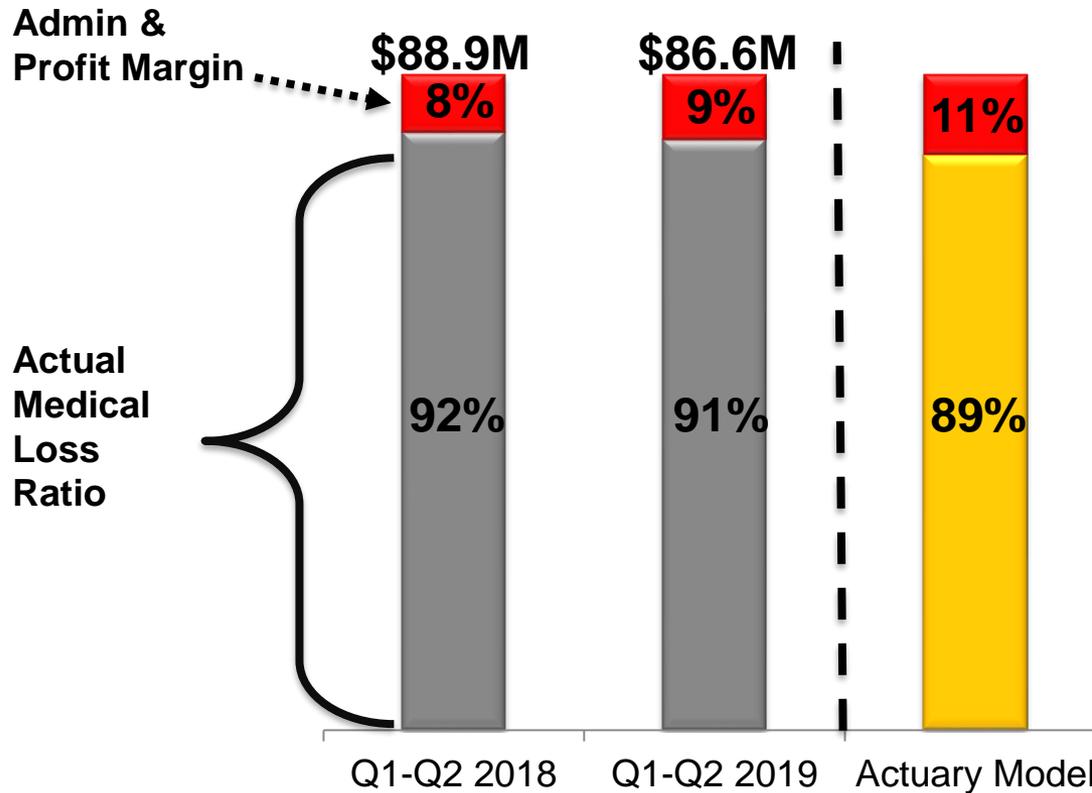
- ❑ DHCF and HSCSN entered into a risk sharing arrangement to limit the financial gains and losses under the contract through the application of risk corridors.
 - The arrangement sets risk corridors around an annual target Medical Loss Ratio established during rate setting. For the current rate setting period, the target MLR is 89 percent and the risk corridor applies to gains and losses of more than two percent. Thus, if the MCO experiences cost below 87 percent, the District shares in the financial gain.
 - Conversely, if HSCSN incurs cost above 91 percent, 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	Corridor Amount Due
<78%	100%	0%	100% to District
>78-87%	50%	50%	50% to District
>87-91%	0%	100%	No payment
>91-100%	50%	50%	50% to MCO
>100%	100%	0%	100% to MCO

- ❑ Thus far in 2019, HSCSN's medical expenses as a percent of its revenue (91%) was slightly above the threshold for the Medical Loss Ratio (89%) set during rate development; however, the marginal amount falls within the acceptable ranges and would not have triggered the risk-sharing provision if this was the final result for the annual reporting period.

In The First Half Of 2019 HSCSN Spent Slightly Above The 89 Percent Target For Risk Sharing Based On The Actuarial Model For 2019, In Line With 2018 Reported Results

HSCSN Revenue And Claims Cost For Q1-Q2 June 2018 Compared to Q1-Q2 June 2019



Risk Share Based on 89% MLR		
	Q1-Q2 2018	Q1-Q2 2019
Total (At Risk) or Underspend	\$(2.9M) ²	\$(1.6M) ²
Amount Due to MCO	\$0.6M ³	\$0 ³
Amount Due to District ¹	-	-

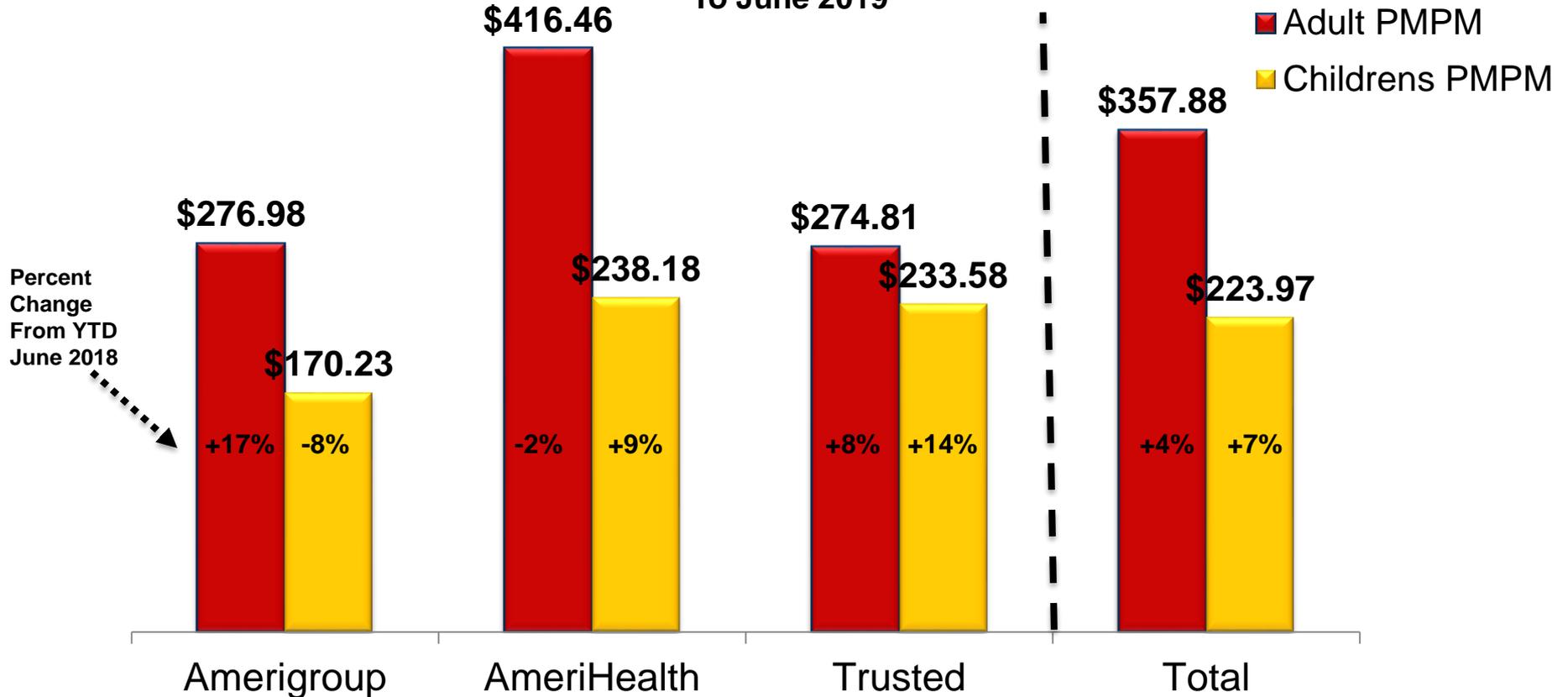
1. Estimated amount of surplus due to the District
 2. Estimated amount spent over level (At Risk) or under level (Underspend) set by Medical Loss Ratio
 3. Estimated amount payable to MCO based on allocation of at risk amount to District.

Notes: MCO revenue does not include DC Exchange/Premium Taxes and Risk Share, per the MLR letter and calculations provided by the MCO. Administrative expenses include all claims adjustment expenses as reported in quarterly balance and income statement reports, excluding cost containment expenses and DC Exchange/Premium taxes as reported in the income statement calculation provided by the MCO. Total annual incurred claims (including IBNR) and cost containment expenses as of June 30, 2019, net of reinsurance recoveries.

Source: Self reported quarterly statements submitted to DHCF by HSCSN.

