



District of Columbia's Managed Care Quarterly Performance Report

(April 2016 – June 2016)

Department of Health Care Finance

October 2016
Washington DC

Presentation Outline

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

Managed Care Represents DHCF's Largest Provider Expenditure

- ❑ DHCF's managed care program is the largest single expenditure in the agency's budget consisting of the Medicaid and Alliance publicly-funded health insurance programs.
- ❑ As of June, 2016, more than 179,807 Medicaid beneficiaries and just over 12,350 Alliance enrollees were assigned to one of the four following Managed Care Organizations (MCO):
 - AmeriHealth Caritas DC (AmeriHealth)
 - MedStar Family Choice (MedStar)
 - Trusted Health Plan (Trusted)
 - Health Services for Children With Special Needs (HSCSN)
- ❑ All four health plans offer comprehensive benefits. Three of these health plans -- AmeriHealth, MedStar, and Trusted -- operate under full risk-based contracts while HSCSN works under a risk sharing arrangement with the District.
- ❑ The District spent more than \$984.3 million on MCO services in FY2015. A little more \$828.8 million of this amount funded the full risk-based contracts signed by AmeriHealth, MedStar, and Trusted, while approximately \$155 million funded the risk sharing contract with HSCSN.

DHCF Implements A Performance Review Of Its Managed Care Program

- ❑ The contracts for the three full risk-based plans were awarded in 2013 as the first step initiated by DHCF to reform a troubled program.
- ❑ Prior to this award, DHCF's managed care program was hampered by ambiguous contract language, financially unstable providers, and de minimis reporting requirements that made it difficult to assess the performance of the plans.
- ❑ Accordingly, to coincide with the new five-year MCO contracts, DHCF initiated a comprehensive review process in FY2014 to assess and evaluate the performance of its three full risk-based health plans.

Purpose Of The CASSIP Performance Review

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

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

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

Overview of CASSIP

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

Goals Of The Performance Review

□ There are three primary goals of this performance review:

1. Evaluate the degree to which DHCF's three risk-based health plans and the single risk sharing plan successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of health care services.
2. Provide objective data on the performance of the health plans across a number of domains to inform decision making about possible policy changes for the managed care program.
3. Facilitate an assessment of each MCO to help guide decisions regarding contract renewals of each health plan.

Focus Of The Performance Review

- ❑ This report primarily focuses on the period covering the first two quarters of 2016 (1/1/16-6/30/16). The following questions are addressed for each MCO.
 - What was the financial condition of the MCOs during the first six months of 2016? Were the health plan revenues sufficient to cover claims and operating cost?
 - Did the MCOs successfully execute the administrative responsibilities required of a managed care plan – timely claims processing, robust member encounter systems, and appropriate use of claims denial procedures?
 - Did the full risk-based MCOs successfully meet the 85% threshold requirement for medical spending while otherwise containing cost? What service levels were achieved for primary care visits as well as mental health penetration rates for children and adults?
 - As a risk-sharing plan, did HSCSN exceed the 89% threshold requirement for medical spending? As a result what is the financial impact for DHCF?
 - What is the status of the District's pay-for-performance plan for the three full-risk MCOs?

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Summary Of Key Findings

(Continued)

- ❑ This report summarizes the 6-month performance in 2016 of the District's Medicaid managed care plans in five areas: financial condition, administrative performance, beneficiary service utilization, health plan medical spending, and the coordination of members' care.

Financial Conditions - Full Risk-Based Health Plans

- ❑ The District's three full-risk health plans are generally in very good financial condition. Each plan reports Risk-Based Capital (RBC) positions that are above the required level of 200 percent. Moreover, two of the three plans -- AmeriHealth and Trusted -- were able to pay both its members' health care expenses and administrative cost and record a profit through six months in 2016. But, MedStar's estimated quarterly RBC, while above the annually mandated standard, continued to decline relative to the health plan's performance in 2015.
- ❑ Each of the health plans are sufficiently liquid reporting ample cash reserves to pay claims that have been incurred but were not submitted for payment during the 6-month period. Similarly, all the three full risk-based plans are positioned to cover claims for a significant number of days without having to use long-term assets. However, some attention will be focused on the unusually sharp decline in Trusted's current position relative to June of 2015. Trusted officials report that the company invested approximately \$23.5M of cash into US treasuries and bonds. These investments have 90 day maturity dates but can be converted to cash at any time according to company officials.

