



District of Columbia's Managed Care Quarterly Performance Report

(January 2015 – June 2015)

Department of Health Care Finance

December 2015
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.
 - Monthly, more than 188,000 Medicaid beneficiaries and just over 15,000 Alliance members 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)
- ❑ Three of these health plans -- AmeriHealth, MedStar, and Trusted -- offer comprehensive benefits and operate under full risk-based contracts 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. These plans are the focus of this report

DHCF Implements A Performance Review Of Its Managed Care Program

- ❑ The contracts for these three 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-minimus 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 health plans

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 successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of health care services
2. Provide objective data on the performance of the health plans across a number of domains to inform decision making about possible policy changes for the managed care program
3. Facilitate an annual report card evaluation of each MCO to help guide decisions regarding contract renewals for the health plans

Focus Of The Performance Review

- ❑ This report mostly focuses on the period covering the first two quarters of 2015. The following questions are addressed for each MCO.
 - What was the financial condition of MCOs during the first six months of 2015? Were annual 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 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?

Focus Of The Performance Review (continued)

- What was the rate at which Medicaid beneficiaries used the emergency room for low acuity or non-emergency health problems? What proportion of these visits should the health plans have been reasonably expected to prevent?
- What proportion of inpatient hospital admissions for Medicaid beneficiaries over the 12-month period were potentially avoidable? What proportion of these potentially avoidable admissions should the health plans have been reasonably expected to prevent.
- Were the level of hospital readmissions a problem for the health plans' members? If so, what proportion of those readmissions should the MCOs have been expected to prevent?

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Summary Of Key Findings

- ❑ This report summarizes the 6-month performance 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

- ❑ The strong financial performance observed for both Trusted and AmeriHealth in 2015 has been sustained over the first six months of 2015. Meanwhile, MedStar, which incurred significant losses in 2014, reported an operating profit for the first two quarters of 2015 of \$3 million – 3 percent. Moreover, all three plans report sufficient liquidity to cover expenses for a significant number of days without having to use long-term assets.
- ❑ The health plans also had ample monthly reserves to pay claims that have been incurred but were not submitted for payment during the 6-month period. However, Trusted's cash reserves are inflated by an unusually high denial of inpatient claims that was associated with the execution of new edit criteria. This development bears close monitoring in the future.

Summary Of Key Findings

(continued)

Financial Conditions (continued)

- ❑ All three health plans have Risk-Based Capital (RBC) positions that are above the required level of 200%. MedStar injected the required capital to increase its RBC by nearly 150 percent over the insufficient level reported by the health plan in 2014.

Administrative Performance

- ❑ For the most part, the three health plans successfully executed the major administrative requirements of the program during the first six months of 2015. The provider networks continue to be strong and appropriately diverse to meet the varied medical needs of the beneficiaries in the plans. Claims are being paid on time -- within 30 days as required by prompt payment rules -- and, based on a full year of data from 2014, there is no evidence that the health plans have been unjustifiably denying claims to build cash reserves.
- ❑ As stated, though, in the 1st two quarters of 2015, Trusted reported a large number of denied inpatient claims that management attributed to new payment edits. This problem, which significantly inflated Trusted's liquidity measures, is being addressed by the health plan.
- ❑ Finally, the process of submitting encounter claims has improved for all plans in general, but Trusted needs to give more attention to lingering issues of accuracy and timeliness.

Summary Of Key Findings

(continued)

Medical Expenses

- ❑ The three health plans met the required spending level for medical expenses of 85 percent. While MedStar continues to have the highest cost beneficiaries on a per-member-per-month basis, there was no growth in their membership's medical expenses from last year. At the same time, MedStar's spending on children dropped sharply from 2014.
- ❑ By comparison, AmeriHealth and Trusted are experiencing lower costs from last year for their adult Medicaid populations but the medical expenses for children have risen significantly. Moreover, the observed drop in inpatient cost for Trusted is likely an artifact of new system edits and is not likely to be sustained.
- ❑ Despite success in containing medical spending over previous year's level, the beneficiaries' cost for MedStar, and to a lesser degree Trusted, are still not aligned with overall member risk levels. Unaddressed, this will create future net income challenges.

Summary Of Key Findings

(continued)

Medical Expenses (continued)

- ❑ Alliance beneficiaries are becoming increasingly more expensive to cover with both AmeriHealth and MedStar witnessing double digit growth rates. Trusted shows a decline in expenses for this group but again, this is undoubtedly related to the high denial of inpatient hospital claims.
- ❑ The physician visit rates for adults and children in 2014 were generally positive and this pattern reemerged in 2015. In both quarters, nearly 8 of 10 children on Medicaid visited a physician with AmeriHealth having the highest visit rate. For adults, the visit rate was lower at 65 percent but steady for all plans except Trusted. Notably, 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 January 31, 2016.

Summary Of Key Findings

(continued)

Care Coordination

- ❑ The care coordination challenges that plagued the District's three full-risk health plans in 2014 have not abated in the first two quarters of 2015. Namely, their members' use of the emergency room for routine care, the repeated occurrences of potentially avoidable hospital admissions, and the problem of hospital readmissions remain stubborn challenges.
- ❑ As has been shown, these problems come with a cost. Current estimates suggest the health plans are spending an additional \$36 million more per year due to this problem with the highest cost -- \$18 million -- generated by hospital readmissions.
- ❑ To encourage better performance against these core measures, DHCF will initiate a pay-for-performance program beginning January 1, 2016. This program will require the health plans to show measurable improvement against benchmarks for these indicators or face the loss of up to 2 percent of their capitated payment.

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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%. 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% 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 beneficiaries evince greater medical risk in the form of disease prevalence, receive higher risk scores and greater payments. MCOs with lower risk members 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 members 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 requirement
 - 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 first report on the health plan's management of the denied claims process in June 2015 and some of the results are summarized in this document

For Medicaid Membership, MedStar Has Experienced A 28 Percent Growth Rate Since The Beginning Of The Five-Year Contract Period

MCO	Medicaid July 2013 Enrollment	Medicaid June 2015 Enrollment	Net Change
AmeriHealth	91,585	97,065	5,480 (+5.9)
MedStar	32,536	41,817	9,281 (+28.5)
Trusted	26,204	27,443	1,239 (+4.7)

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

MCO	Medicaid & Alliance July 2013 Enrollment	Medicaid & Alliance June 2015 Enrollment	Net Change
AmeriHealth	98,019	103,980	5,961 (+6.0)
MedStar	35,911	45,334	9,423 (+26.2)
Trusted	28,803	30,245	1,442 (+5.0)

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

The Revenue For All Three Health Plans Was Sufficient To Cover Both Claims And Administrative Cost During The First Six Months Of 2015

MCO Revenue and Expense Data for January 2015 to June 2015

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

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	\$226.0M	\$191.5M	\$19.0M	\$15.5M
MedStar	\$102.7M	\$93.3M	\$6.3M	\$3.0M
Trusted	\$62.8M	\$53.5M	\$6.8M	\$2.5M

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 June 30 2015, 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

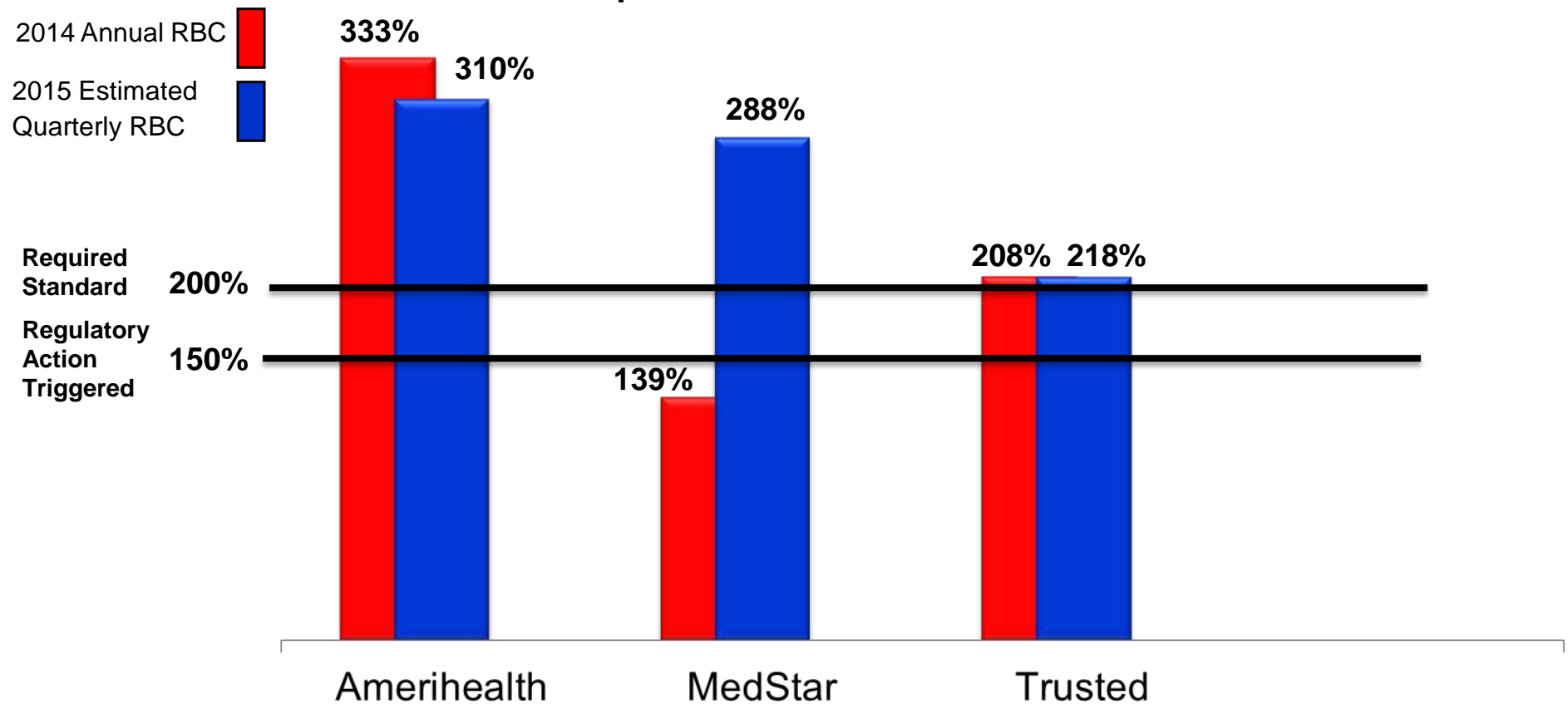
- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims
- ❑ MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) which 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 2014 financial statement filed with DISB to a more recent 6-month proxy measure for 2015 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% or more of Authorized Control Level.
 2. **Company Action Level** - Total Adjusted Capital of 150% to 200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.
 3. **Regulatory Action Level** - Total Adjusted Capital of 100 to 150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems
 4. **Authorized Control Level** - Total Adjusted Capital 70 to 100% of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.
 5. **Mandatory Control Level** - Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

Currently All Three Health Plans Report Risk Based Capital Levels That Exceed The Required Threshold

Estimated 2015 Quarterly Risk-Based Capital For Managed Care Plans Compared To 2014 Annual Level



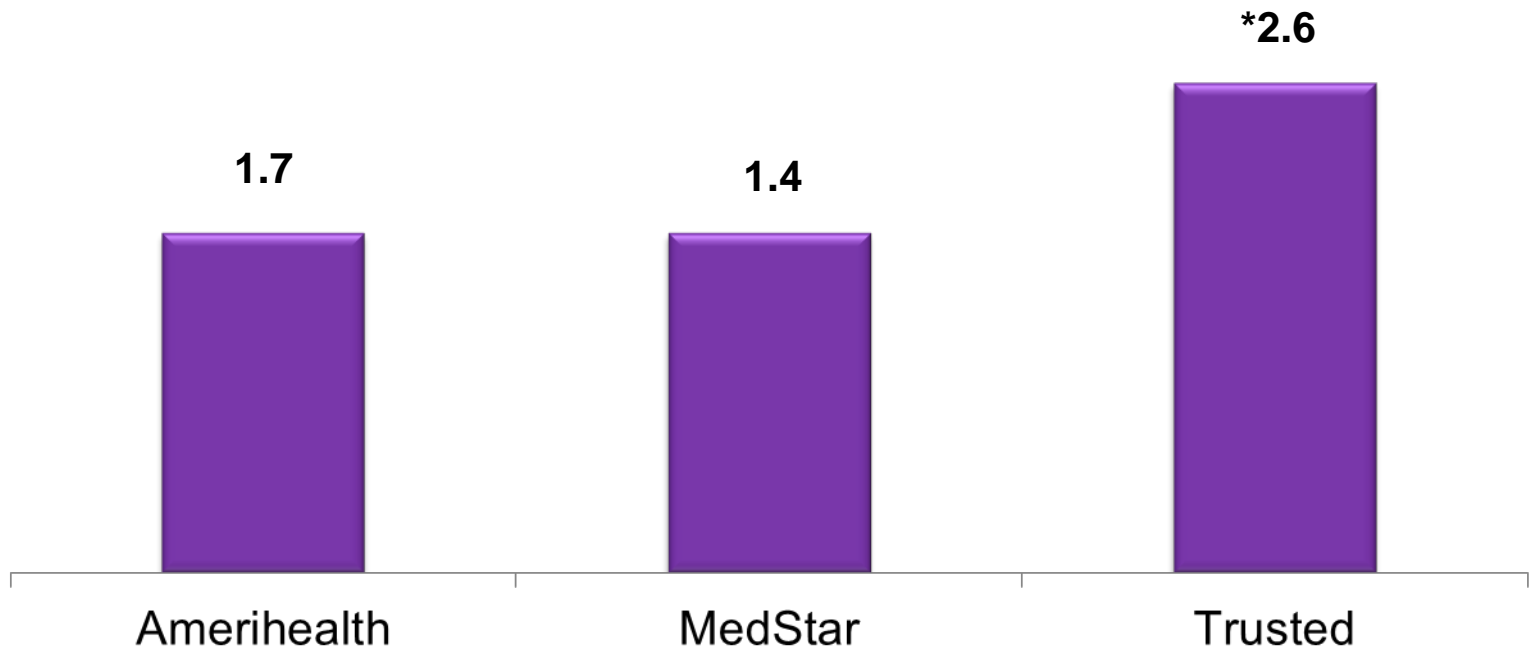
Source: Reported figures are from the MCO's annual 2014 and quarterly 2015 financial statements filed with DISB.