Marginal Increases In Year-Over-Year Medical Expenses Were Observed In The First Half Of 2019 For Adults And Children In The Medicaid Program; AmeriHealth's Total PMPM Costs Remain Considerably Higher Than That Of The Other Two MCOs, Due To A Disproportionate Share Of High-Utilizer Enrollees With Rheumatoid Arthritis, Diabetes, And Asthma

Medicaid Adult And Children Medical Expenses Per-Member, Per-Month, January 2019 To June 2019

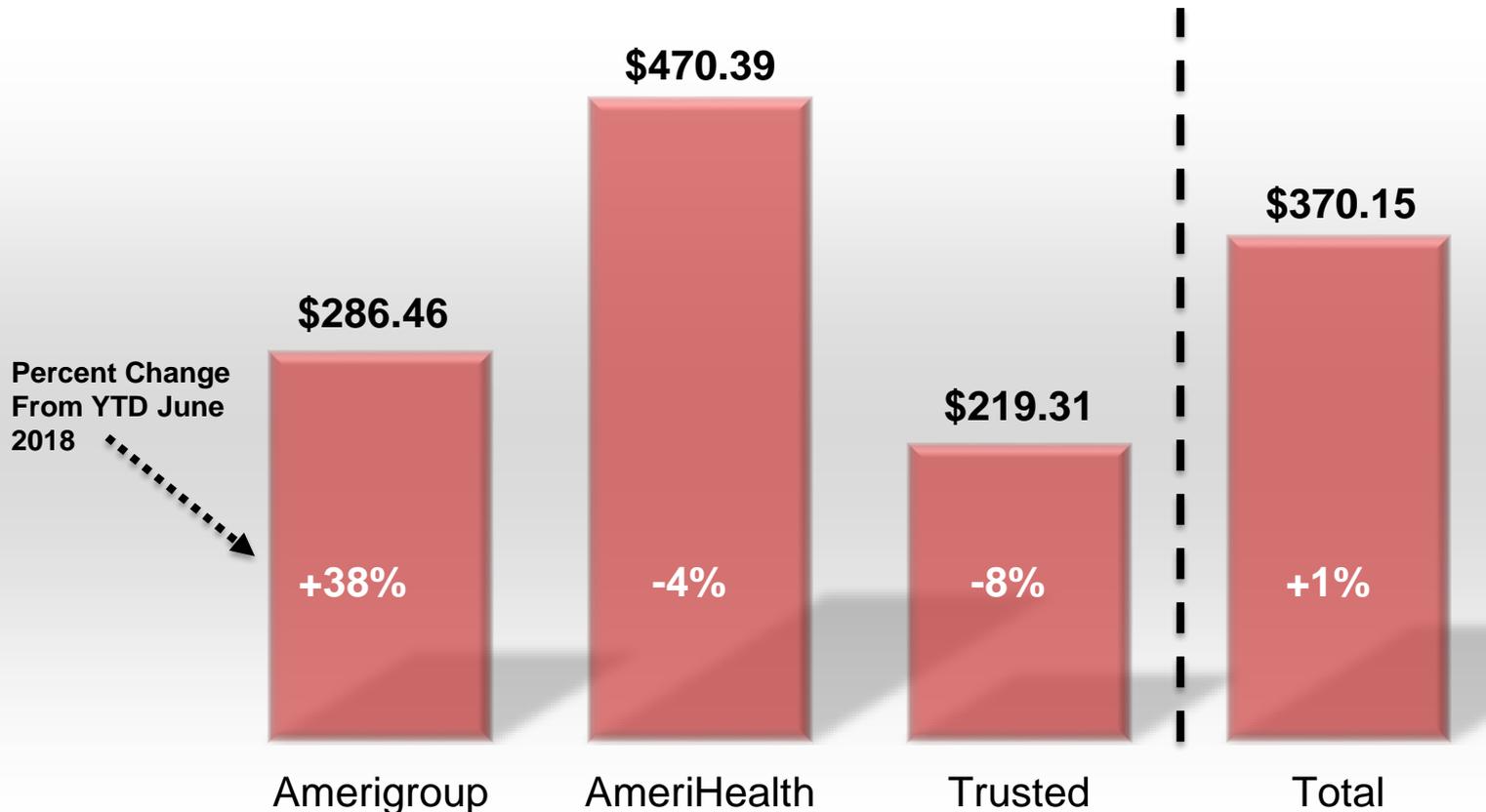


Notes: Incurred from January 1, 2019 to June 30, 2019, paid as of July 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2019 to June 30, 2019 compared to January 1, 2018 to June 30, 2018. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 21 in this analysis for the three full risk-based MCOs.

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

Though Overall Cost Growth Has Leveled-Off For The Alliance Population In Total, AmeriHealth's Costs Nearly Double That Of The Other Two MCOs On A Per-Member, Per-Month Basis Due In Part To Oncological Pharmaceutical Spending And Related Inpatient, Outpatient And Physician Medical Service Spending

Alliance Adult Medical Expenses Per-Member, Per-Month, January to June 2019

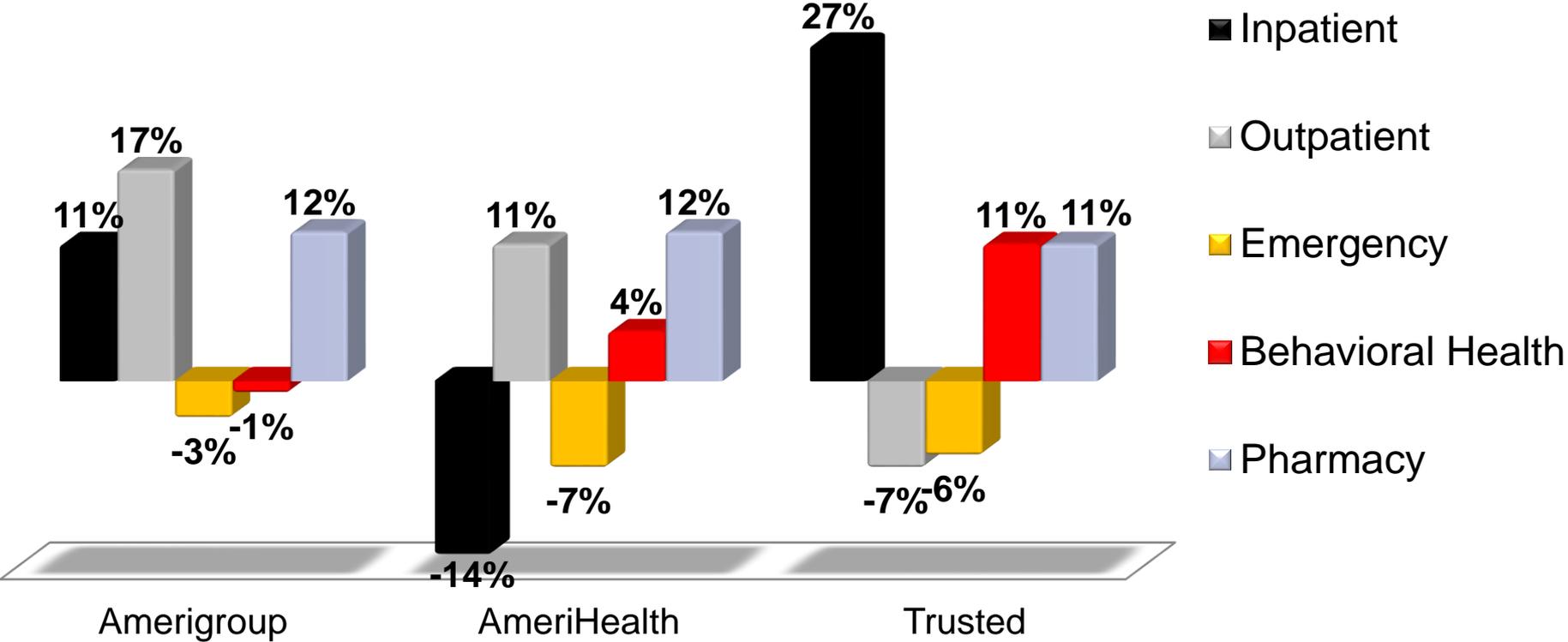


Notes: Incurred from January 1, 2019 to June 30, 2019, paid as of July 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2019 to June 30, 2019 compared to January 1, 2018 to June 30, 2018. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 21 in this analysis for the three full risk MCOs.

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

For Adults On Medicaid And Compared To The Same Time Period Last Year, Amerigroup and Trusted Reported Notable Cost Growth In Inpatient And Pharmacy High-Cost Service Categories, While AmeriHealth Experienced Reductions In Inpatient And Emergency Costs