Summary Of Key Findings

(Continued)

Financial Conditions - Shared Risk Health Plan

- ❑ After suffering huge losses in 2015, it appears that HSCSN's financial position has stabilized, with an estimated RBC of 234 percent through June of 2016. Undoubtedly, DHCF's decision to provide a rate enhancement of more than \$13 million was a critical factor in strengthening HSCSN's financials.
- ❑ HSCSN past struggles with maintaining sufficient cash-flow to pay providers during the 3-month period in 2016 have been addressed both with a DHCF payment owed to HSCSN on the risk-corridor adjustments due for 2014 and 2015 and an adjustment to HSCSN's capitation rates for the period of January 2016 through September 2016.
- ❑ Still, though HSCSN's cash position as of June 2016 is more favorable than was observed during the 1st Quarter of 2016, the current number of days that the company is able to pay claims without having to liquidate long-term assets -- 33 -- is not ideal. As with Trusted, this bears close scrutiny going forward to assess whether the allocation of short term and long-term assets by these companies is in the best interest of the Medicaid program.

Summary Of Key Findings

(continued)

Administrative Performance- All Health Plans

- ❑ Four areas are typically evaluated to assess a health plan's 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 health plans are, on balance, properly managing these significant responsibilities. Notably:
 - The health plans have constructed comprehensive and diverse provider networks to ensure access to a full range of services;
 - With the exception of HSCSN, which was waiting for delayed federal approval of a rate adjustment, the health plans are in full compliance with the District's prompt pay requirements;
 - There is no evidence that MCO's are denying high rates of claims without justification; and,
 - MCO encounter claims are, for the most part, submitted in a comprehensive fashion and with a high degree of accuracy but both Trusted and MedStar must improve their dental encounter submissions

Summary Of Key Findings

(continued)

Medical Expenses: Full-Risk-Based Health Plans

- ❑ The three full risk health plans satisfied the federal requirement that at least 85 percent of the health plans' revenue from capitated payments be spent on the medical expenses of its members. MedStar continues to spend a significantly higher rate -- 96 percent as of June 2016 -- which virtually ensures the plan will operate at a loss while creating upward pressure on the rates the District's will be required to pay health plans for future rate setting periods.
- ❑ Overall, the cost to provide Medicaid managed care for children and adults is growing at slightly elevated levels of eight and six percent respectively. Driving these increases are the rising cost of inpatient care witnessed for AmeriHealth and the growing expense of mental health services for adults and children across all three health plans. Notably, the cost of Medicaid adult inpatient care is 23 percent for AmeriHealth and children's mental health spending is up by double digits for all plans.
- ❑ Among the three full risk health plans, only MedStar appears to be experiencing higher member medical cost that can be justified by the relative risk profile of its beneficiaries. This is seen in the plan's much higher cost for more expensive forms of care -- inpatient, outpatient, and pharmacy services -- along with a substantially higher rate of inpatient admissions.

Summary Of Key Findings

(continued)

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

- ❑ For the Alliance program, though membership growth is modest, the per member, per month spending increases from this time in 2015 are substantial, reaching 17 percent overall, 22 percent for AmeriHealth, and 10 percent for the other two plans. This raises anew the question of whether the program's eligibility process encourages a selection bias causing those persons who are actively seeking medical treatment for an illness to disproportionately enter the program. A more detailed study of this issue is underway at DHCF.
- ❑ There are no appreciable changes in the physician visit rates for adults and children – the results are generally positive overall and for each health plan approaching nearly 80 percent for children as of June 2016.
- ❑ For adults, the visit rates have room for improvement – hovering around 60 percent and near 50 percent for Trusted. DHCF staff continue their work with Trusted to identify strategies to address this issue.

Summary Of Key Findings

(continued)

Medical Expenses: Shared Risk Health Plan

- ❑ HSCSN's 89 percent spending level on medical expenses after six months in 2016 is now in line with the threshold which provides the anchor for its rate, thereby relieving some pressure on the operating margins for the plan.
- ❑ Nonetheless, though moderating, HSCSN's overall medical expenses on a per-member basis per month basis -- more than \$2,111 -- increased by 9 percent from levels witnessed in the 2nd Quarter of 2015. Increases in inpatient, outpatient, physician and pharmacy contributed significantly to the overall increase.
- ❑ With a more medically fragile population, the higher expenses observed for this health plan are to be expected. The rate of growth in these expenses, however, must be more effectively managed. Through efforts to improve its case management structure, HSCSN reports that it will address this problem going forward. This issue will be closely monitored by DHCF staff.

Summary Of Key Findings

(continued)

Care Coordination

- ❑ The care coordination challenges that plagued the District's three full-risk health plans in 2014 and 2015 that 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 -- remain stubborn challenges.
- ❑ Due to changes in the rate review process by CMS, DHCF was forced to delay its plans to implement a pay-for performance program. Originally scheduled to start January 1, 2106, DHCF moved the start date to October 1, 2016.
- ❑ Now approved by CMS, this program will require the health plans to show measurable improvements against benchmarks for specific patient outcome measures or face the loss of up to 2 percent of their capitated payment - potentially \$16 million.