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 Three Health Plans Have Sufficient Cash Reserves On Hand To Pay Estimated Incurred But Not Reported Claims

Estimated Number Of Months Reserves Compared To Average Monthly Incurred Claims For The Period Covering January 2015 to June 2015

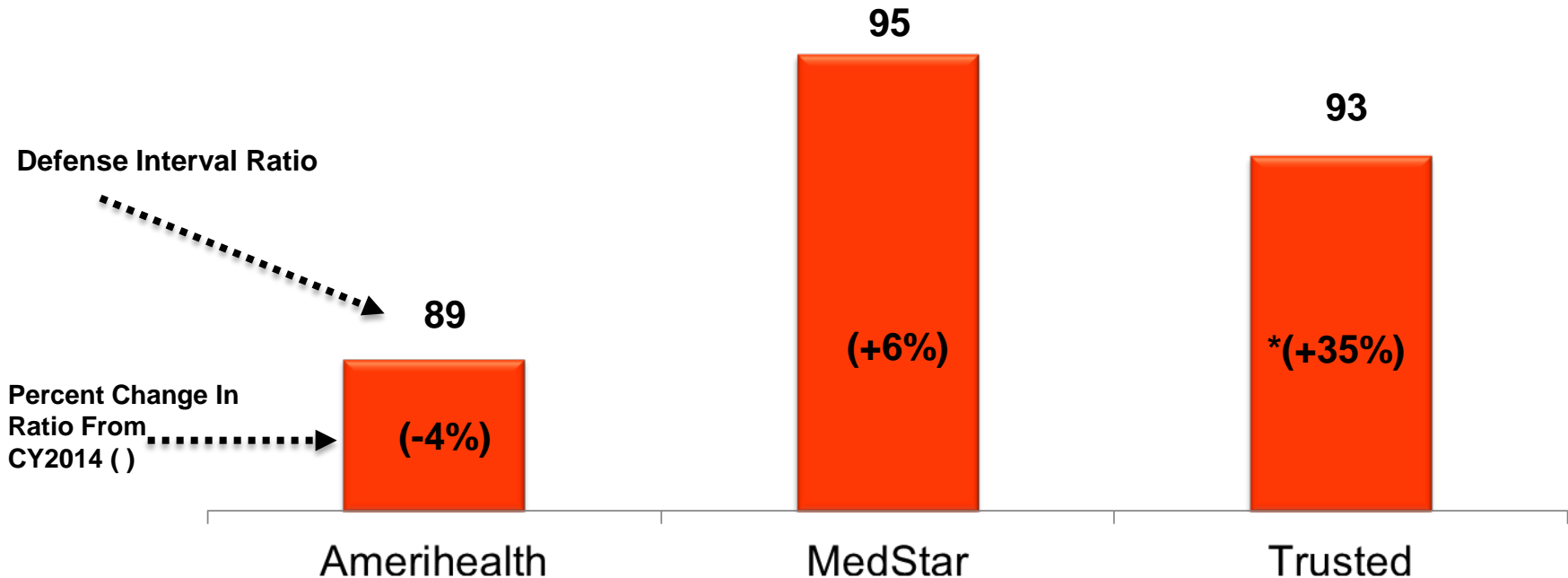


*Note: The figure for Trusted is inflated as the company implemented certain changes in claim submission protocols in mid-March 2015 which significantly increased initial claim denials from providers. As of June 30, 2015 the IBNR related to these claims was approximately \$9.5 million.

Source: IBNR is based on amount reported on the MCO's quarterly filings.

Though AmeriHealth Experienced A Decline In Its Defensive Interval Ratio – Which Compares MCO Assets To Company Liabilities – The Overall Levels Remain Favorable For All Three Health Plans

Days In A Year That MCOs Can Operate On Existing Cash Without Having To Access Long-Term Assets For The Period Covering January 2015 to June 2015



Note: Mercer calculated the Defensive Interval Ratio as cash and equivalents divided by daily operating expenses for the period from January to June 2015 measured in days. *The figure for Trusted is inflated as the company implemented certain changes in claim submission protocols in mid-March 2015 which significantly increased initial claim denials thereby increasing the company's reported cash and equivalents from providers. As of June 30, 2015 the IBNR related to these claims was approximately \$9.5 million.

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

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

Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

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

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

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

All Three Health Plans Continue To Operate With Sufficient Networks Ensuring Patient Access To Care

The Number of Providers In The MCO Networks Compared to Contract Requirements as of June 2015

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	69	548	53	863	65	524
MedStar FP	30	644	14	405	19	496
Trusted	20	496	10	174	13	462

Source: This information is self-reported and attested by the MCOs as of June 30, 2015 and verified by Department of Health Care Finance and the Enrollment Broker through a sampling of providers.

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

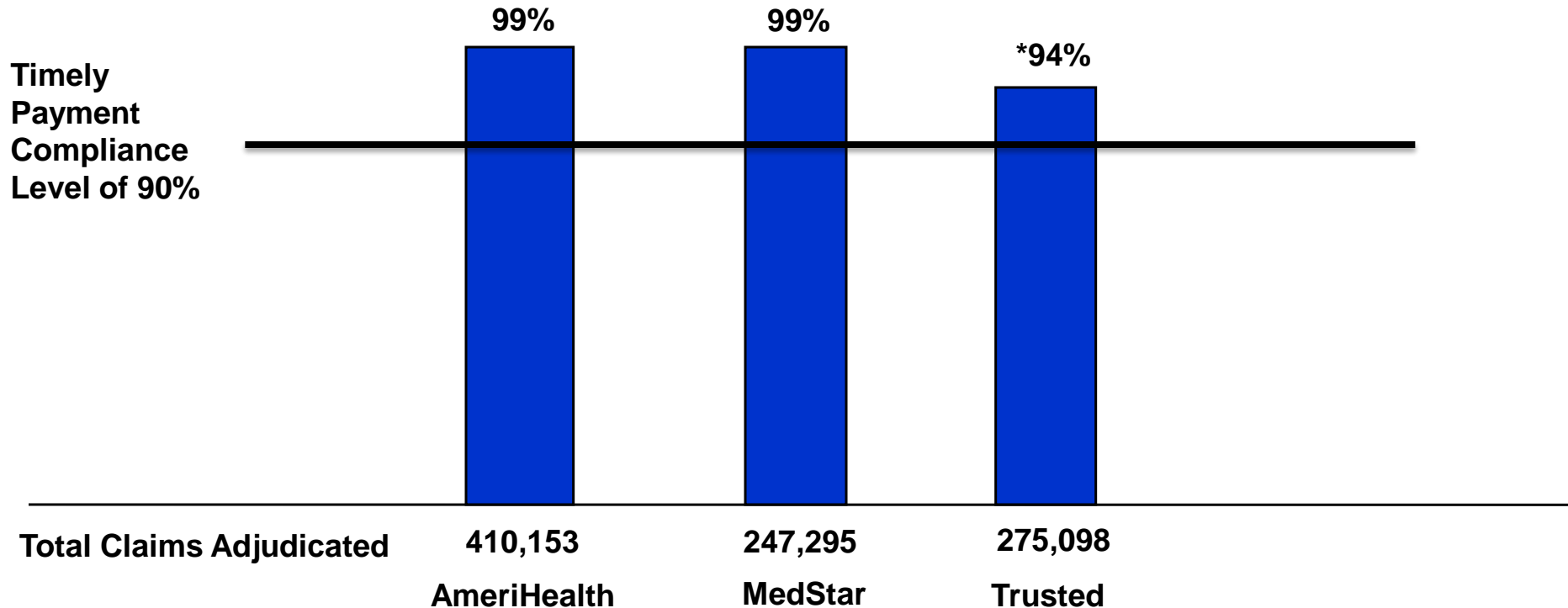
- ❑ Through electronic claims processing, the District's three managed care organizations are required to pay or deny clean claims within 30 days to satisfy timely filing requirements

- ❑ 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

Over The First Six Months Of 2015, The Three Health Plans Continue To Pay Claims In Compliance With The District's Timely Payment Requirement

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement, January 2015 to June 2015



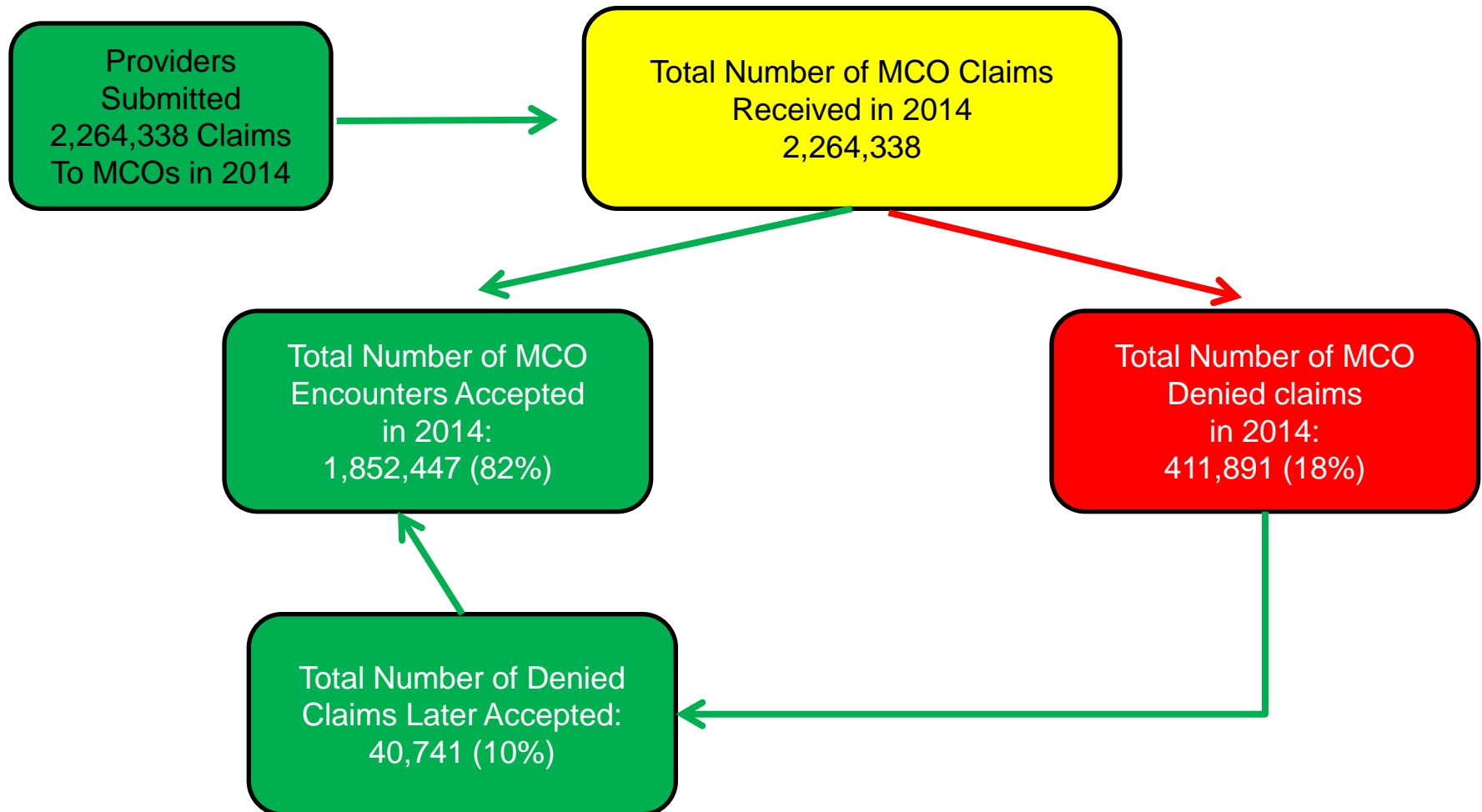
Note: This number does not reflect a large number of inpatient claims that Trusted denied under a new system of edits. These claims will be paid during the course of 2015.