Percent Change in Expenses From YTD June 2018 to YTD June 2019

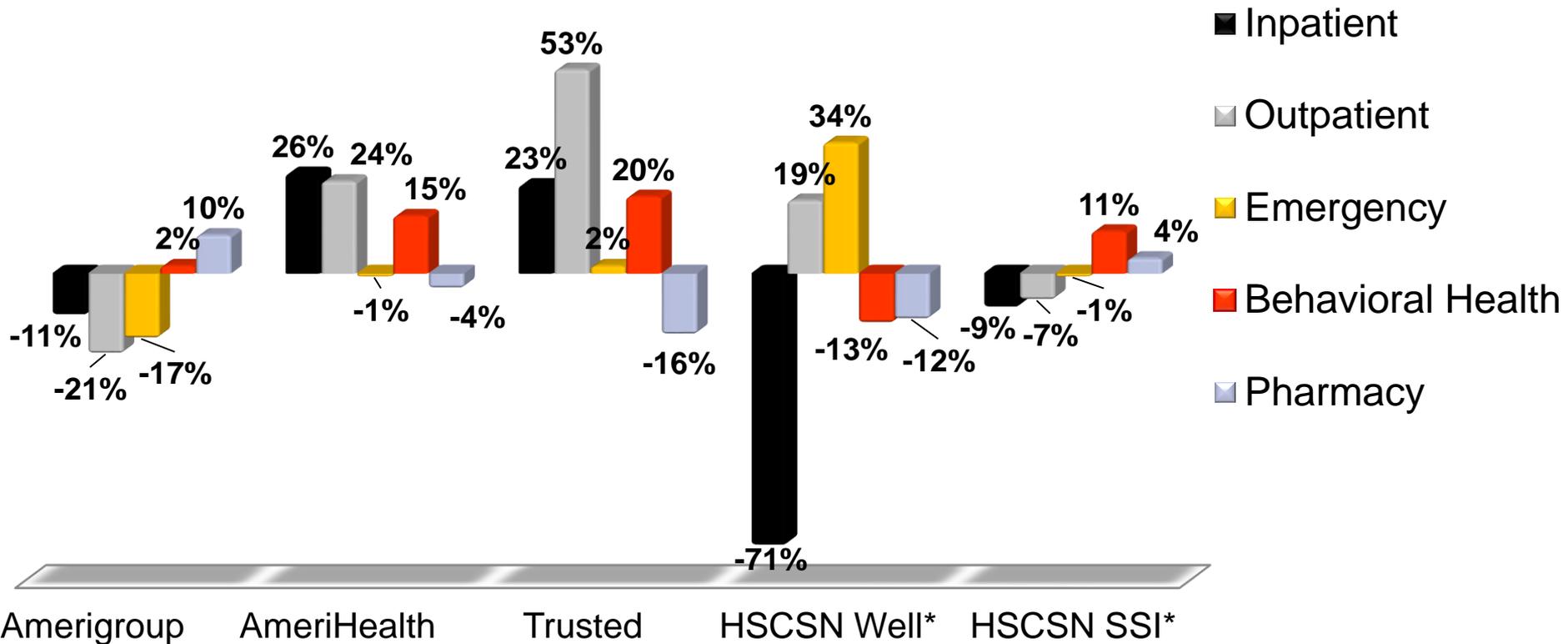


Notes: Incurred from January 1, 2019 to June 30, 2019, paid as of July 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2019 to June 30, 2019 compared to January 1, 2018 to June 30, 2018. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ.

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

For Children On Medicaid, As Compared To Prior Periods, AmeriHealth And Trusted Reported Notable Increases In Inpatient Costs, While Amerigroup And HSCSN Reported Considerable Decreases In Inpatient Expenditures For Both HSCSN's Well And SSI Populations

Percent Change in Expenses From YTD June 2018 to YTD June 2019

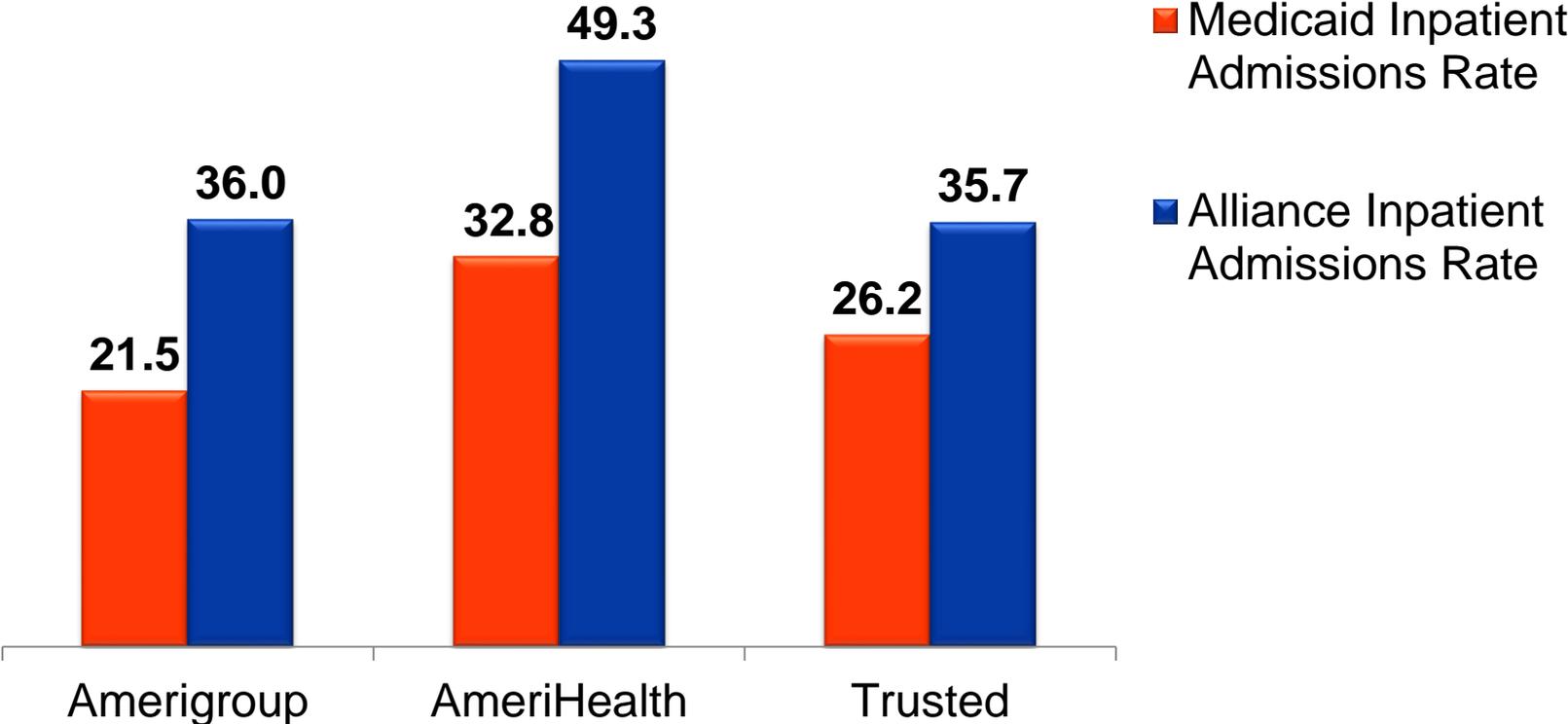


Notes: Incurred from January 1, 2019 to June 30, 2019, paid as of July 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2019 to June 30, 2019 compared to January 1, 2018 to June 30, 2018. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 21 in this analysis for the three full risk MCOs and age 26 for HSCSN. *HSCSN's financial results are reported for both the Well and children who have special health care needs and receive Supplemental Security Income (SSI) benefits.

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

AmeriHealth Inpatient Admission Rates Remain Higher Than The Other Two MCOs, Undoubtedly Related To The Higher Risk Members That Have Transferred Into The Plan

Total Number Of Inpatient Admissions Q1 – Q2 CY2019 Per 1000 Members



Notes: The current frequency of Index Admissions analysis for the period January 2019 to June 2019 includes encounters that are stamped by DHCF's MMIS both "Paid and Denied" encounters. These encounters include Medicare crossover claims.

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

AmeriHealth Continues To Report Higher Medical Costs And Corresponding Enrollee Risk Scores For Both The Adult And Child Population; Not Observed For The Other Two Full Risk MCOs

Ranking On Enrollee Risk Scores As Of May 2019

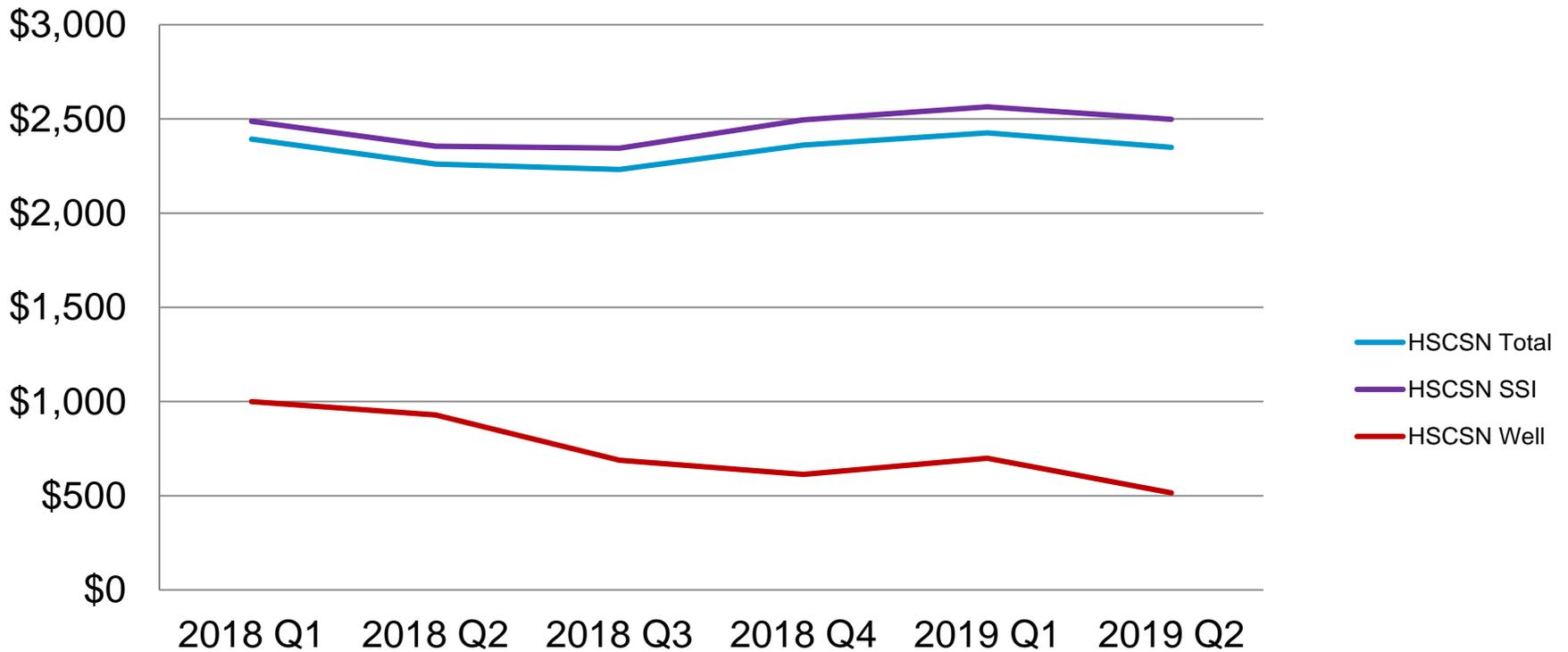
		Low	Medium	High
Ranking On Medical Cost	Low	Amerigroup – Adult Amerigroup – Child Trusted - Adult		
	Medium		Trusted - Child	
	High			AmeriHealth – Adult AmeriHealth – Child