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

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

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

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

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

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

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

The Rate Of Medicaid Enrollment Growth Among The Plans Since June 2016 Continues To Be Strongest For MedStar

MCO	Medicaid July 2013 Enrollment	Medicaid June 2016 Enrollment	Net Change (%)
AmeriHealth	91,585	96,478	5%
MedStar	32,536	47,903	47%
Trusted	26,204	29,869	13%
HSCSN	5,595	5,557	-.006%

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

This Pattern Is Unaltered By The Inclusion Of Alliance Enrollment Numbers

MCO	Medicaid & Alliance July 2013 Enrollment	Medicaid & Alliance June 2016 Enrollment	Net Change
AmeriHealth	98,019	102,451	4.5%
MedStar	35,911	51,493	43%
Trusted	28,803	32,656	13%
HSCSN	--	--	--

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

While MedStar's Losses In 2016 Continue -- Now Reaching Nearly \$2 Million -- Revenues Paid By DHCF Through June 2016 Were Sufficient To Cover Both Claims And Administrative Cost For The Remaining Plans

MCO Revenue and Expense Data for January 2016 to June 2016

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

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	\$236.9M	\$202.2M	\$17.9M	\$17.9M
MedStar	\$120.6M	\$115.4M	\$7.1M	(\$1.9M)
Trusted	\$71.0M	\$60.3M	\$5.8M	\$4.9M
HSCSN	\$87.1M	\$76.5M	\$7.0M	\$3.7M

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 August 31, 2016, net of reinsurance recoveries.

***Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

Source: MCO Quarterly Statement filed by the health plans 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

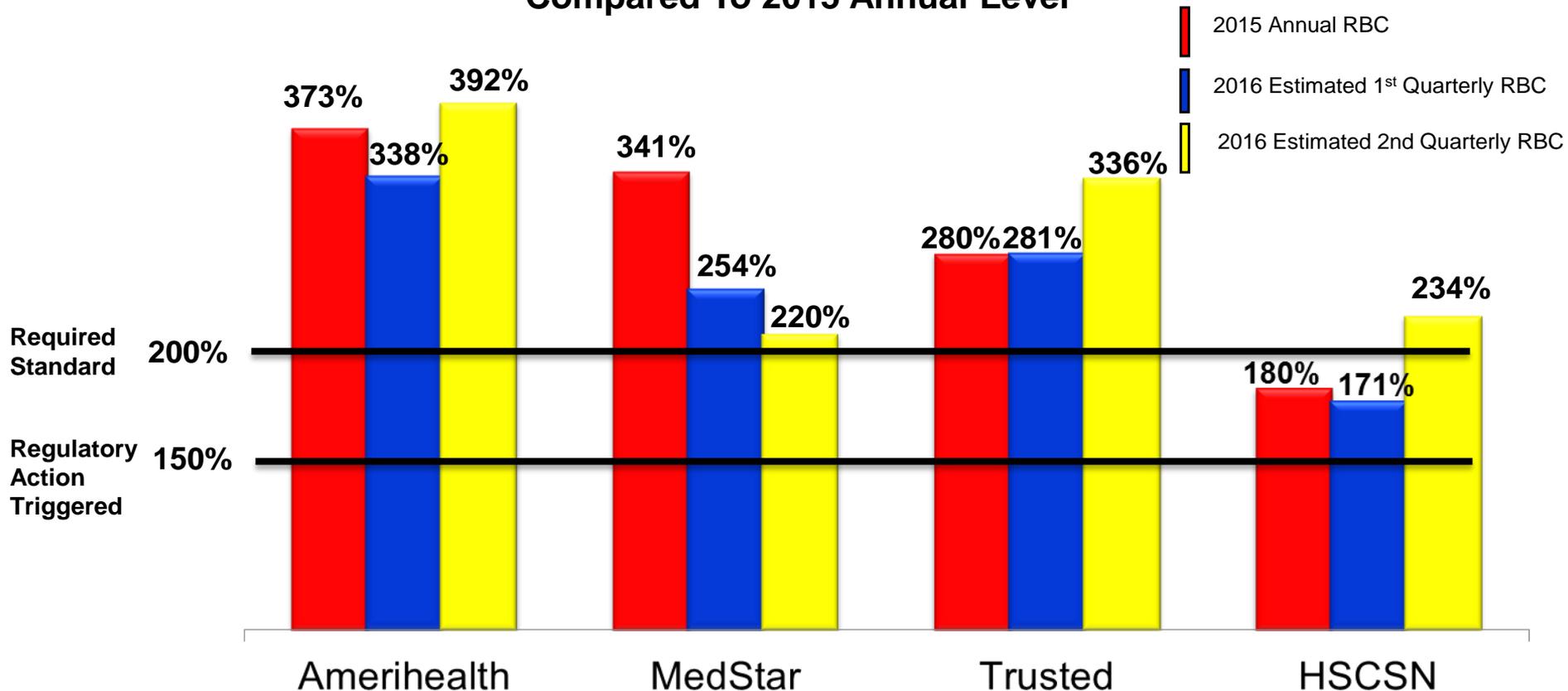
- ❑ The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims.
- ❑ MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) that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

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

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

All Four Health Plans Maintained Risk Based Capital Levels That Exceed Recommended Standards Although MedStar's RBC Performance Continues A Downward Trend Since 2015

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



Note: There are no required District Risk-Based Capital reporting requirements for HSCSN. The reported numbers are for calculated for this report.