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

The Issue of Claims Denial -- Which Focuses On Whether The Managed Care Companies Are Acting In Good Faith -- Must Also Be Evaluated

- ❑ Because the District's 30-day timely payment requirement does not apply to claims that are initially denied, some providers express concerns that managed care plans are 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 health plans' networks, and potentially cause access to care issues for beneficiaries in the Medicaid and Alliance programs
- ❑ Therefore, DHCF addresses this issue by reporting on the incidence of denied claims in the managed care program and the reasons for the denials. Additionally, outcomes for claims that were initially denied but subsequently approved and repaid are also examined

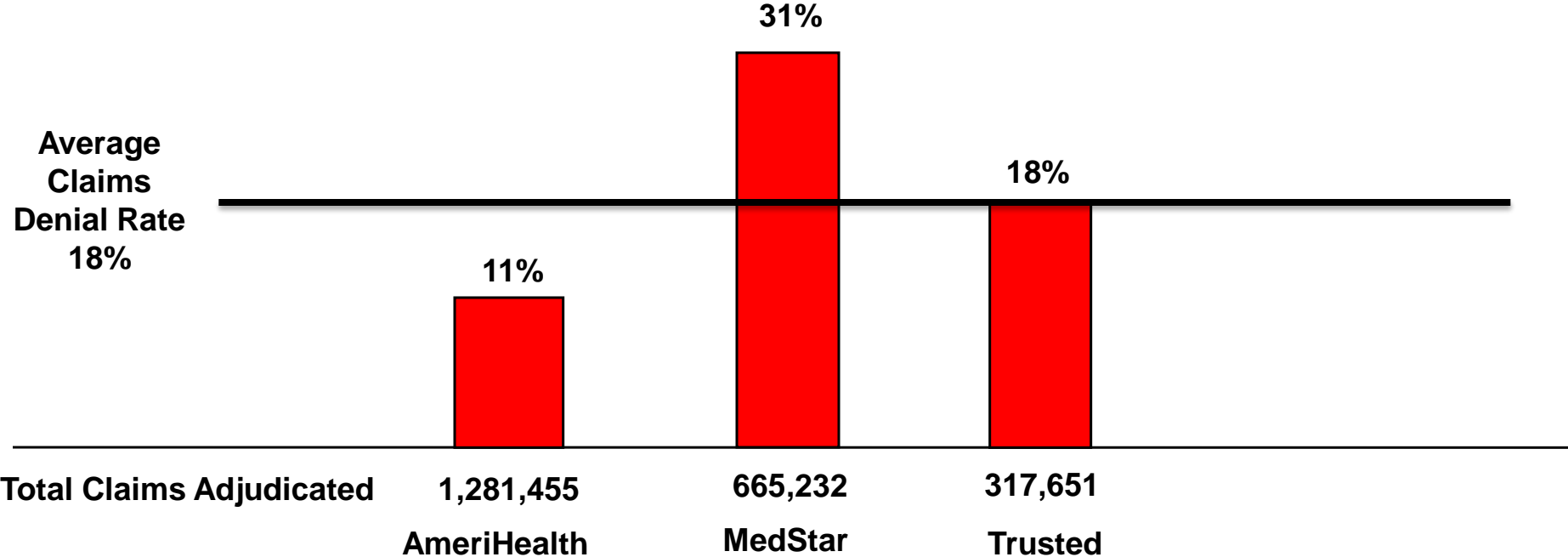
Less Than Two Of Every Ten Claims Submitted For Payment To The District's MCOs Are Denied



Note: Patient encounters with 2014 dates of service from DHCF's MMIS system were merged with MCO files containing denied claims for the same period. The claims run out period was through February 2015.

MedStar's Claims Denial Rate Is Significantly Above The Districtwide Average For The Three Health Plans

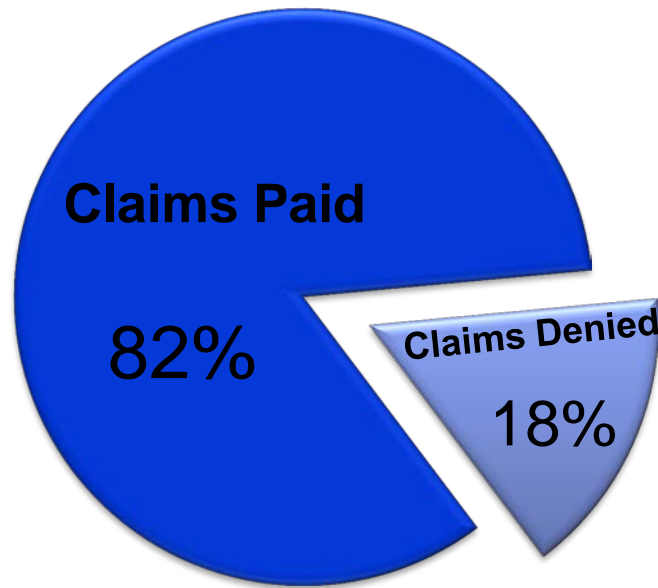
Claims Denial Rates For Each Full-Risk Health Plan, 2014



Source: DHCF's MMIS and MCO claims denial files.

MCOs Deny Claims For Many Reasons But The Most Frequent Relates To Service Coverage

MCO Claims Denial Rate, 2014



N = 2,264,338

■ Paid ■ Denied

Denial Reason	Total Claims	Percent of Total Claims Denied
Service coverage issue	74,471	21%
Duplicate Claim*	42,187	12%
Provider network issue	31,366	9%
Untimely filing issue	28,031	8%
Denied - LabCorp responsibility	23,054	6%
Exceeded allowable units issue	20,810	6%
Member eligibility issue	20,433	6%
Other reasons	120,311	32%

Note: *Approximately 13% of duplicate claims were submitted more than once.
Source: DHCF's MMIS and MCO claims denied files.

The Rate Of Denied Claims Are Highest For Two Of The Smallest Provider Groups Calling Into Question A MCO Cash Management Motive

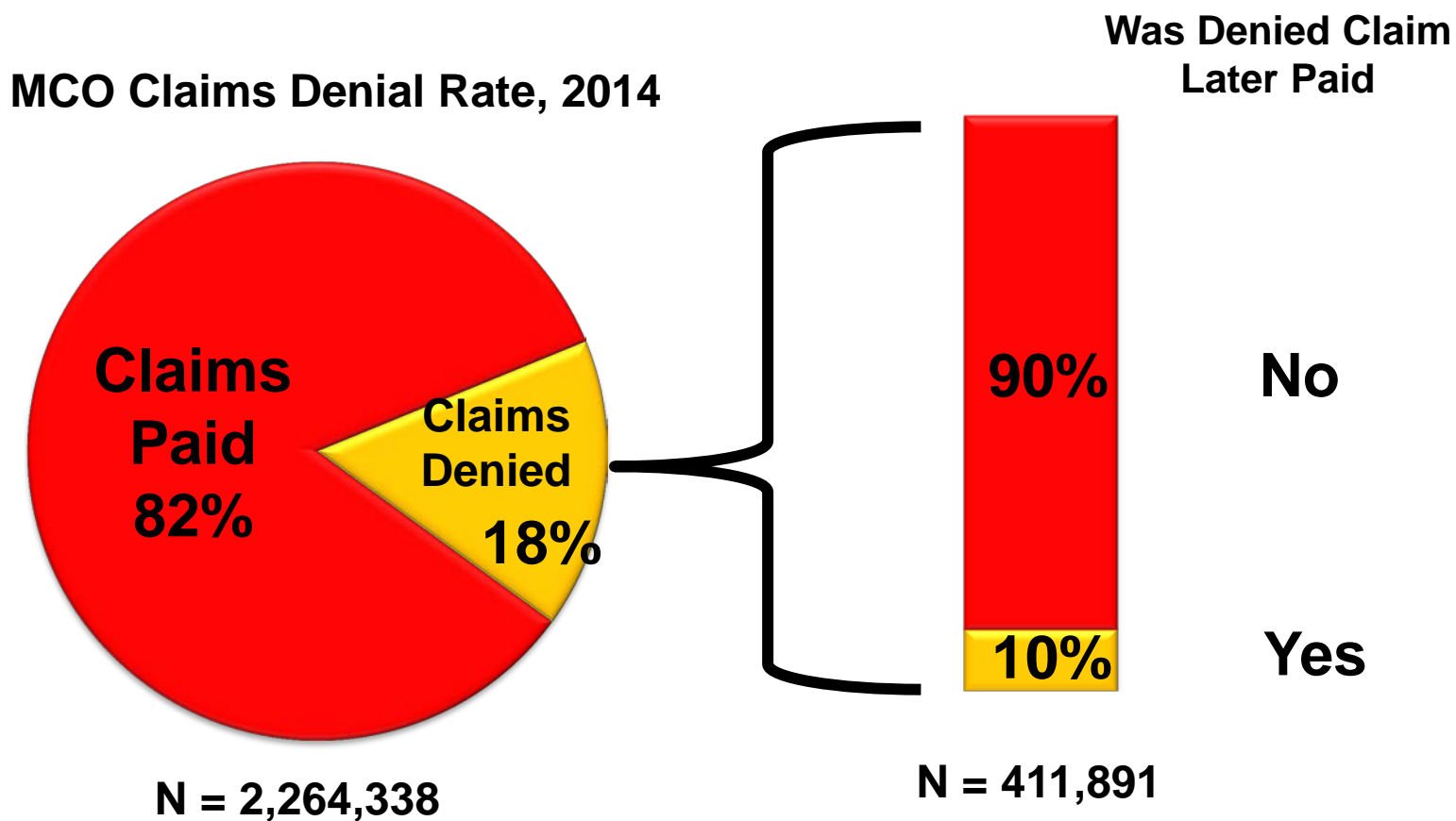
Denied Claims By Provider Type, 2014

Provider Type	Number of Total Claims	Claims Denied as a Proportion of Total
Private Clinic	36,420	53%
Mental Health Clinic	24,248	33%
Nurse Practitioner	37,533	23%
DME	20,085	23%
Physician	939,089	22%
Hospital	269,784	22%
FQHC	103,530	11%
Pharmacy	262,014	11%

Note: *Approximately 13% of duplicate claims were submitted more than once.

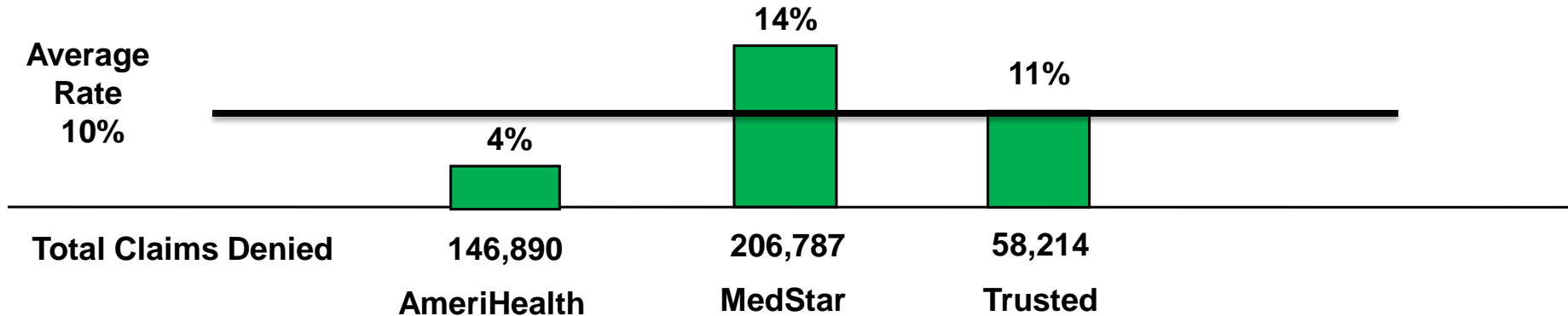
Source: DHCF's MMIS and MCO's denied claims files, 2014