Notes: Expenses incurred from January 1, 2019, to June 30, 2019, and paid as of July 31, 2019. The expenses do not reflect adjustments to account for IBNR claims. Children are defined as persons up to age 19 in this analysis. Risk scores are derived from pharmacy data, and were applied retroactively to capitation rates paid starting May 1, 2019 to better align payments with cost. For capitation rates paid from January to April 2019, age and gender factors were applied.

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

HSCSN's Total Medical Expenses Align With 2018, With Low Emerging Trends Driven By Home Health And Behavioral Health Services

HSCSN's Medicaid Children Medical Expenses Per-Member, Per-Month, Q1 2018 Through Q2 2019

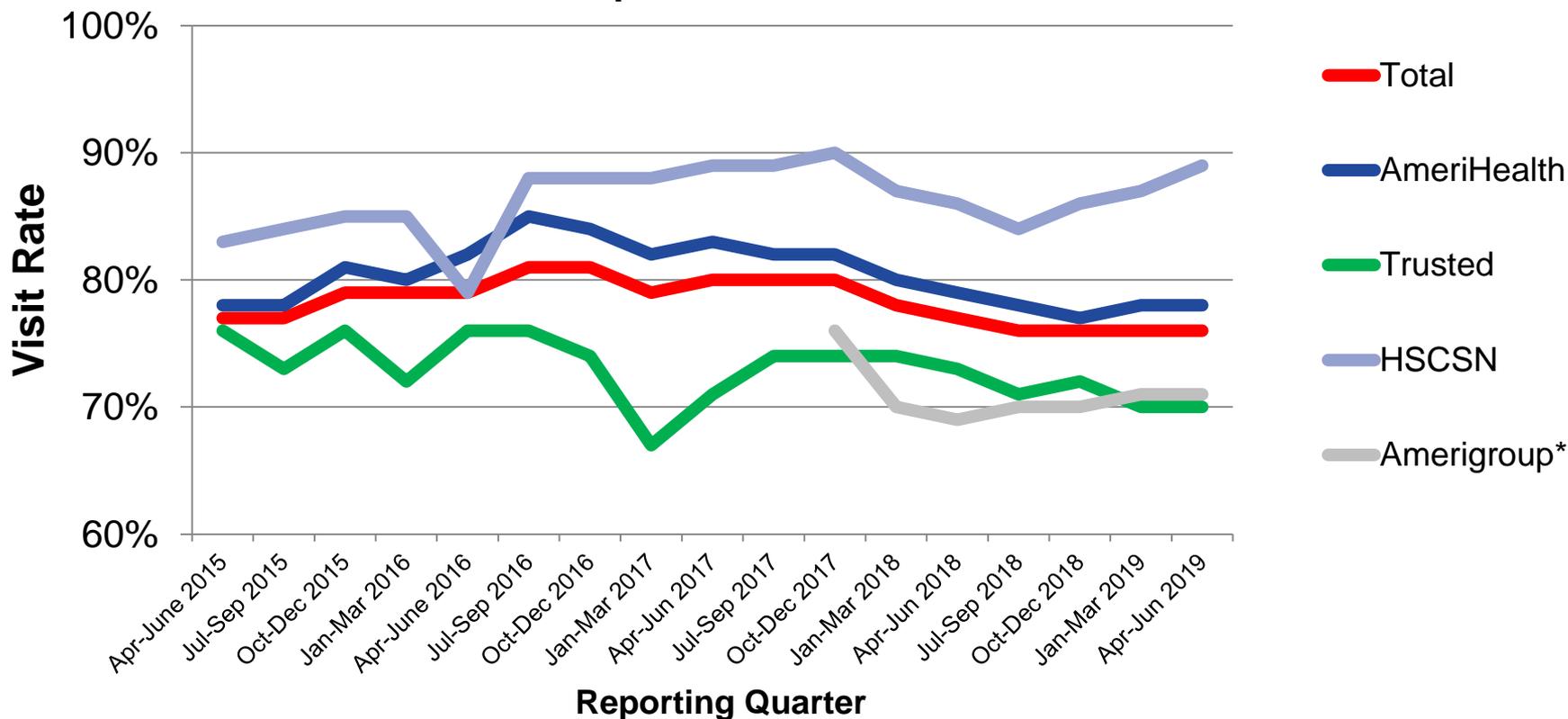


Notes: Expenses incurred from January 1, 2019, to June 30, 2019, and paid as of July 31, 2019. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 26 for HSCSN. HSCSN's financial results are reported for both the Well and children who have special health care needs and receive Supplemental Security Income (SSI) benefits.

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

Annual Children's Physician Visit Rates Increased Slightly For Most Plans Compared To 2018 Results, Except For Trusted

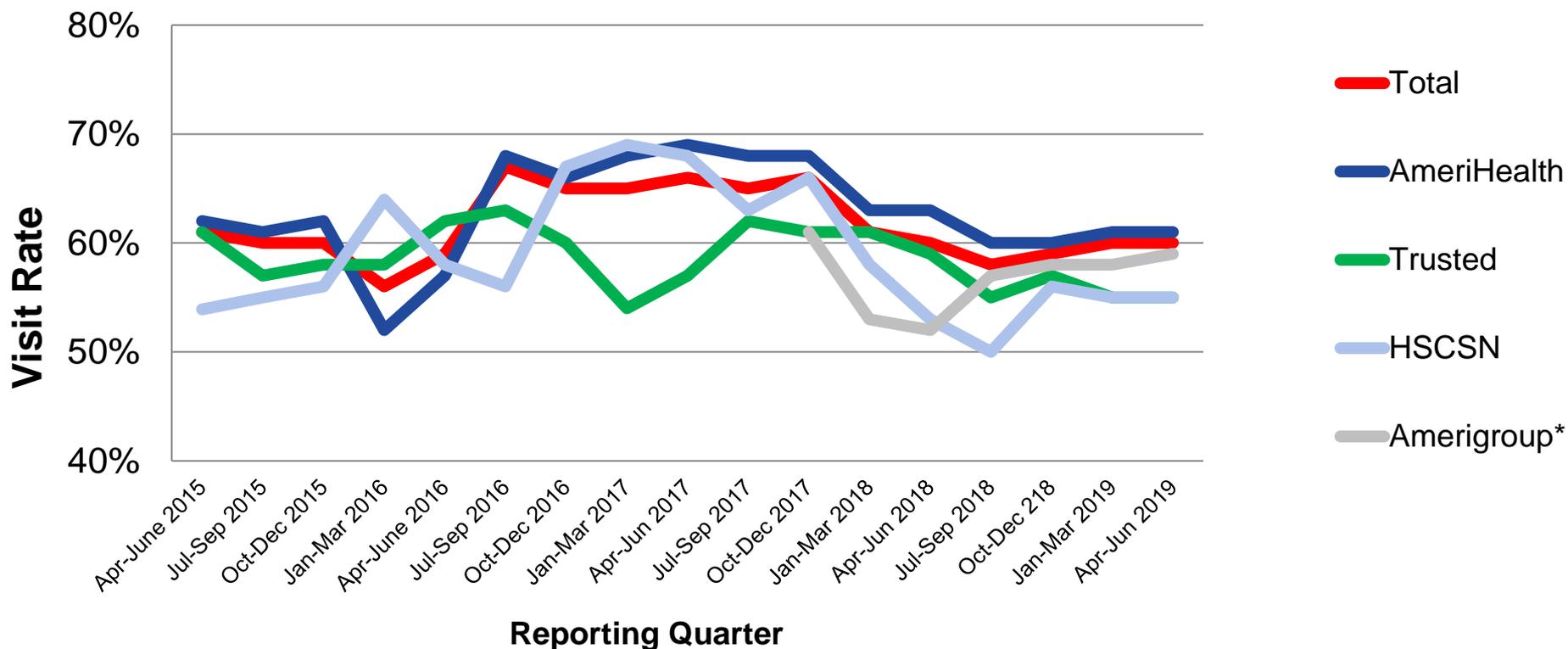
Medicaid Annual Physician Care Visit Rates For Children Enrolled In Managed Care, April 2015 to June 2019



Notes: In each quarter, only members who were enrolled with the MCO for three months continuously during the period and had 6 months of continuous Medicaid participation from that quarter are included in this analysis. This analysis is based on encounters from DHCF's MMIS system and does not include supplemental MCO data, which may cause results to differ from similar rates calculated in other reports. *In 2017 DHCF awarded new contracts for the District MCOs for FY18. Amerigroup's results represent data from October 2017 through June 2019. Source Encounter data submitted by MCOs to DHCF.