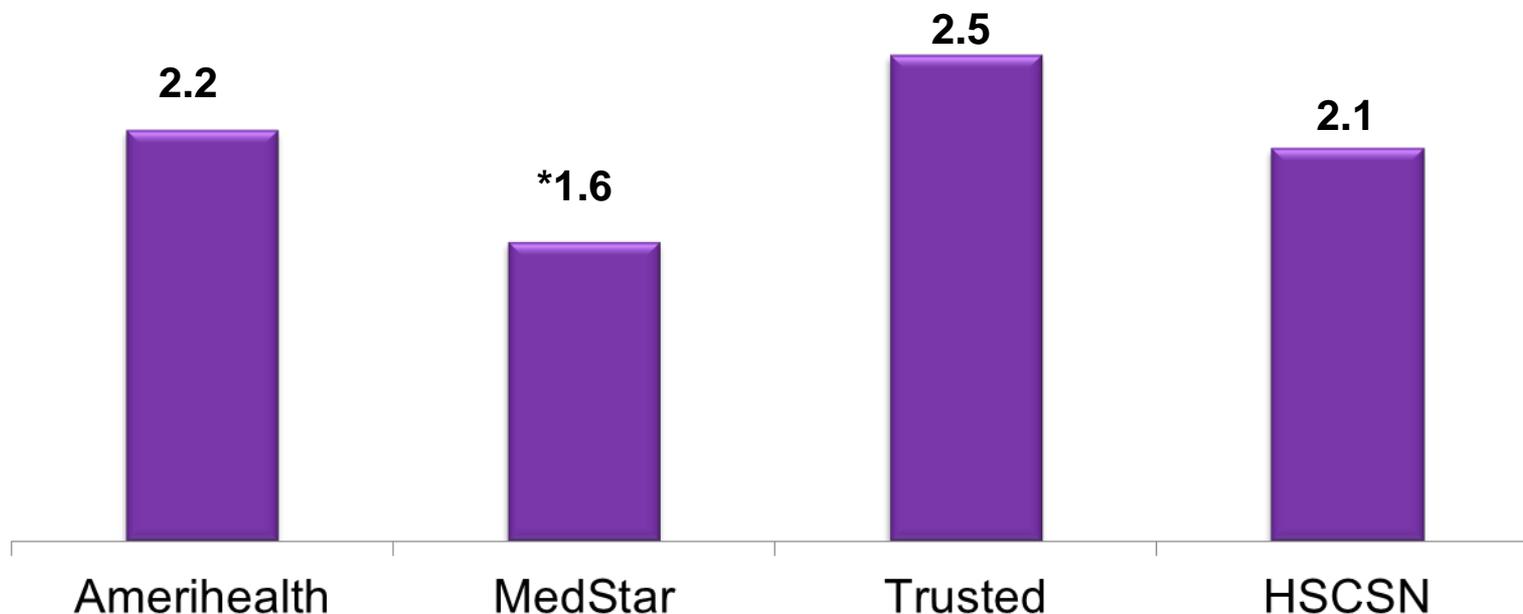
Source: Reported figures are from the MCO's annual 2015 and quarterly 2016 financial statements filed with DISB for the full risk MCOs and self reported financials for shared risk MCO.

MCOs Must Maintain Adequate Reserves To Pay “Pipeline” Claims

- ❑ It is paramount in managed care that MCOs maintain a reserve to pay for services that have been provided but not yet reimbursed.
- ❑ This claims liability represents an accrued expense or short-term liability for the MCOs each month and health plans that fail to build a sufficient reserve may not be able to pay claims when they eventually clear the billing pipeline.
- ❑ Typically, MCOs are expected to retain a reserve equal to between one to two months' worth of claims, depending on how quickly claims are processed.
- ❑ In this report, DHCF reports the reserves MCO's have available to satisfy incurred but not reported claims. This analysis is based on calculations provided by Mercer using data on the monthly claim's experience for each plan to calculate the reserves on hand.
- ❑ We also provide an analysis of the number of days the health plans can operate without accessing long-term assets. This is described as a Defensive Interval Ratio which is, in essence, a liquidity measure -- the degree to which the MCOs can survive on liquid assets without having to make use of either investments from the market or by selling long term assets.