Only Ten Percent of Claims Initially Denied Were Later Paid



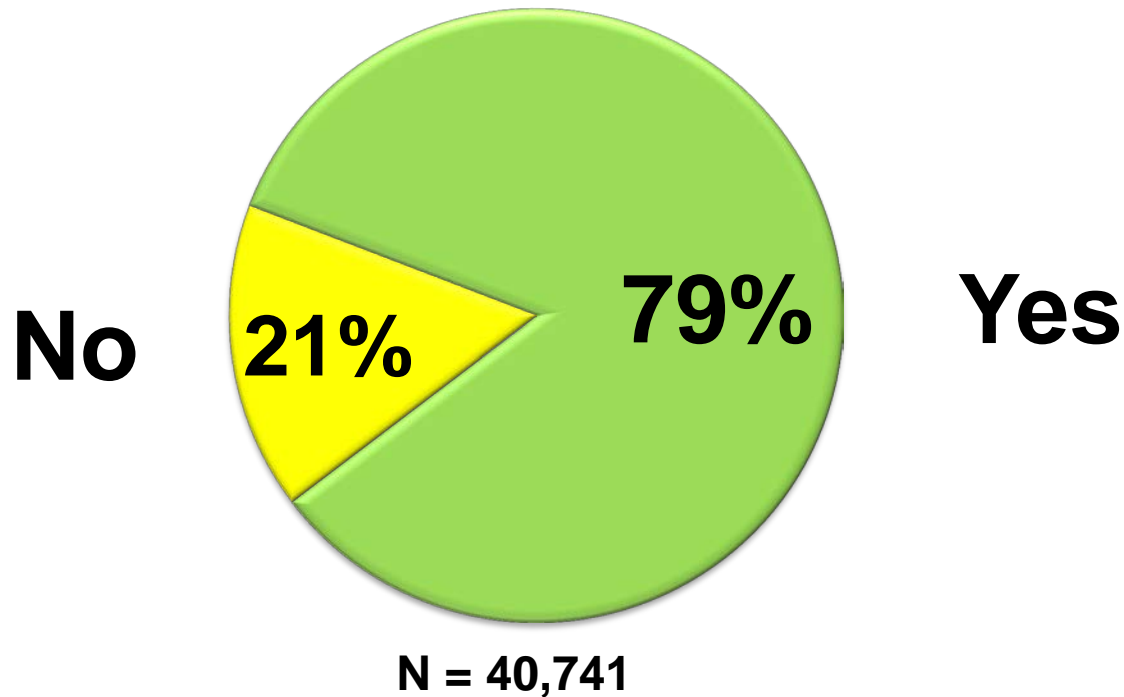
The Payment Rates For Initially Denied Claims Vary Across The Three Health Plans But Do Not Raise Cause For Concern

MCO Pay Rates For Claims Originally Denied, 2014



Though Not Required, MCOs Still Paid Nearly Eight of Ten Claims That Were Initial Denied Within 30 Days

Was Denied Claim Paid Within 30 Days Of Initial Denial



Note: Patient encounters with 2014 dates of service from DHCF's MMIS system were merged with MCO files containing denied claims for the same period. The claims run out period was February 2015.

For Some Provider Types, However, The Average Time That Elapsed Before Claims That Were Paid After Initially Being Denied Was High

Provider type	Average Number Of Days From Initial Denial To Acceptance
Dentist	15
Hospital	21
Nursing Facility	26
Physician	36
Mental Health Clinic	40
Lab	42
DME	55
Pharmacy	58
FQHC	66

The Health Plans Have Successfully Constructed Encounter Data Files But Trusted Must Improve The Accuracy Of Its Submissions

Number of Recorded Encounters And Accuracy Transfer Rate, January 2015 to June 2015

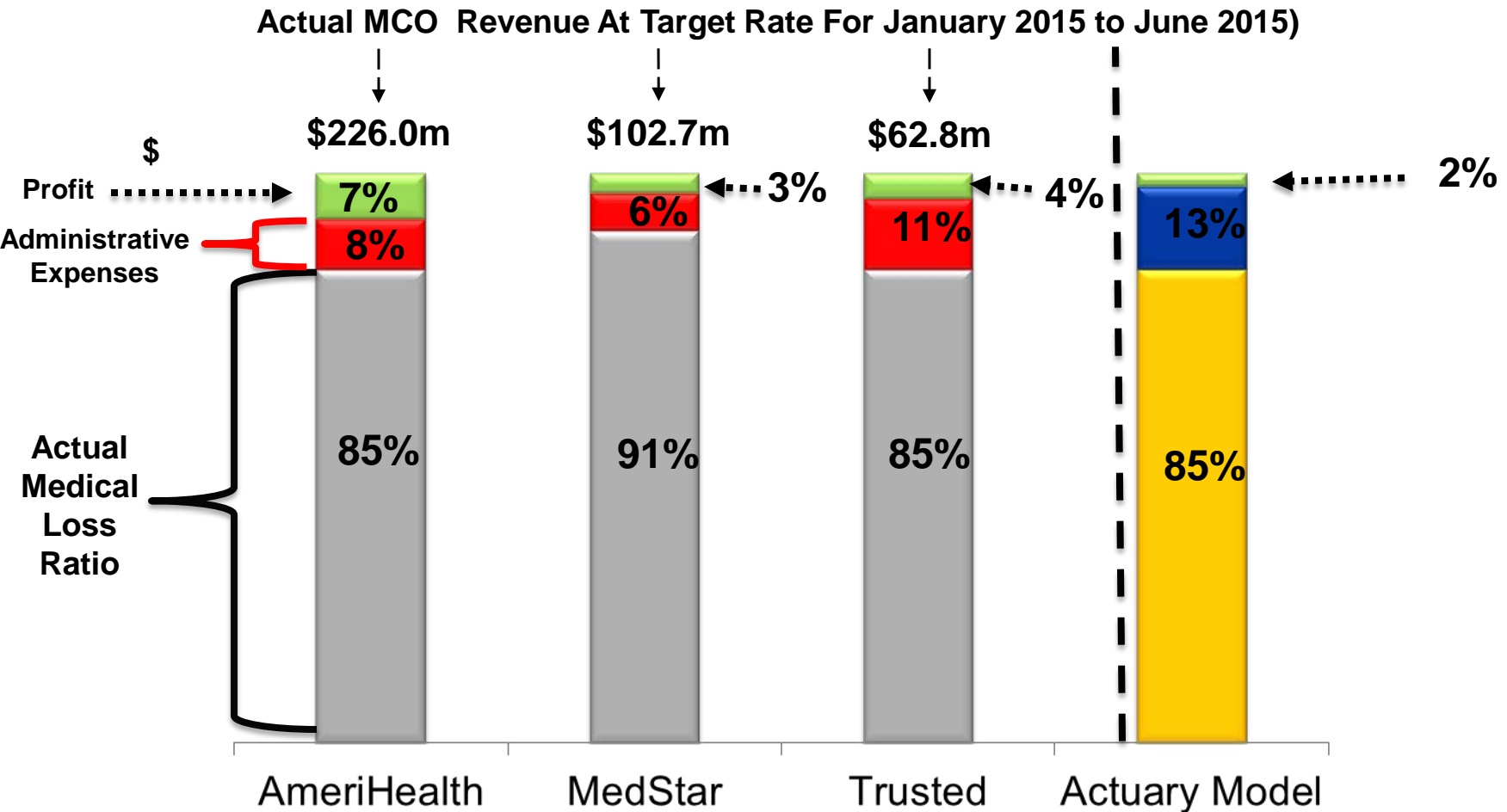
MCO	Average Monthly Enrollment	Total Encounters	Total Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	109,983	251,940	2.2	91%
MedStar	46,419	99,703	2.1	97%
Trusted	31,689	139,611	4.4	80%

Source: Department of Health Care Finance Medicaid Management Information System as of June 2015

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All Three Health Plans Spent The Required Amount On Beneficiary Medical Expenses, Responsibly Managed Administrative Cost, And Earned Profits Beyond The Rate Assumed In The Actuary's Model

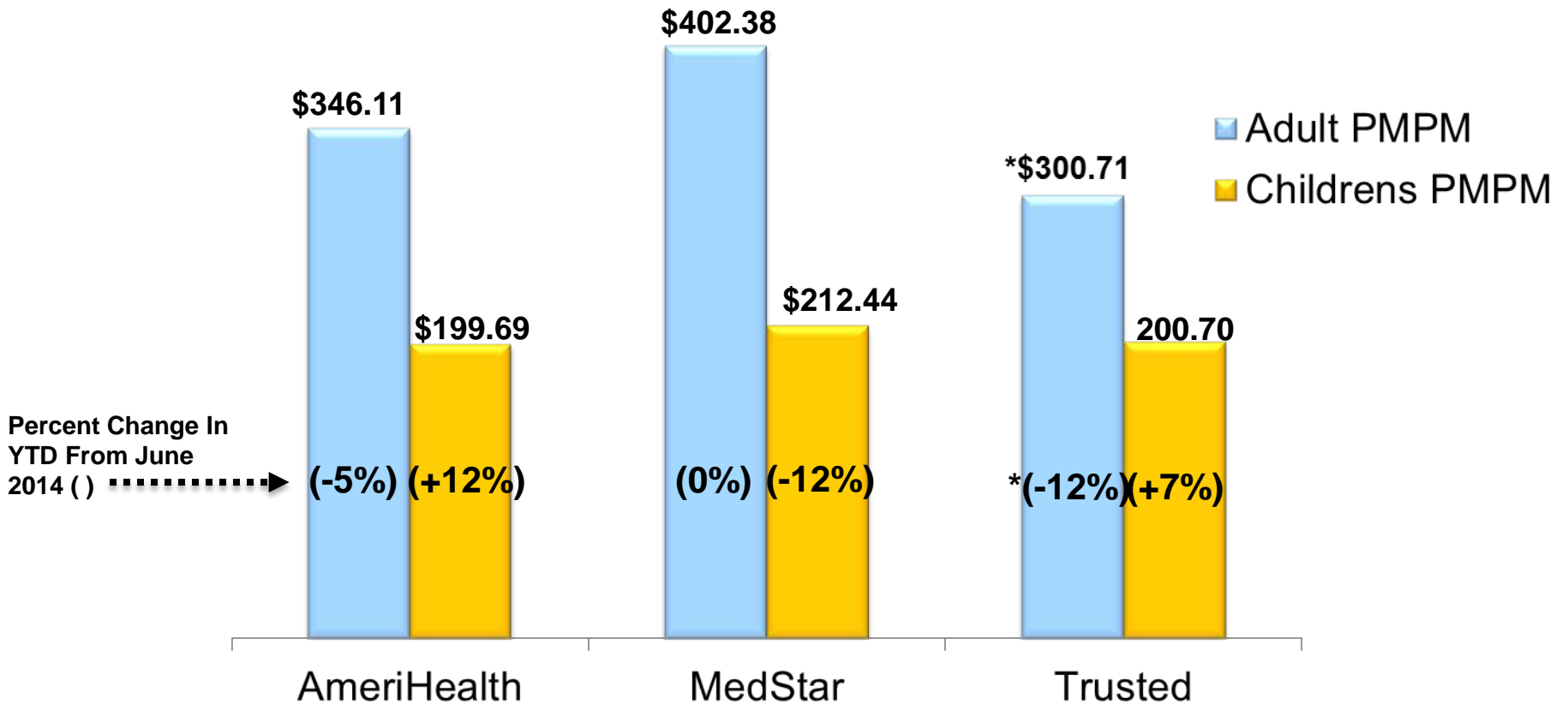


Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

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

There Is Significant Across Plan Variation In The Medicaid Per-Member, Per-Month Medical Expenses But The Claims Cost For Adults Either Declined Or Showed No Growth For The Plans