Well-Child Children's Visit Rates Increased Slightly For Most Plans In CY2019 Q1-Q2, Except Trusted And HSCSN

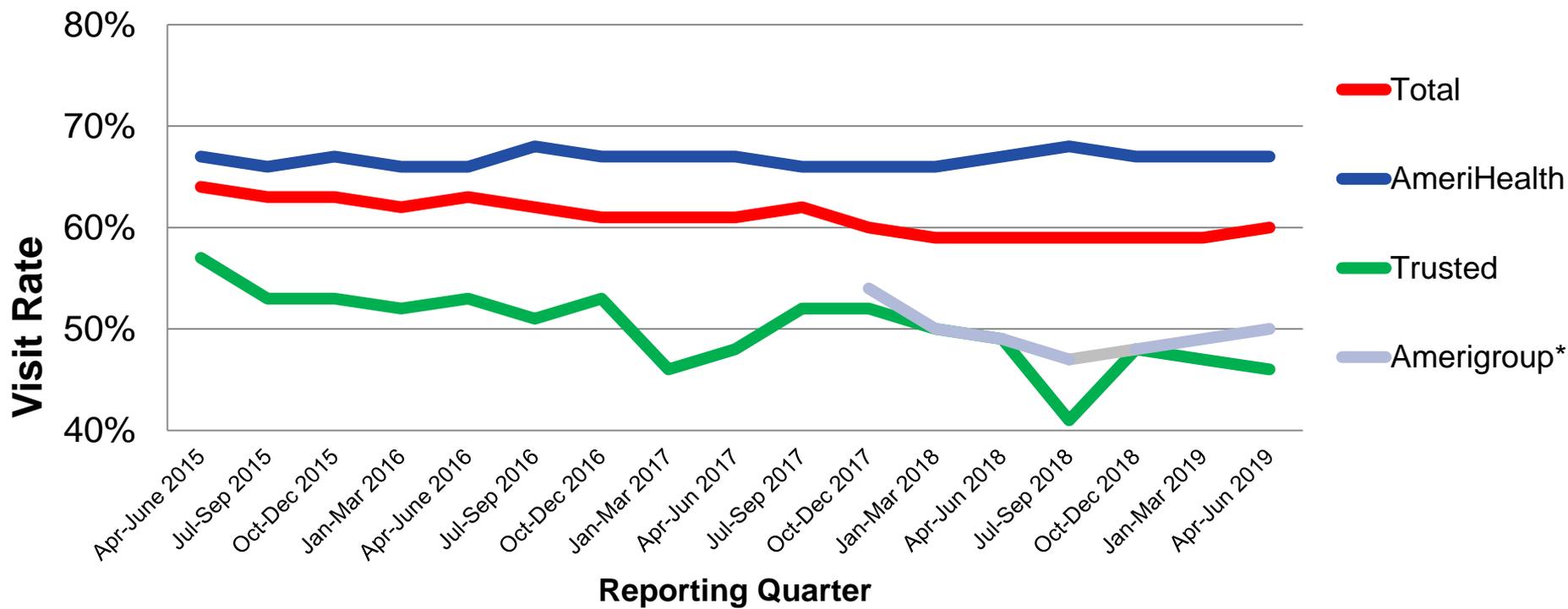
Medicaid Annual Well-Child Visit Rates For Children Enrolled In Managed Care, April 2015 to June 2019



Notes: In each quarter, only members who were enrolled with the MCO for three months continuously during the period and had 6 months of continuous Medicaid participation from that quarter are included in this analysis. This analysis is based on encounters from DHCF's MMIS system and does not include supplemental MCO data, which may cause results to differ from similar rates calculated in other reports. *In 2017 DHCF awarded new contracts for the District MCOs for FY18. Amerigroup's results represent data from October 2017 through June 2019. Source: Encounter data submitted by MCOs to DHCF.

Annual Adult Physician Visit Rates Are Mostly Unchanged, With A Slight Increase For Amerigroup And Decreases For Trusted In CY2019 Q1-Q2

Medicaid Annual Physician Care Visit Rates For Adults Enrolled In Managed Care, April 2015 to June 2019

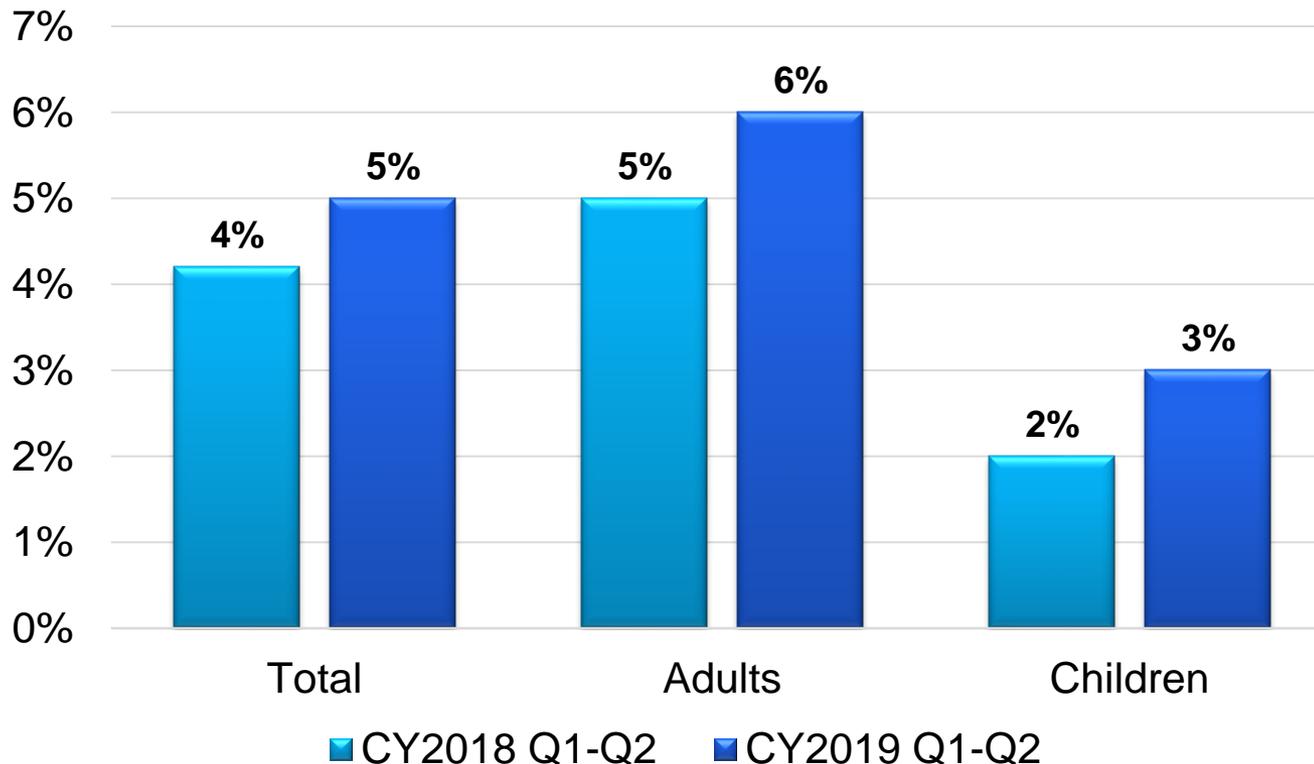


Notes: In each quarter, only members who were enrolled with the MCO for three months continuously during the period and had 6 months of continuous Medicaid participation from that quarter are included in this analysis. This analysis is based on encounters from DHCF's MMIS system and does not include supplemental MCO data, which may cause results to differ from similar rates calculated in other reports. *In 2017 DHCF awarded new contracts for the District MCOs for FY18. Amerigroup's results for 2017 represent data from October 2017 through June 2019.

Source: Encounter data submitted by MCOs to DHCF.