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

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

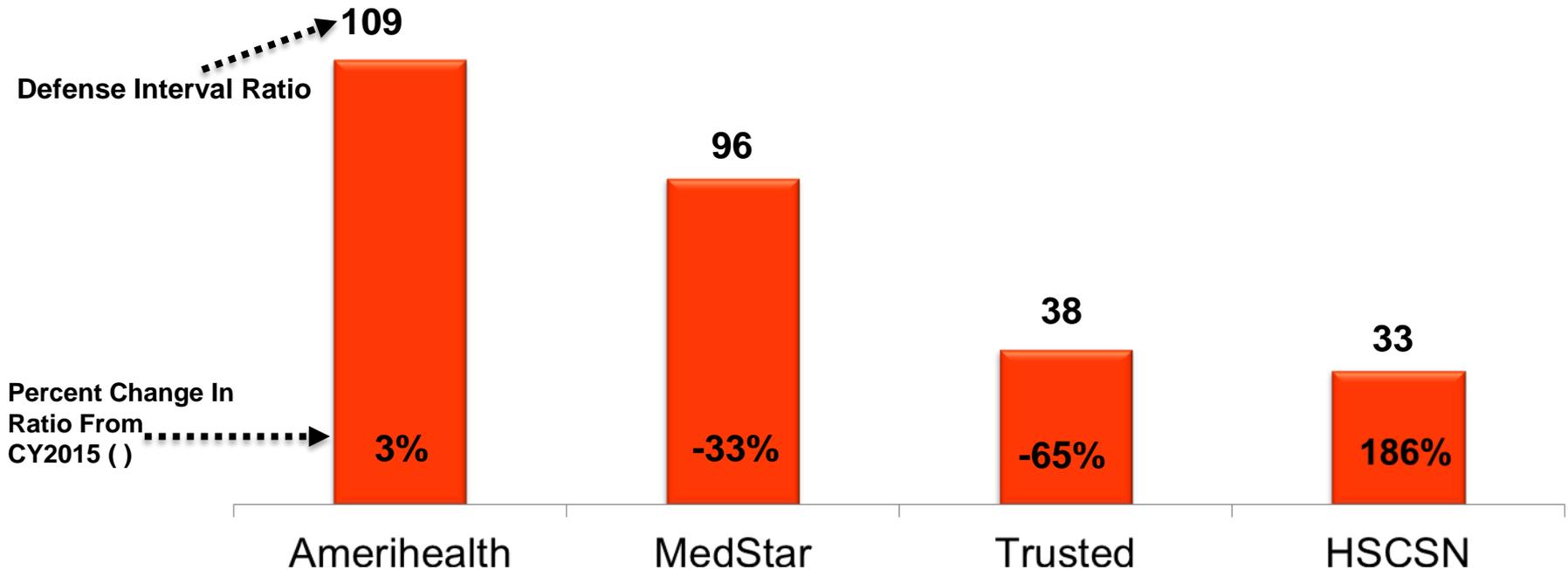


*Note: MedStar officials report that its monthly reserve figure includes data from its operations in other states and is also adversely impacted by the manner in which it pays the required Affordable Care Act fees. MedStar has been asked to provide a District specific monthly reserve figure going forward.

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

The Overall Liquidity Measures Mitigate Some Of The Concerns About HSCSN's Position In Last Quarter And, While Levels For All Plans Now Appear Adequate, The Continued Deterioration Observed For MedStar And A Sharp Downturn For Trusted Warrant Closer Attention

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



Note: Trusted officials report that the company invested approximately \$23.5M of cash into US treasuries and bonds. These investments have 90 day maturity dates, but can be converted to cash at any time according to company officials.

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

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

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

Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

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

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

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

As Of June 2016, All Health Plans Have Impaneled Substantially More Physicians Than Required By Contract Standards

The Number of Providers In The MCO Networks Compared to Contract Requirements

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
AmeriHealth	68	557	46	718	62	350
MedStar FP	34	721	16	405	22	447
Trusted	22	692	10	227	14	378
HSCSN	--	862	--	1198	--	176

Source: This information is self reported by the MCOs to the District's Enrollment Broker as of June 30, 2016 and verified by the Department of Health Care Finance through a sampling of providers.

Accuracy Issues In The Submission Of Encounters Remain For Trusted And MedStar Stemming Mostly From Dental Claims

Number of Recorded Encounters And Accuracy Transfer Rate, April 2016 to June 2016

MCO	Average Monthly Enrollment	Total Encounters	Average Encounters Per Enrollee	Accuracy Rate	Accuracy Rate Year Ending 2015
AmeriHealth	96,205	336,221	3.4	97%	92%
MedStar	47,399	159,158	3.3	85%	97%
Trusted	29,788	89,621	3.0	78%	89%
HSCSN	5,213	79,156	15.1	95%	97%