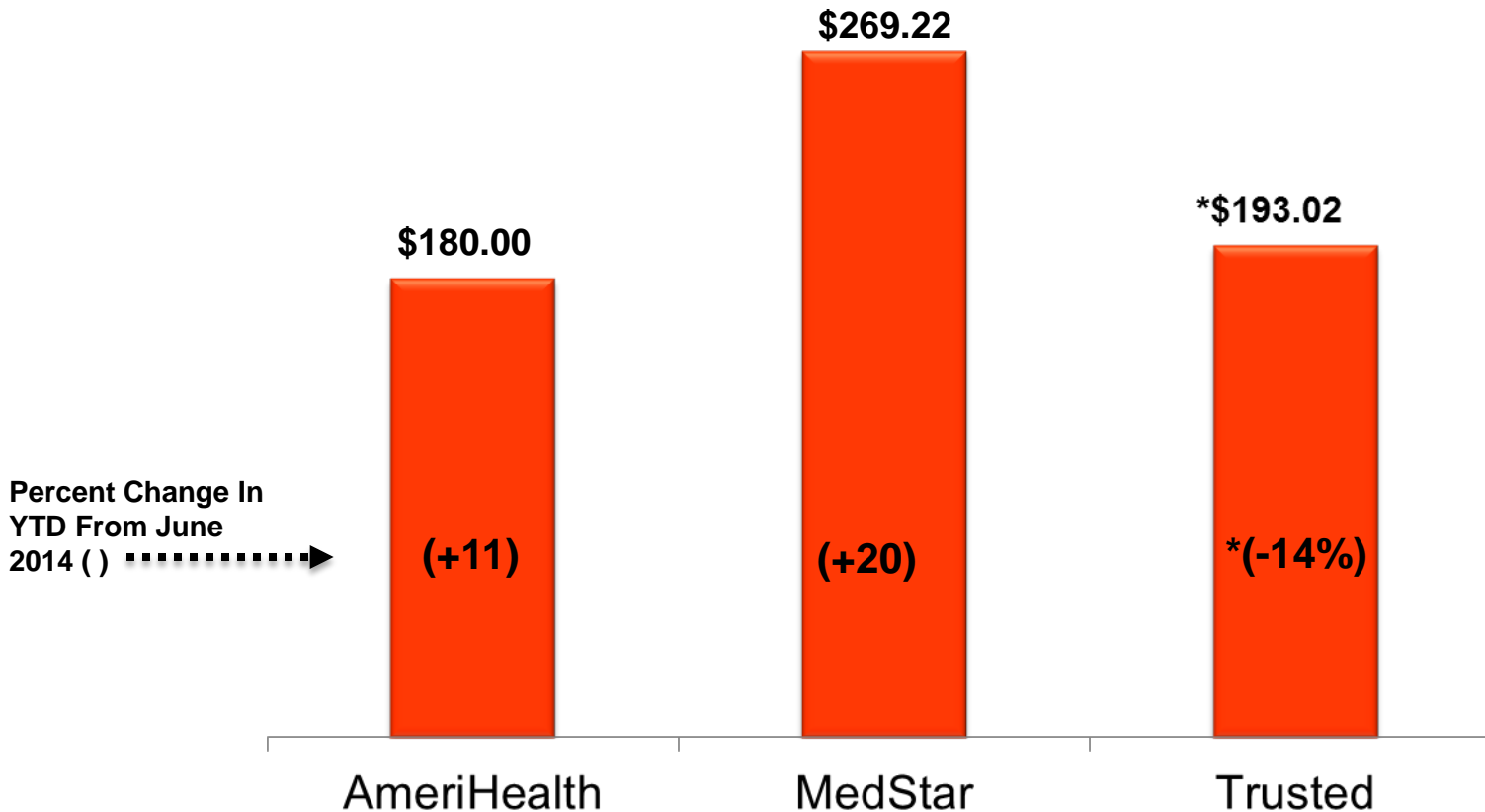
Medicaid Adult And Children Medical Expenses Per-Member, Per-Month, January 1, 2015 to June 30, 2015



Notes: Expenses incurred from January 1, 2015 to June 30, 2014 and paid as of August 31, 2015. The expenses do not reflect adjustments to account for INBR claims. Children defined as person up to age 21 in this analysis. *A large volume of claims denied by Trusted using new procedures have likely impacted this number. Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

There Is Also Wide Across Plan Variation In Alliance Adult Per-Member, Per-Month Medical Expenses And Two Plans -- AmeriHealth and MedStar -- Witnessed Double Digit Cost Growth Over The Same Time Period

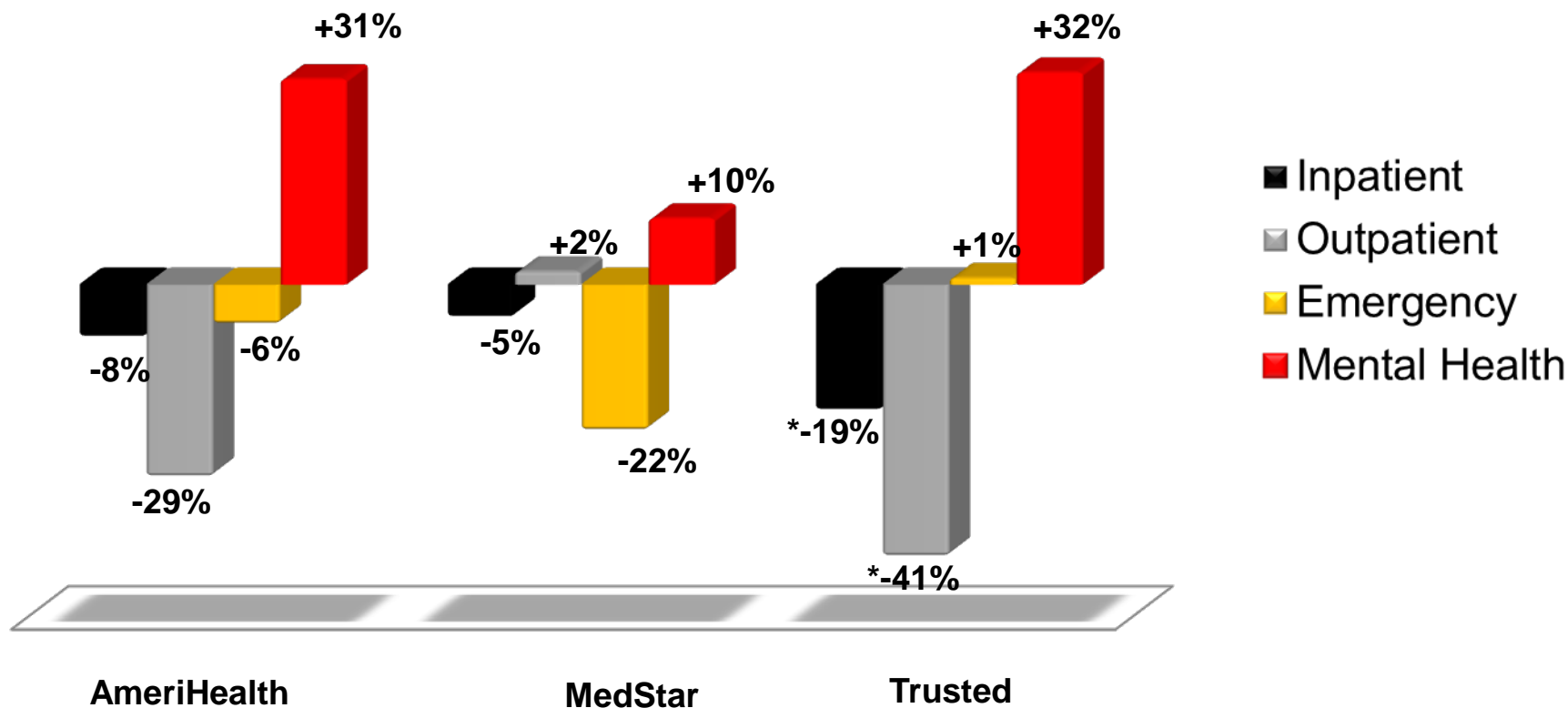
Alliance Adult Medical Expenses Per-Member, Per-Month, January 1, 2015 to June 30, 2015



Notes: Expenses incurred from January 1, 2015 to June 30, 2015 and paid as of August 31, 2015. The expenses do not reflect adjustments to account for INBR claims. Children defined as person up to age 21 in this analysis. *A large volume of claims denied by Trusted using new procedures have likely impacted this number. 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, All Three Health Plans Show A Decline In Per-Member, Per-Month Expenses For Key Medical Services Not Including Mental Health Care

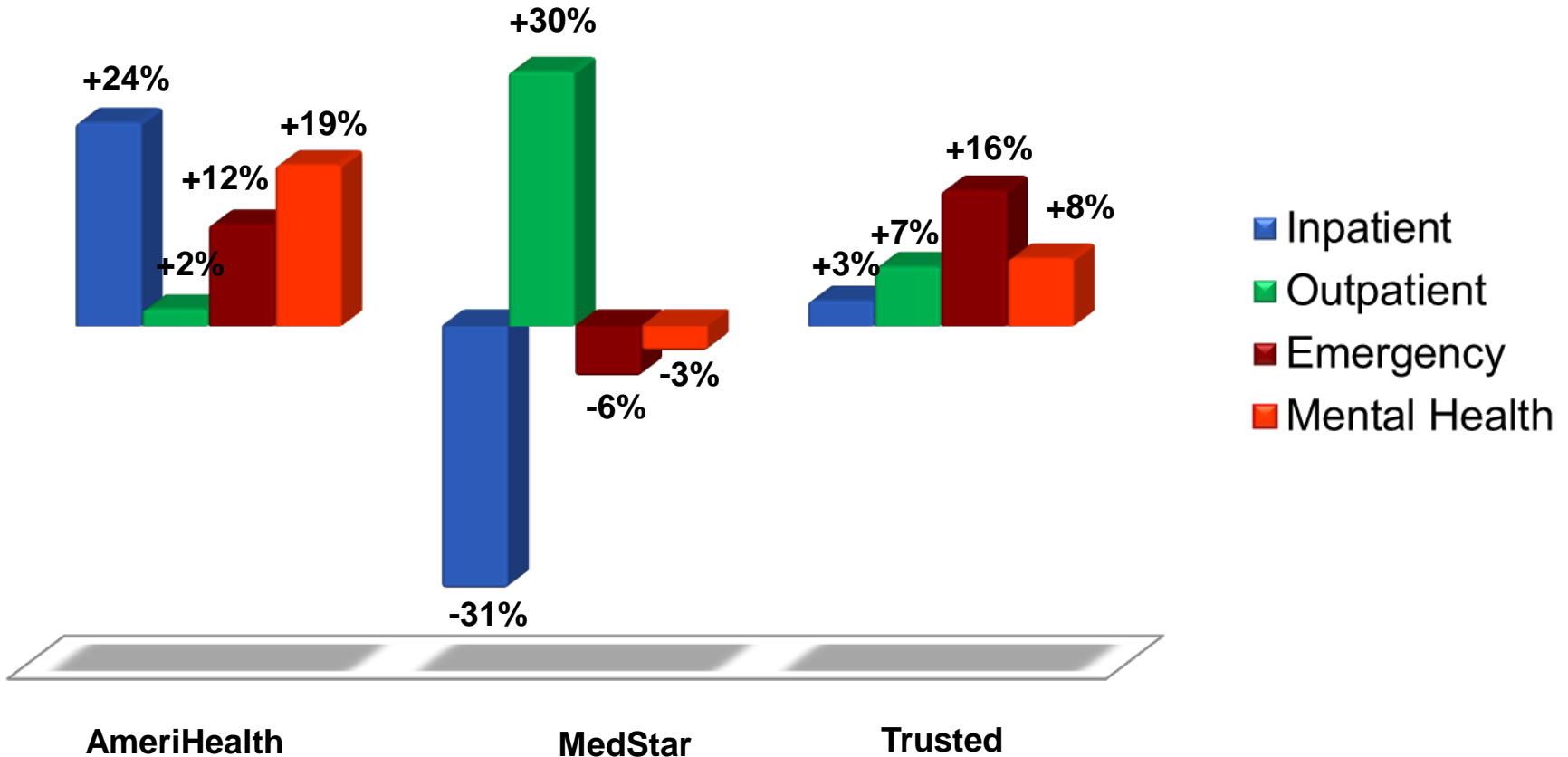
Percent Change in Expenses June 2015 Year-to-Date Compared To June 2014 Year-to-Date



Note: *The expenses do not reflect adjustments to account for INBR and thus understates Trusted's true inpatient cost due to a high number of denied encounter.
 Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

For Children, Both AmeriHealth And Trusted Witnessed Sometimes Sharp Increases In The Per-Member, Per-Month Cost For Certain Medical Services

Percent Change in Expenses June 2015 Year-to-Date Compared To June 2014 Year-to-Date



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

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 Beneficiary Medical Costs With Their Assigned Risk Scores

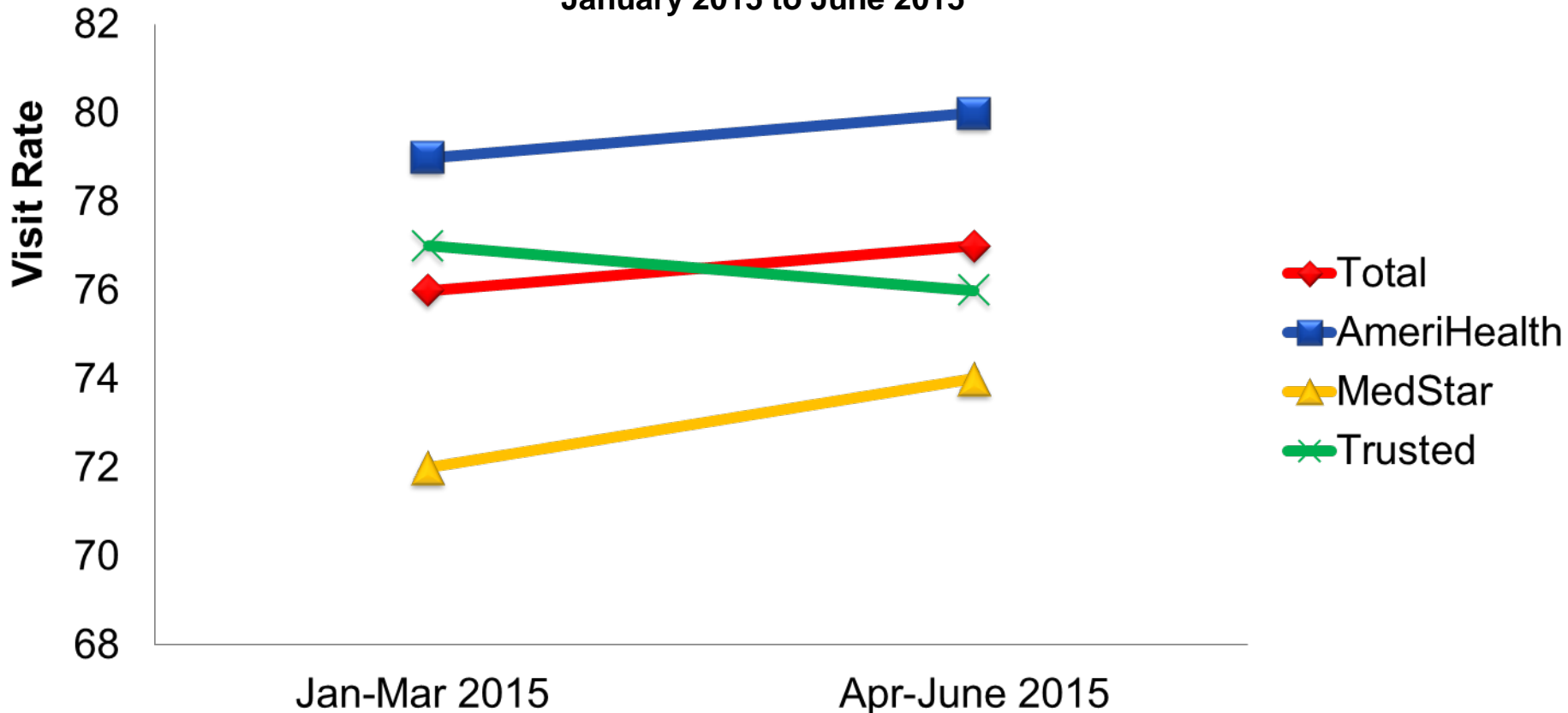
Ranking On Beneficiary Risk Scores As Of May 1, 2015

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

Notes: Expenses incurred from July 1, 2013 to June 30, 2014 and paid as of August 31, 2014. The expenses do not reflect adjustments to account for INBR 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.