Utilization Rate For Medicaid-Funded Mental Health Rehabilitation Services Increased From CY2018 Q1-Q2 To CY2019 Q1-Q2

Percent of MCO Members Receiving Mental Health Rehabilitation Services During CY2018 Q1-Q2 and CY2019 Q1-Q2

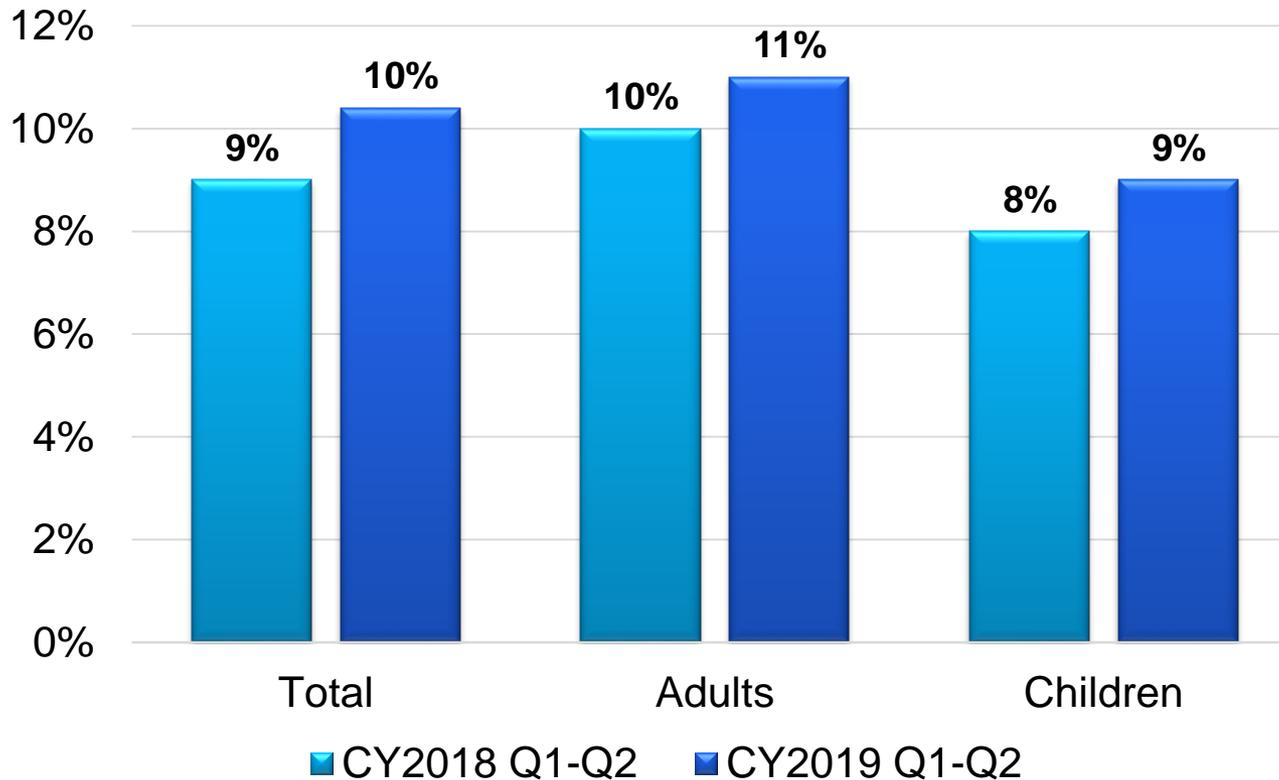


Total MCO Enrollment by Population Group, Regardless of Service Use

Population Groups	CY2018 Q1-Q2	CY2019 Q1-Q2
Adults	131,089	124,830
Children	75,492	77,059
Total	206,581	201,889

Utilization Rate For Any Outpatient Mental Health Services Also Increased From CY2018 Q1-Q2 To CY2019 Q1-Q2

Percent of MCO Members Receiving Any Mental Health Services During CY2018 Q1-Q2 and CY2019 Q1-Q2



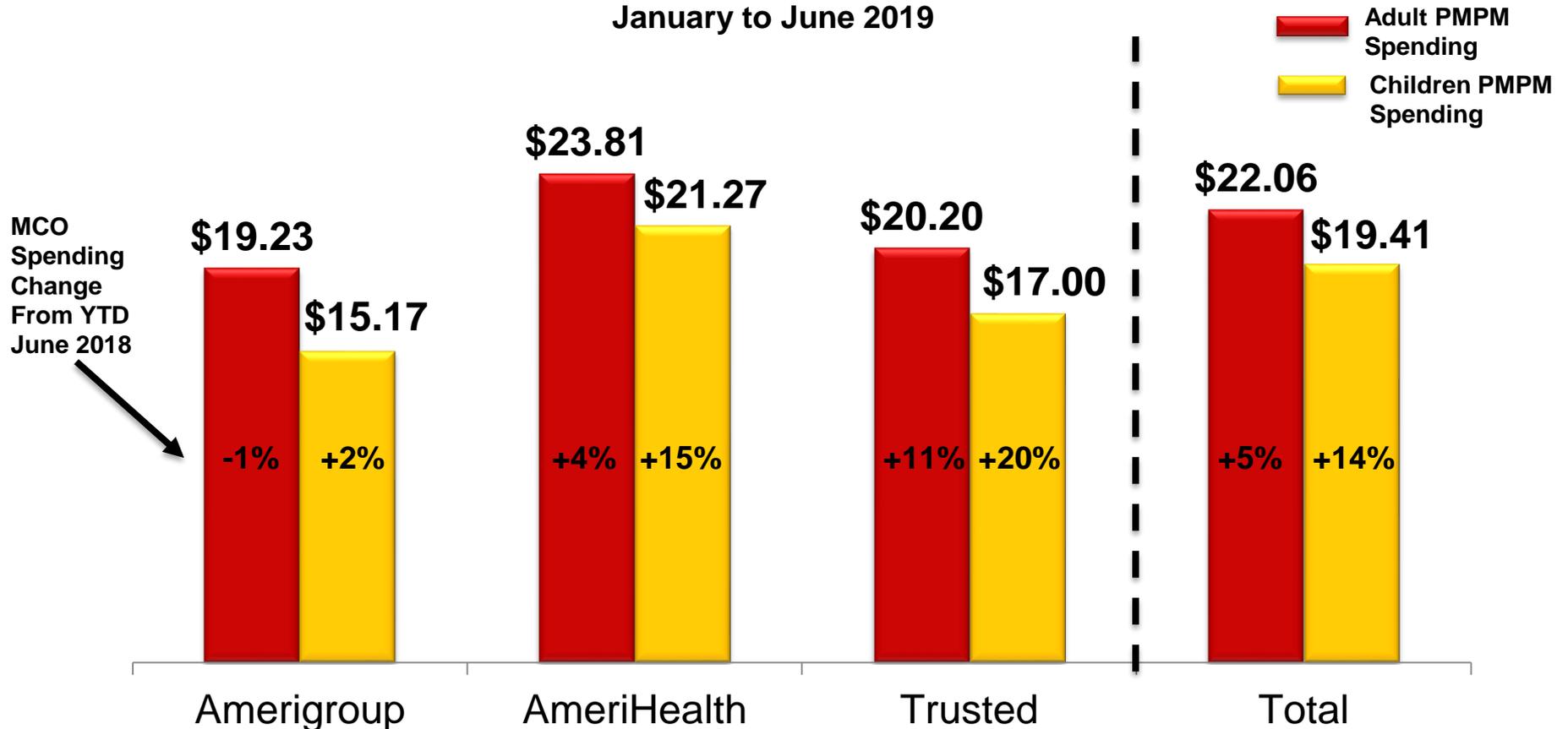
Total MCO Enrollment by Population Group, Regardless of Service Use

Population Groups	CY2018 Q1-Q2	CY2019 Q1-Q2
Adults	131,089	124,830
Children	75,492	77,059
Total	206,581	201,889

Notes: The data presented above are based on claims from MMIS with dates of service from January 1 – June 30, 2019, with a claims run out period through August 2019. Source: MMIS claims data. Any outpatient mental health services are identified using a combination of procedure and diagnosis codes on claims. These services are delivered by various providers such as free standing mental health clinics (FSMHS).

Overall On A Per-Member, Per-Month Basis MCOs Continued Their Five-Year Trend Of Increased Spending On Medicaid-Funded Behavioral Health Services

Per-Member, Per-Month MCO Expenses For Behavioral Health Services, January to June 2019



Notes: Incurred from January 1, 2019 to June 30, 2019, paid as of July 31, 2019 for Amerigroup, AmeriHealth and Trusted. Change in average PMPM expense, January 1, 2019 to June 30, 2019 compared to January 1, 2018 to June 30, 2018. IBNR is estimated based on historical payment lags. This short runout period results in a high degree of uncertainty for IBNR estimates and final results will differ. Children defined as person up to age 21 in this analysis for the three full risk MCOs.