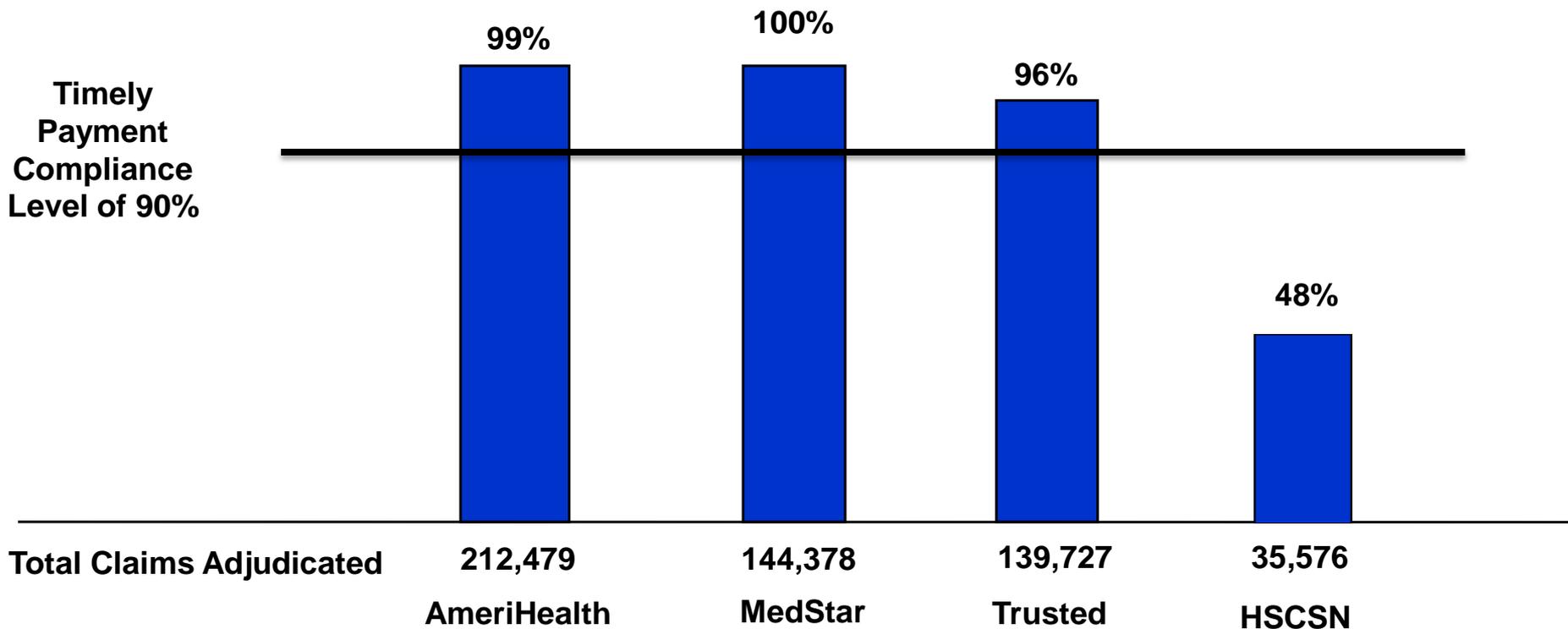
Source: Department Of Health Care Finance Medicaid Management System as of March 2016

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

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

While Three Of The Four Health Plans Met The District's Timely Payment Requirement During The 2nd Quarter Of 2016, HSCSN Was Unable To Do So Because of Delays In Federal Approval Of The Plan's Adjusted Rates

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



Note: The 30 timely payment requirement only applies to "clean claims" that meet the requirement for payment.