Headed By AmeriHealth, The Physician Visit Rate For Children Exceeded 70 Percent For All Three Plans During The First Half Of 2015

Medicaid Quarterly Physician Care Visit Rates For Children Who Were Enrolled In Managed Care, January 2015 to June 2015

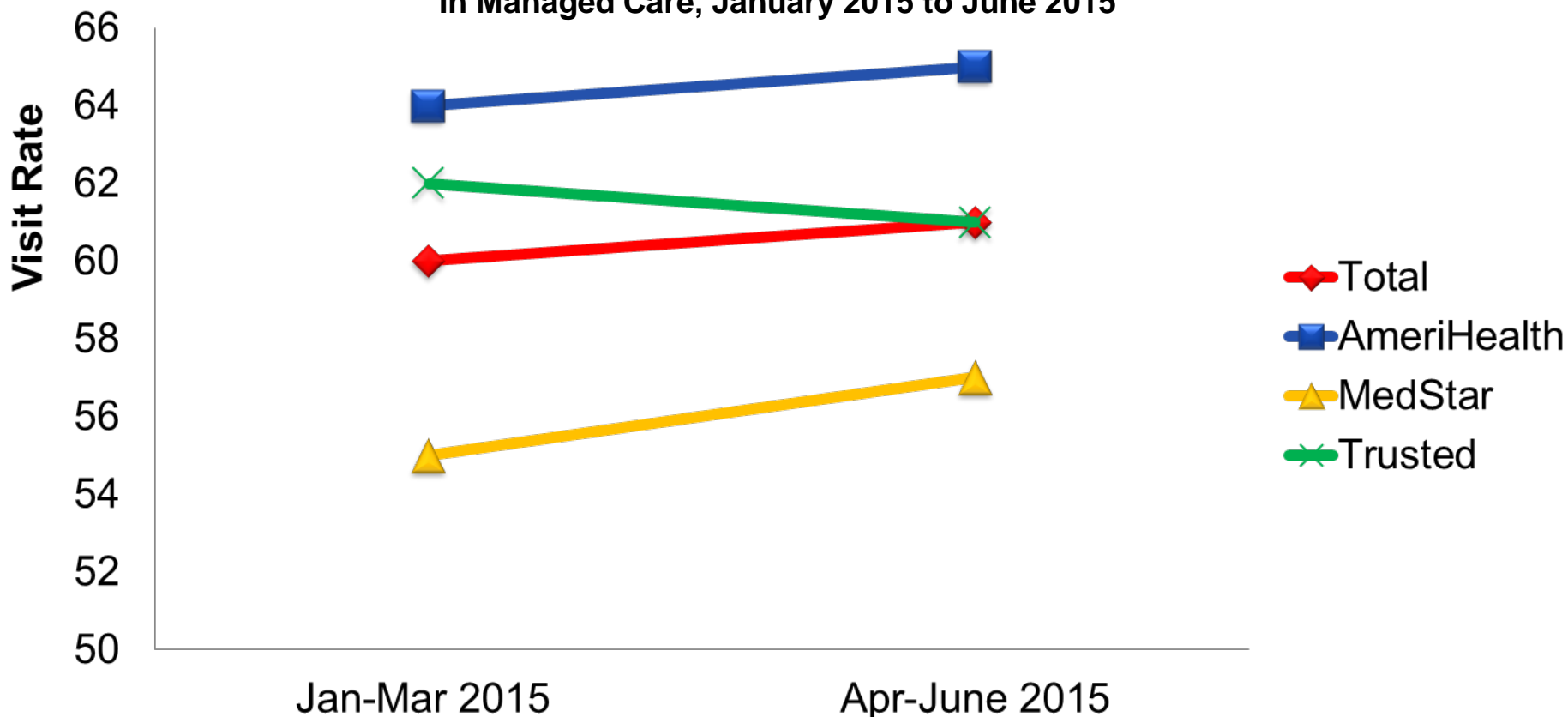


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The Physician Visit Rate For Children With An Added Well-Child Component Is Uneven Across The Three Plans, Beneath 60 Percent For MedStar, And Declining For Trusted

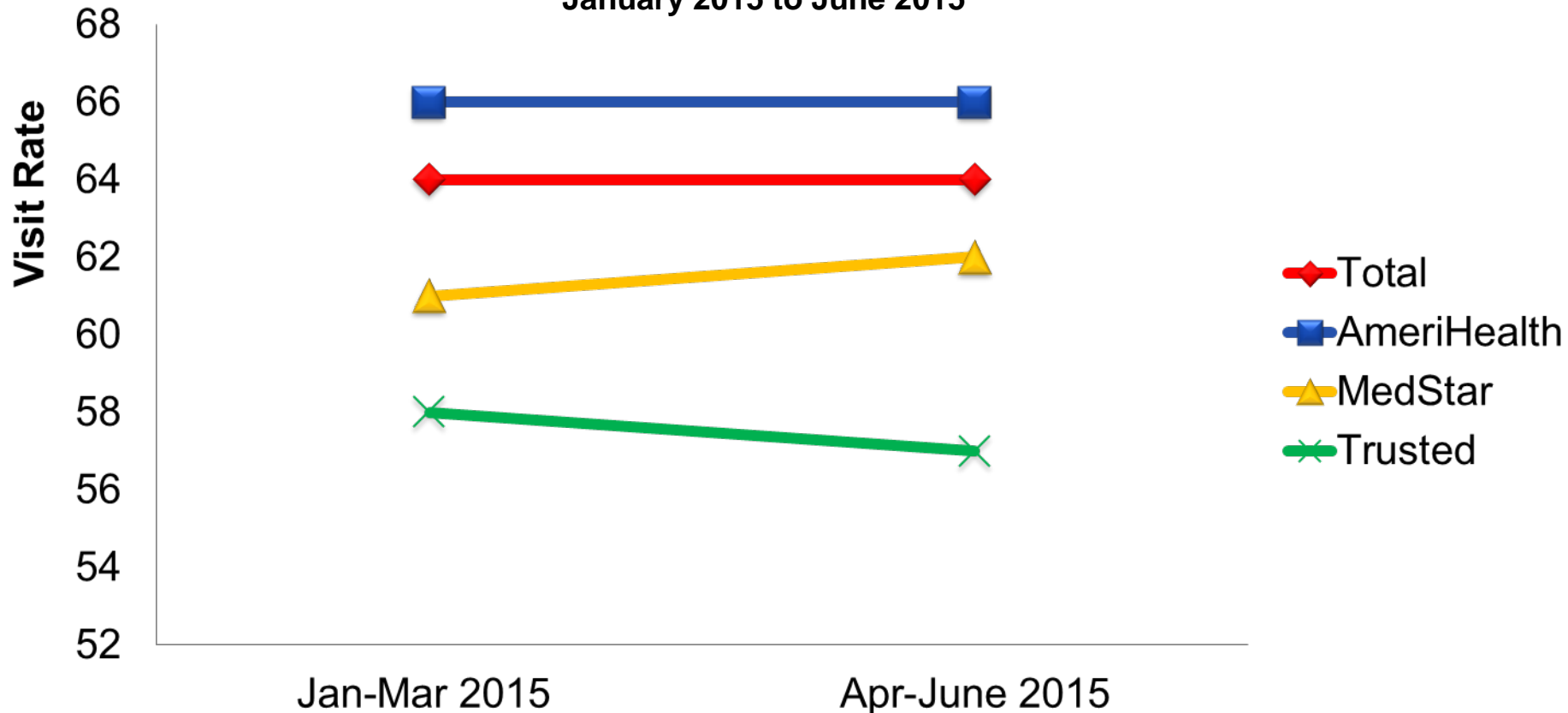
Medicaid Quarterly Physician Care and Well Child Visit Rates For Children Who Were Enrolled In Managed Care, January 2015 to June 2015