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

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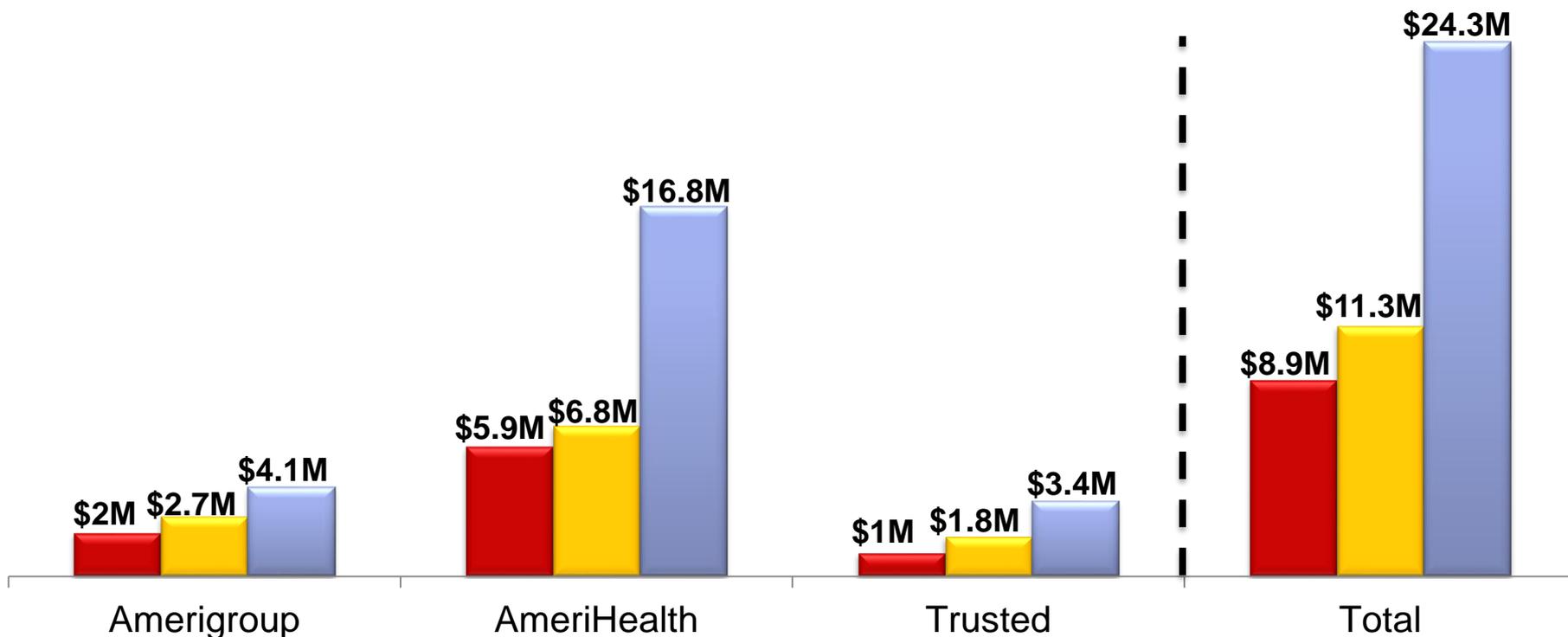
DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The MCOs To Coordinate Enrollee Care

- ❑ 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.
- ❑ After reviewing several years of data, DHCF can now more closely examine the following performance indicators for each of the District's three MCOs:
 - 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.

All Three MCOs Can Save Millions By Reducing Their Medicaid Members' Use Of The ER For Non-Emergencies, Reducing Potentially Avoidable Hospital Admissions, And Slowing The Rate Of Hospital Readmissions

Managed Care Spending Attributed To Beneficiary Outcomes That Are Potentially Avoidable Through The Use Of Robust Care Coordination Programs

■ Low Acuity ER ■ Avoidable Admissions ■ Hospital Readmissions



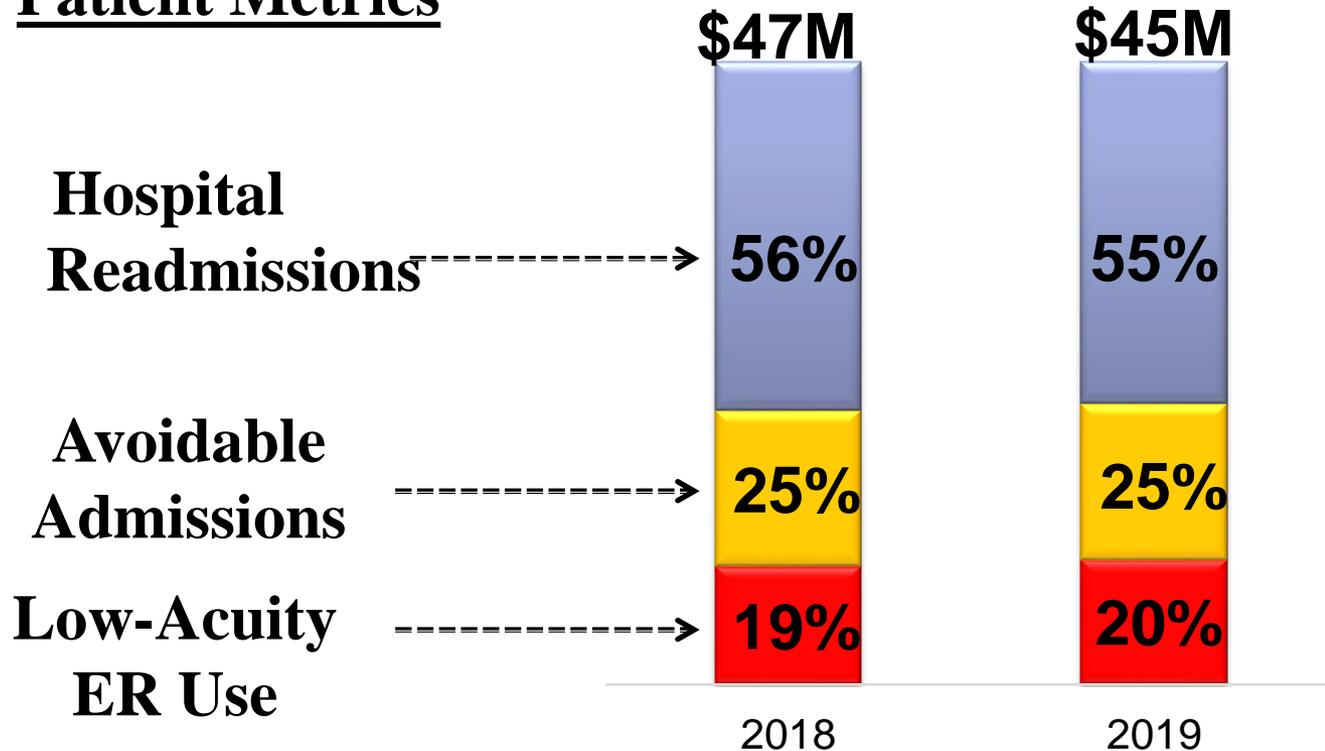
Notes: Current annual results for 2019 reflect data incurred in April 2018 through March 2019 with payment runout through June 2019. Total avoidable costs include Health Home enrollees. The amounts listed as potentially avoidable would likely be offset by other costs if the MCOs improved their care management, such as increased outpatient costs due to increased use of outpatient facilities.

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

In Total Approximately \$45 Million In Managed Care Expenses Were Potentially Avoidable*

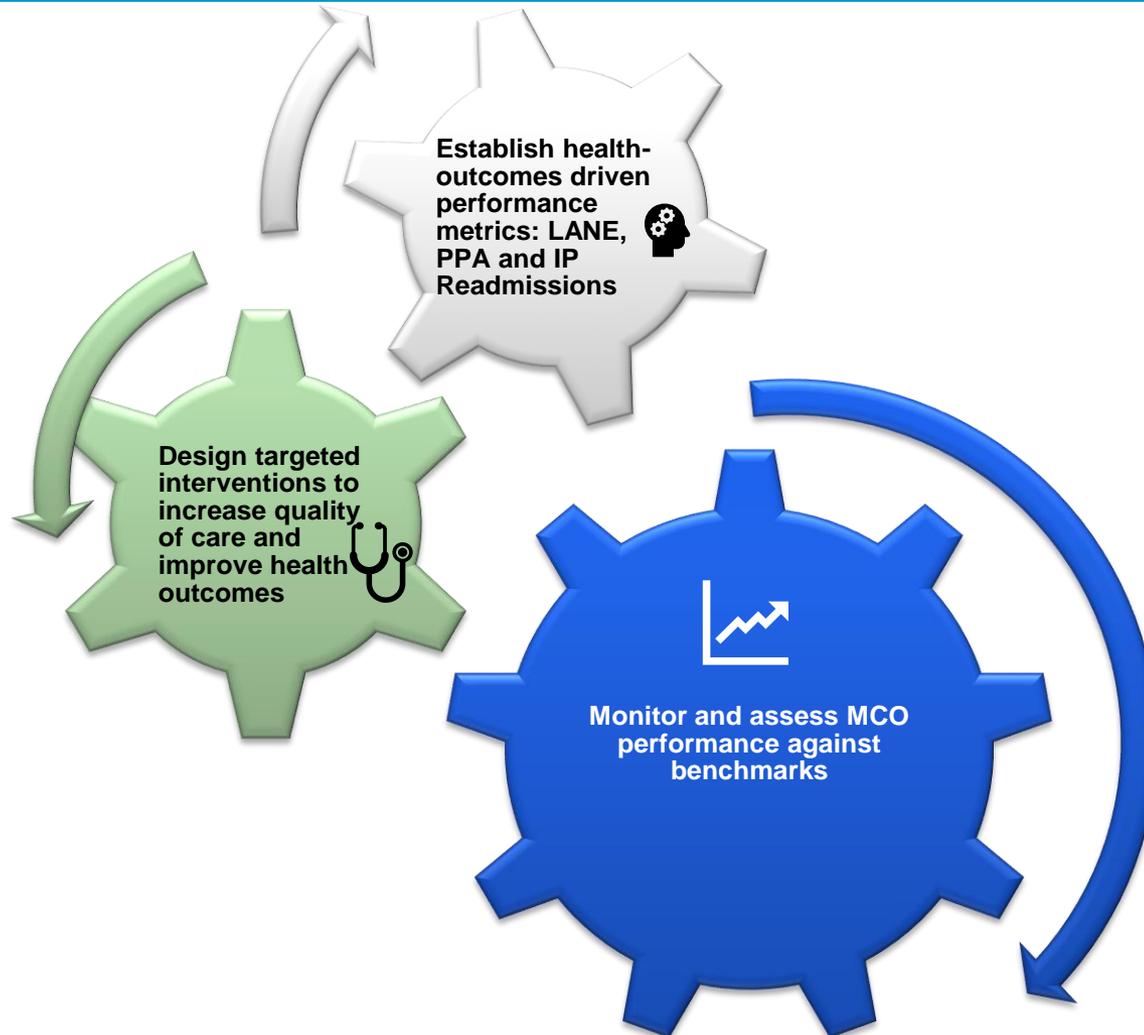
Comparison Of MCO Potentially Avoidable Spending 2018 To 2019