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

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

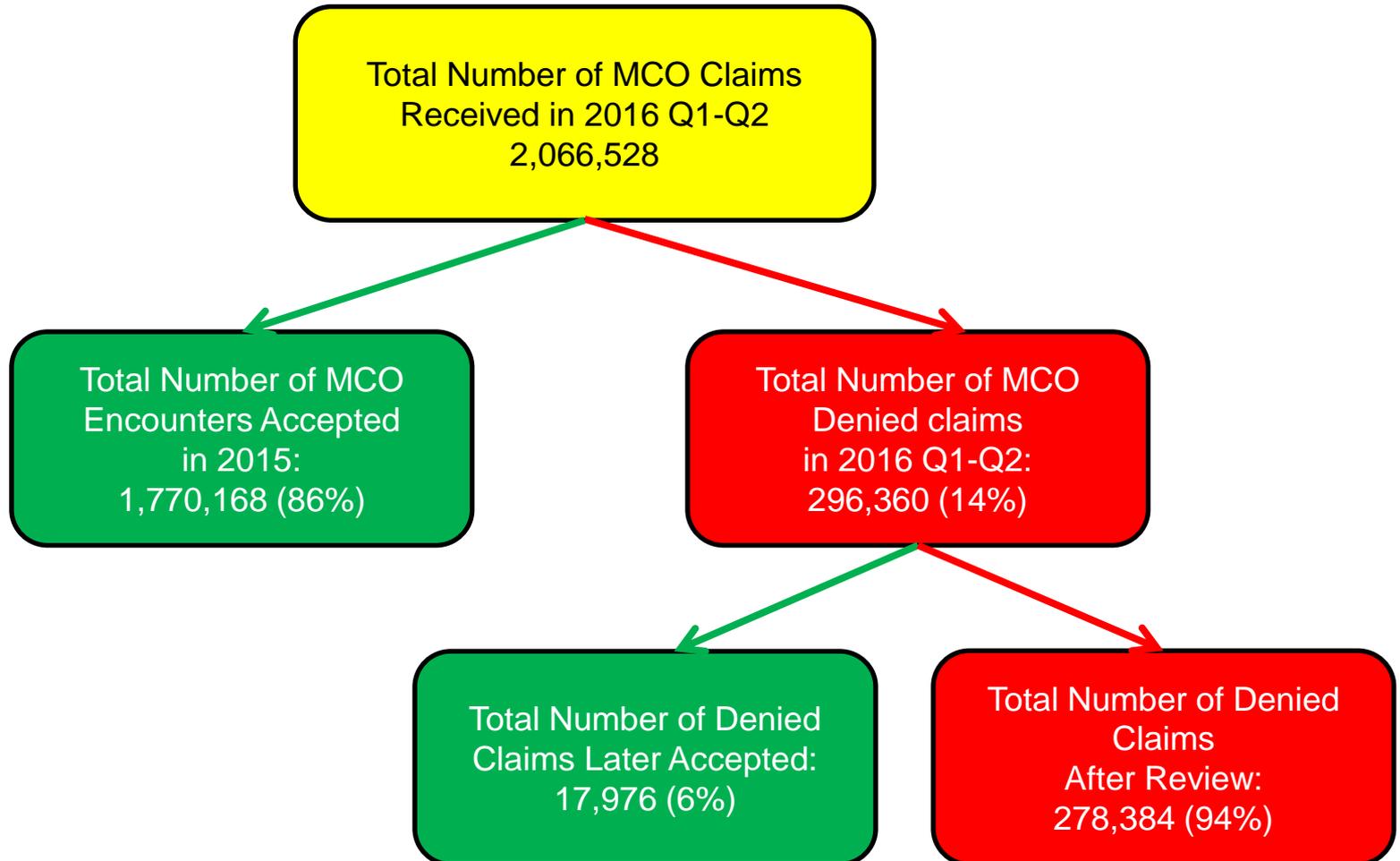
- ❑ Because the District's 30-day timely payment requirement does not apply to claims that are initially denied, some providers expressed concern that managed care plans were unjustifiably denying a high rate of claims as a cash management strategy
- ❑ Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the health plans 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 the first six months of 2016. Additionally, outcomes for claims that were initially denied but subsequently approved and repaid are also examined

More Than Two Million Managed Care Claims Processed In 2016 To Date Were Tracked For This Review

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

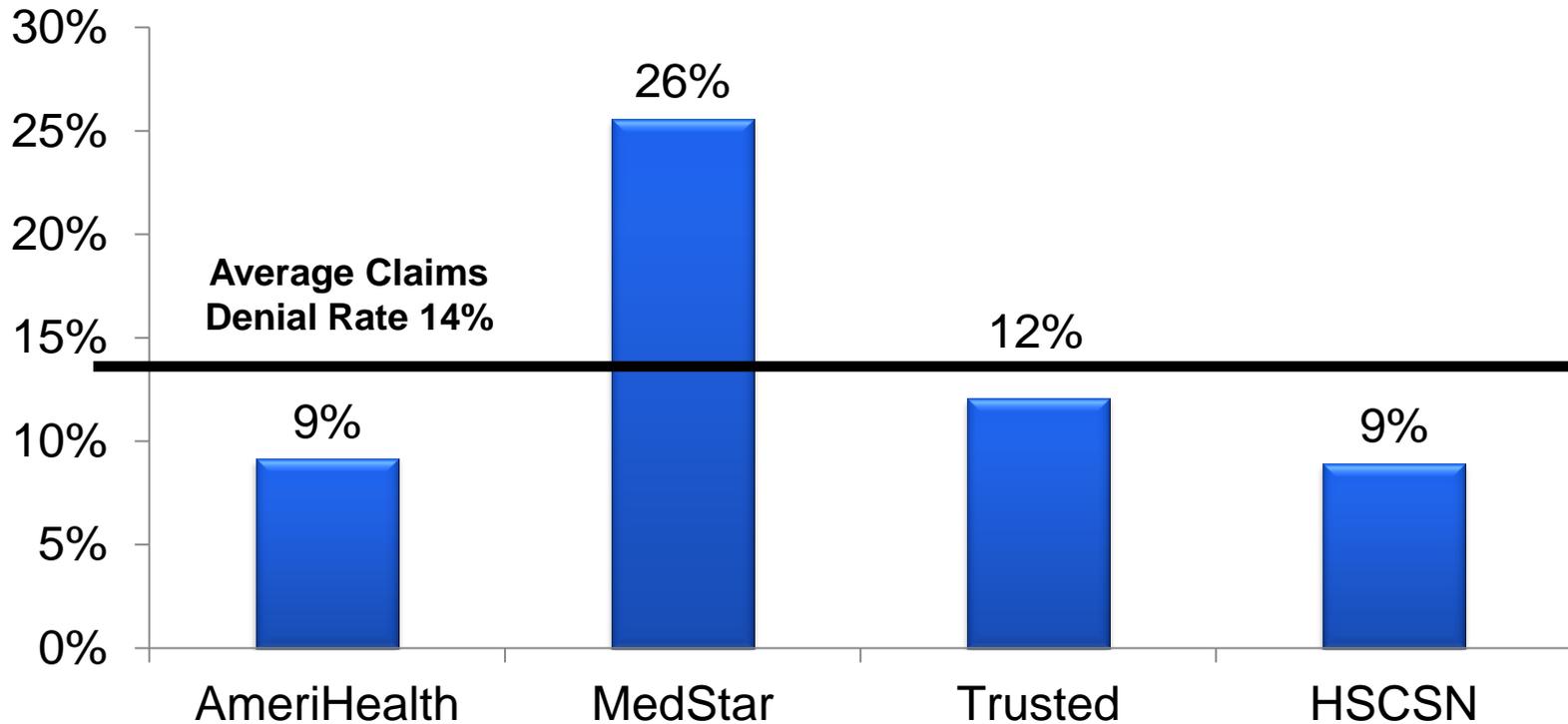
- First, all MCO denied claims with dates of service between January 1 2016 and June 30 2016 were obtained from the District's four MCOs and established as the master dataset. This data extraction yielded approximately 300,000 claims.
- Second, this master dataset was used to categorize provider types 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 and June 30 in 2016 were extracted yielding more than 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.