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, January 2015 to June 2015

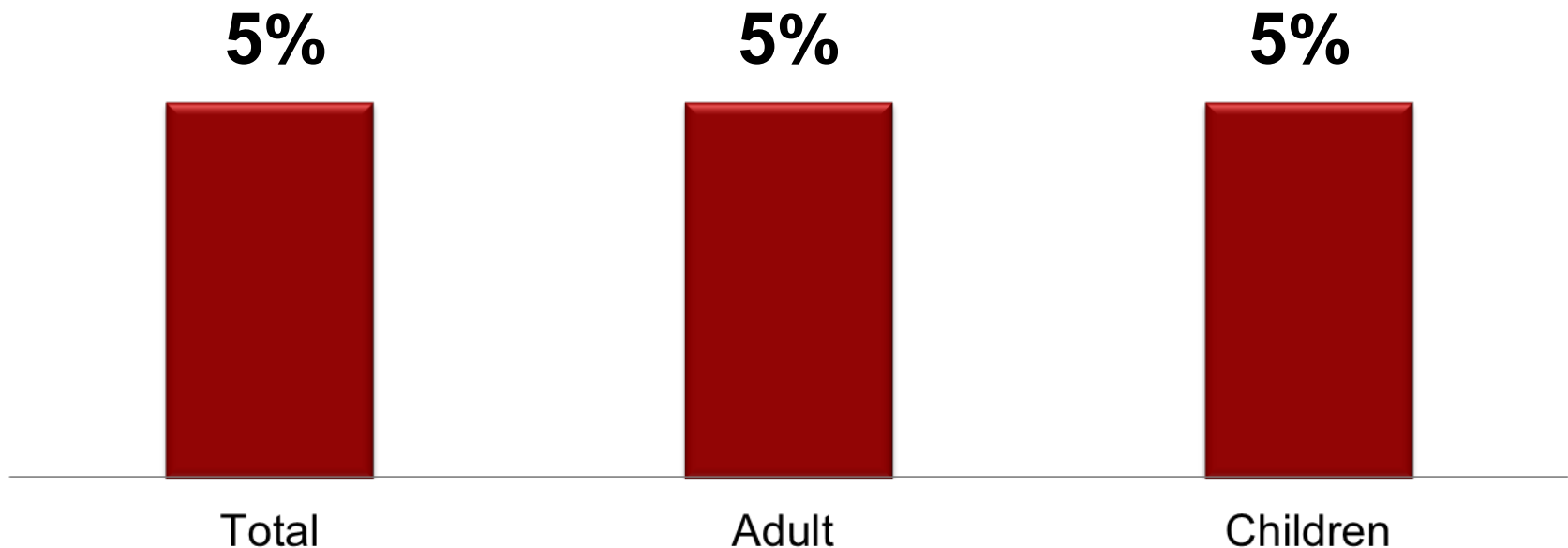


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

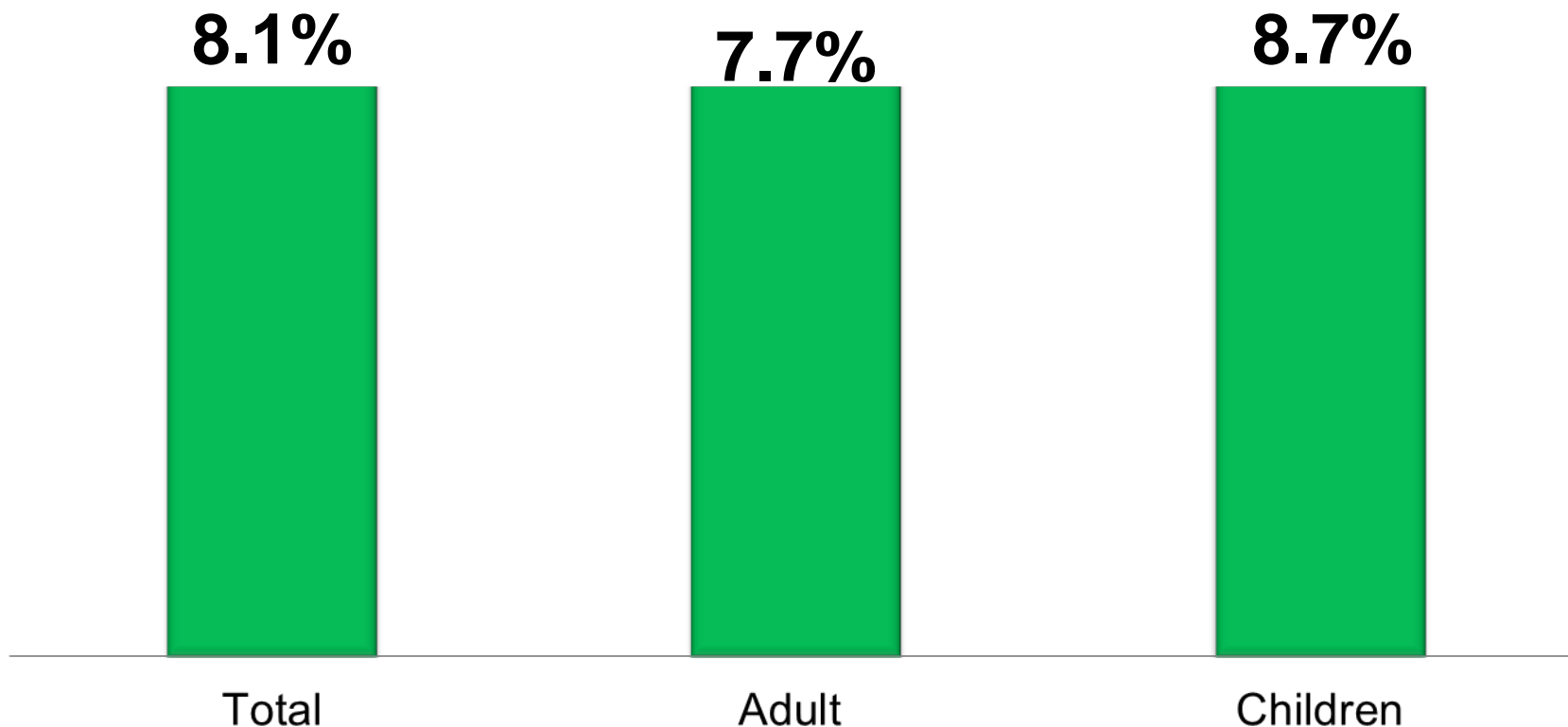
Halfway Through The Calendar Year The MCO Penetration Rate For Medicaid-Funded Mental Health Rehabilitation Services Is The Same For Both Children And Adults

Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans January 2015 to June 2015



When Utilization For Any Mental Health Treatment Is Accounted For, The MCO Total Mental Health Penetration Rate Increases Overall And For Both Adults And Children On Medicaid

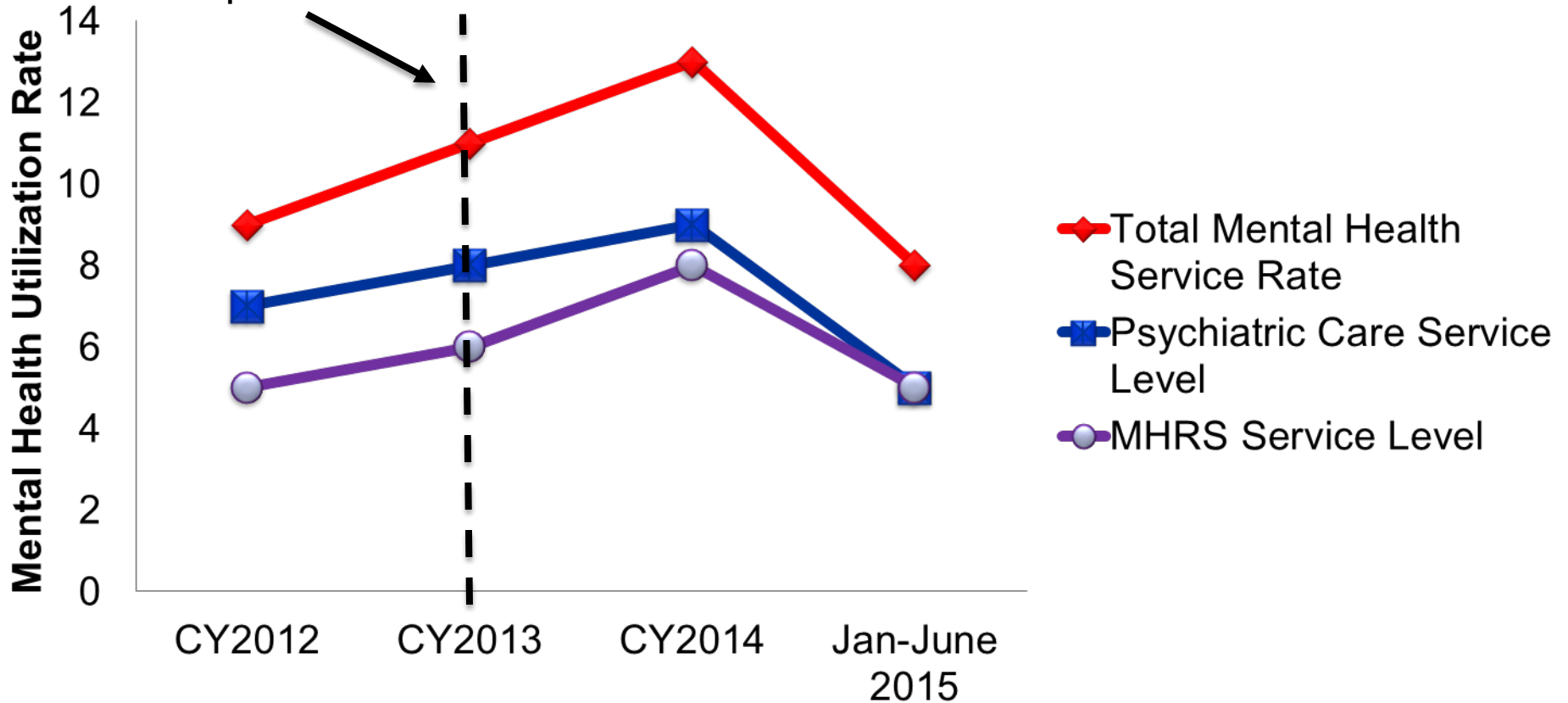
Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans January 2015 to June 2015



Once A Full Year Of Data Is Available for 2015, It Can Be Determined If The Upward Trajectory Observed In The Medicaid Mental Health Utilization Rate For Children Since The District Selected Three New Health Plans In July 2013 Is Continuing

District Selects Three New Health Plans
And Establishes Contract Performance
Requirements

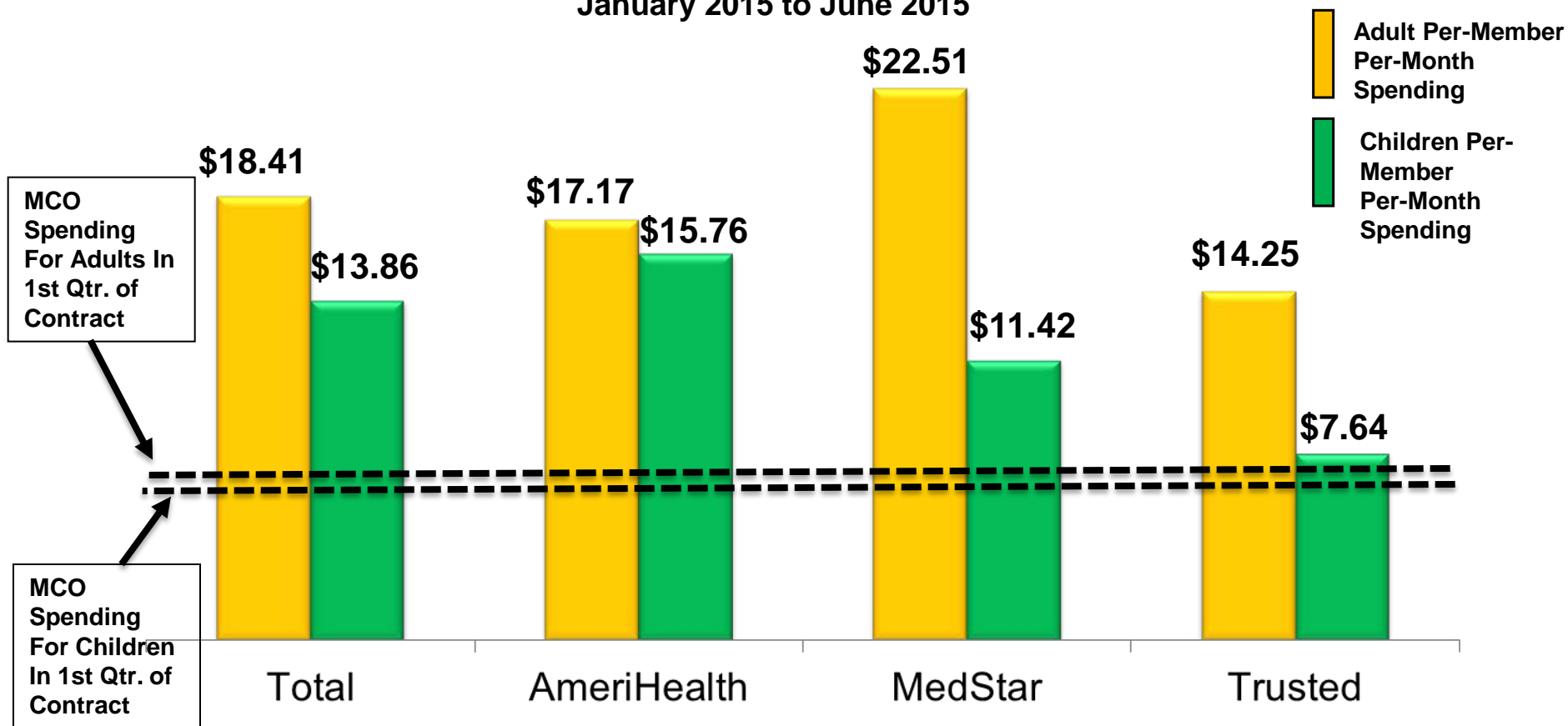
Chart Title



Note: Source: Encounter data submitted by MCOs to DHCF.

Since The 1st Quarter Of The Managed Care Contract (October to December 2013), MCO Spending On Medicaid-Funded Mental Health Services For Both Children And Adults Has Increased Sharply For All Plans Except Trusted

The Per-Member Per-Month MCO Expenses For Behavioral Health Services, January 2015 to June 2015



Notes: The expenses do not reflect adjustments to account for INBR 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