Patient Metrics



Notes: *Current annual results for 2019 reflect data incurred in April 2018 through March 2019 with payment runout through June 2019. The amounts listed as potentially avoidable would likely be offset by other costs if the MCOs improved their care management, such as increased outpatient costs due to increased use of outpatient facilities. Low acuity non-emergent visits are emergency room visits that could have been potentially avoided, identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that are within 30 days of a qualifying initial inpatient admission.
Source: Mercer analysis of MCO Encounter data for DCHFP reported by the MCOs to DHCF.

Pay-For-Performance (P4P) Process At A Glance



In FY2017, DHCF Launched Pay-For-Performance Program As An Incentive For MCOs To Address Care Coordination Problems

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

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

Program Structure Is Based On Cash Withhold

- ❑ The program is funded through a two-percent (2%) withhold of each MCO's actuarially sound capitation payments for non-delivery DCHFP rate cells for the corresponding period. For the current 2019 reporting period, the capitation withhold has been suspended.
- ❑ The 2% withhold is the profit margin for each MCO that is factored into the base per-member, per-month payment rate. Year 3 P4P actual results are based on FY19 (October 2018 – September 2019) experience compared to the Year 1 baseline.
- ❑ The baseline period used to set the target remains April 1, 2015 through March 31, 2016, with runout through September 2016. MCOs must meet the minimum threshold for improvement for all three performance measures in order to earn any portion of the withhold.

Weighting And Scoring System For Pay-For-Performance

- ❑ A scoring system was implemented 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:
 - 10% 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.
 - 7.5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 50% of the of the 33% withhold attributed to these measures.
 - 5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 25% of the 33% withhold attributed to these measures.
 - If reduction in LANE utilization and PPAs are less than the minimum 5% standard from the baseline, the MCOs do not earn any portion of the 33% withhold attributed to the relevant measure.

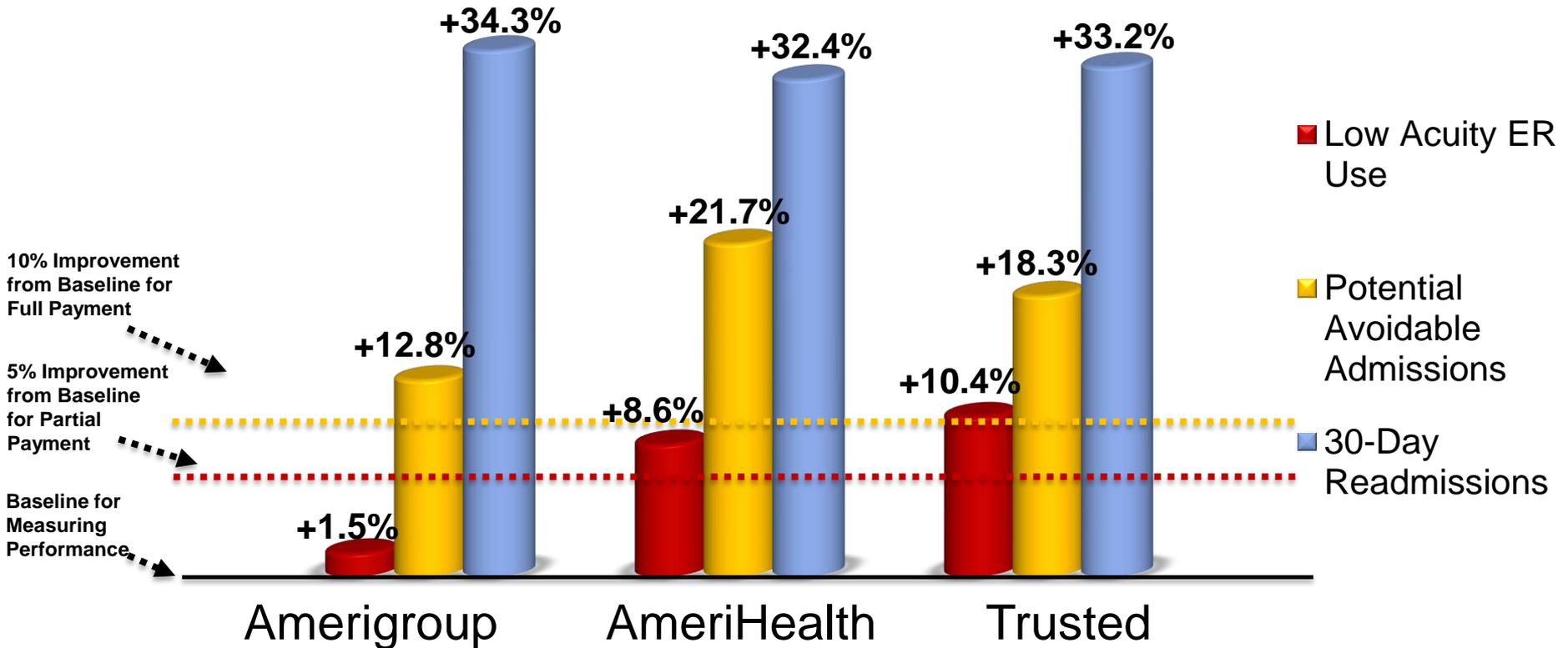
Weighting And Scoring System For Pay-For-Performance

(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 25%, 50% or 100% of the 34% withhold attributed to the measure by demonstrating reductions at 5%, 7.5% and 10% respectively.
- ❑ DHCF relies upon 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 7 months after the measurement period closes in years when the withhold is in effect.

When Comparing The Most Recent Full Year Of Data To Baseline Results, The Majority Of MCOs Met Or Exceeded Established Targets For Pay-For-Performance Quality Measures

Comparison Of 2019 Results To Year One Baseline



Notes: Low acuity non-emergent visits are emergency room visits that could have been potentially avoided, identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that are within 30 days of a qualifying initial inpatient admission. Baseline reflects data incurred April 2015-March 2016. The Year 2 Pay-For-Performance target for each plan is set based on a 10% expected improvement to the baseline for each metric for full payment of withhold, and a 5% minimum improvement on each metric to receive any portion of withhold. Final metrics are net of Health Home enrollees. Current annual results reflect data incurred in April 2018 through March 2019 with payment runout through June 2019, compared to the Baseline.

Source: Mercer analysis of MCO DCHFP Encounter data reported by the MCOs to DHCF.

Presentation Outline

- Goals and Purpose of Managed Care Review
- Summary Of Key Findings
- The Financial Performance of the District's Health Plans
- The Administrative Performance of the District's Health Plans
- MCO Medical Spending and Beneficiary Utilization Patterns
- Care Coordination and Performance Against Program P4P Benchmarks
- Conclusions**

Path To Medicaid Reform For Managed Care

DHCF is focusing on the following Medicaid reform activities in the near and long-term, in order to improve outcomes of Medicaid beneficiaries and create a sustainable healthcare delivery system:

- **More value over volume:** increase expectations for value-based purchasing through managed care, including redesign MCO P4P program to target key conditions of MCO population
- **Increased access to care:** require universal contracting for key providers to mitigate adverse selection in managed care and prevent MCOs from falling short of medical spending requirements
- **Equal distribution of members:** to combat historical erosion of plan membership experienced amongst managed care plans, DHCF will employ equal distribution of membership across the MCOs in 2020
- **Better alignment of payment with underlying health conditions:** adopt a new diagnostic and pharmacy combined risk-adjustment model to better assess beneficiary risk and curtail growing costs for MCOs with high-acuity, high-cost enrollees
- **More coordinated care:** transition FFS Medicaid population to managed care and expand care management requirements for highly vulnerable populations