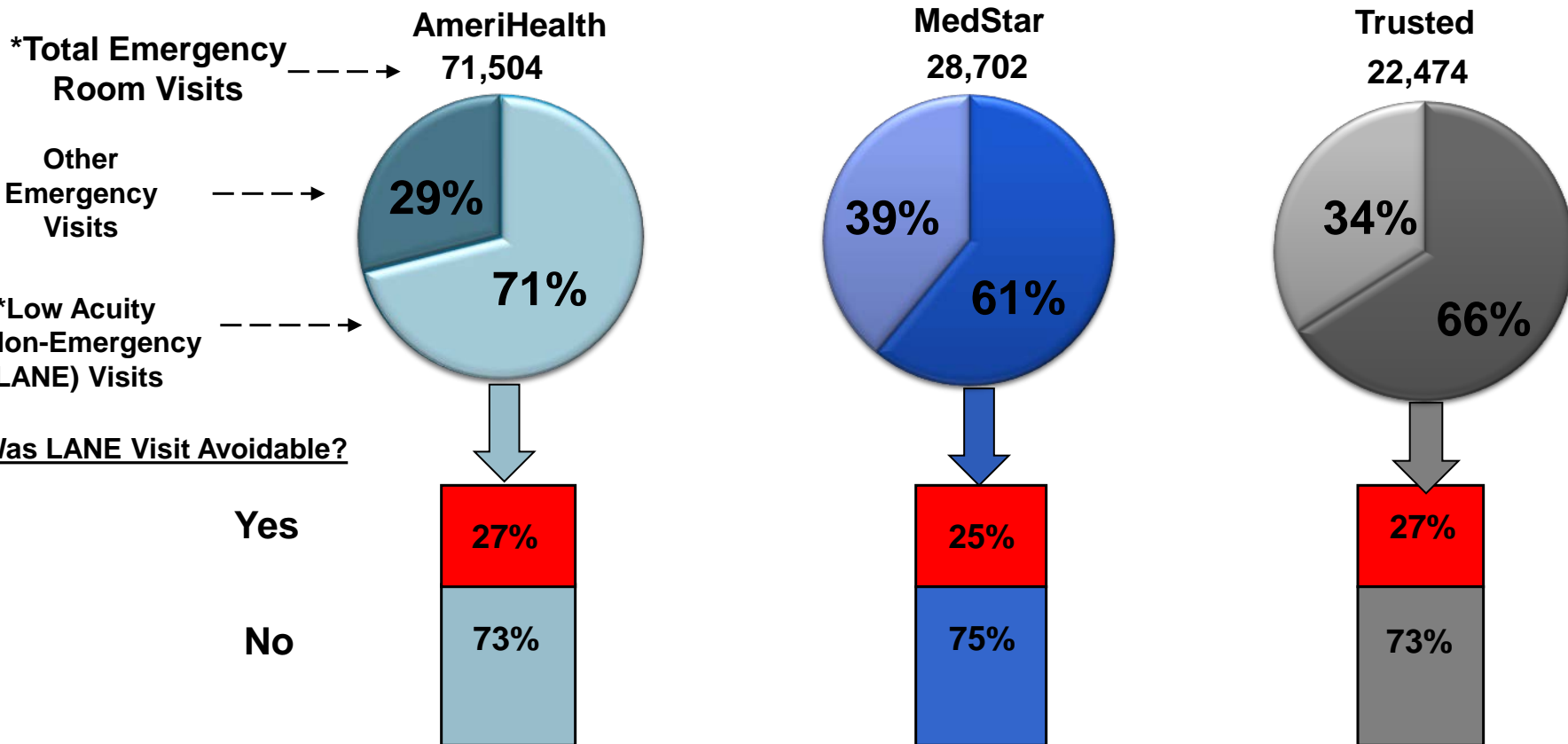
- Goals and Purpose of Managed Care Performance Review
- Summary of Key Findings
- The Financial Condition of The District's Health Plans
- The Administrative Performance Of The Health Plans
- MCO Medical Spending And Member Utilization Patterns
- Care Coordination: Goals and Outcomes**
- Implementation of MCO Pay for Performance Plan

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

- ❑ Achieving high value in health care for Medicaid and Alliance beneficiaries is a preeminent goal of DHCF's managed care program
- ❑ The District's three managed care plans are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management
- ❑ 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

The Beneficiaries For All Three MCOs Use The Emergency Room For Low Acuity Diagnosis At A High Rate And Nearly Three in 10 Of These Visits Are Avoidable

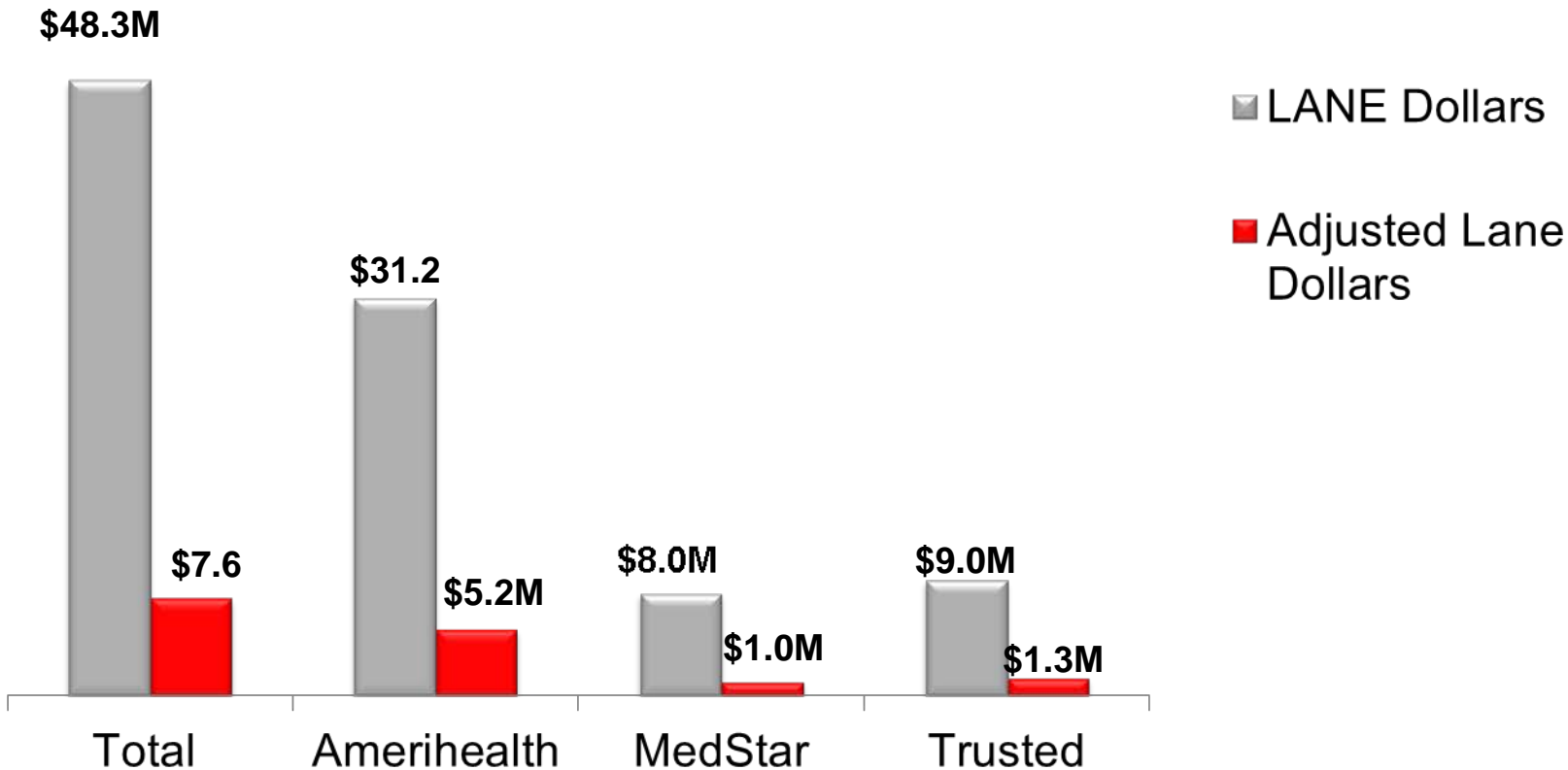
Emergency Room Utilization For Members By Level Of Acuity, January 2015 to June 2015



*Total emergency department visits consists of all visits to the emergency room regardless of diagnosis which did not result in an inpatient admission. **Low acuity non-emergency (Lane) visits are emergency room visits that could have been avoided based on a list of diagnosis applied to outpatient data. Practicing ED physicians and Mercer clinical staff reviewed each LANE code and assigned a target utilization percentage of visits that a highly efficient managed care plan could prevent.

The Low Acuity Avoidable Emergency Room Visits Cost The MCO's Nearly \$8.0 Million

Cost Of Low Acuity Visits Calculated During The Period From January 2015 to June 2015



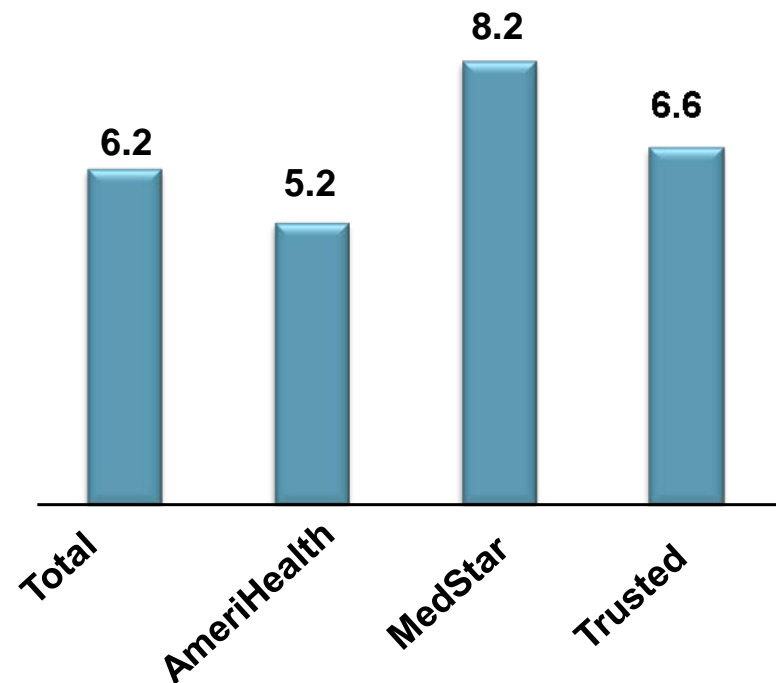
Notes: The LANE dollars are adjusted for the duration of enrollment and percent credibility factors are applied to each diagnosis based on professional judgment.

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

Nearly Seven Percent Of Inpatient Hospital Admissions Were Potentially Avoidable -- With MedStar Having The Highest Level -- Costing MCOs An Additional \$10 Million

Potentially Avoidable Inpatient Admissions (PPA) And The Associated Cost For The Period January 2015 Through June 2015

Adjusted Potentially Avoidable Admissions
As A Percent Of Inpatients Admits



Managed Care Plan	Cost Of PPA	Adjusted Avoidable Admits Per 1000
AmeriHealth	\$4,803,496	5.26
MedStar	\$3,999,526	8.2
Trusted	\$1,916,151	6.6
Total	\$10,619,173	6.2

Note: Results are based on prevention quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) that can be used with hospital discharge data to identify potentially preventable admissions for adults.

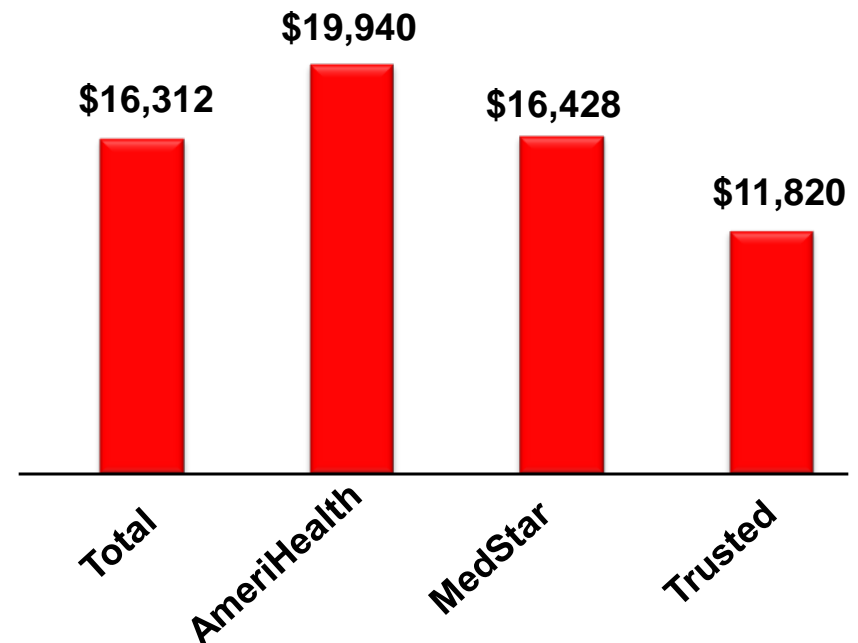
Source: MCO Encounter data provided by MCOs to DHCF.

The Problem of Hospital Readmissions -- Most Acute For Trusted -- Add More Than \$18 Million To MCO Beneficiaries' Medical Cost

Hospital Readmissions Within 30 Days And Associated Cost For The Period From July 2013 Through March, 2014

The Average Cost Per Readmissions For Each Health Plan

Managed Care Plan	Ratio Of Hospital Readmissions To Index Hospital Admissions	Total Cost Of Readmissions
AmeriHealth	1 to 12.6	\$9,543,434
MedStar	1 to 11.1	\$6,255,786
Trusted	1 to 9.9	\$2,313,035
Total	1 to 11.3	\$18,112,256



Note: All-cause 30-day hospital readmissions are "hospitalizations that occur, for any reason, within 30 days of discharge from an index admission." An index admission is defined as any inpatient stay that might produce an avoidable readmission" (Mathematica, 2011). Index admissions are derived from the set of unique hospital stays, and are determined by excluding specific categories of admissions from the set of unique hospital visits such as transfer cases and deaths. Readmission rates are computed as the ratio of admissions that occur within the specified readmission time period to the number of index admissions.

Presentation Outline

- Goals and Purpose of Managed Care Performance Review
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DHCF To Launch Pay-For-Performance Program As An Incentive For MCOs To Address Care Coordination Problems

- ❑ Beginning in January 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. For the period of January 2016 through September 2016, the withhold results in approximately 1.5% of each MCOs' capitation rates
- ❑ The baseline period used for the program is July 1, 2014 through June 30, 2015 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.