MCOs Had an Average Claims Denial Rate of 14 Percent For Claims During The First Two Quarters Of 2016



The Claims Denial Rate For MedStar Was Nearly Twice As High As The 14 Percent Observed For All Plans

Claims Denial Rates For Each Health Plan, 2016 Q1-Q2



Total Claims
Adjudicated

1,075,834

610,188

263,115

117,391

MedStar's Higher Denied Claims Rate Is Driven By Pharmacy Claims Adjudication And Drug Dispensing Issues

Denied claims by provider type for MedStar, 2016 Q1-Q2

Provider type	Number of claims	Percent of total denied
Pharmacy	79,760	51%
Hospital	19,901	13%
Physician	12,065	8%
FQHC	11,237	7%

Most common denial reasons for MedStar, 2016 Q1-Q2

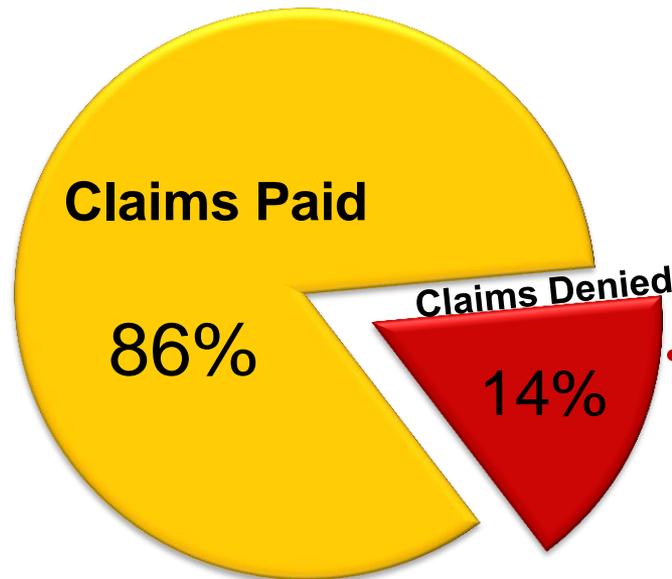
Denial reason	Number of claims	Percent of total denied
*Plan limitation exclusions	79,760	27%
Exceeded drug limitations	19,901	13%
Drug not covered	12,561	9%

*Means service not covered

Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2016 to date.e

MCOs Deny Claims For Many Reasons But The Most Frequent Relate To Service Coverage and Improper Billing

MCO Claims Denial Rate, 2016 Q1-Q2



N = 2,066,528

■ Paid ■ Denied

Most Common Denial Reasons	Total Claims	Percent of Total Claims Denied
Did not meet plan requirements*	80,728	29%
Duplicate claim**	23,305	8%
Incomplete or improper billing	17,225	6%
Member not eligible	15,891	6%

N = 296,360 total denied claims

The Claims Denial Rates Vary Widely By Provider Type and May Indicate Need for Provider Education

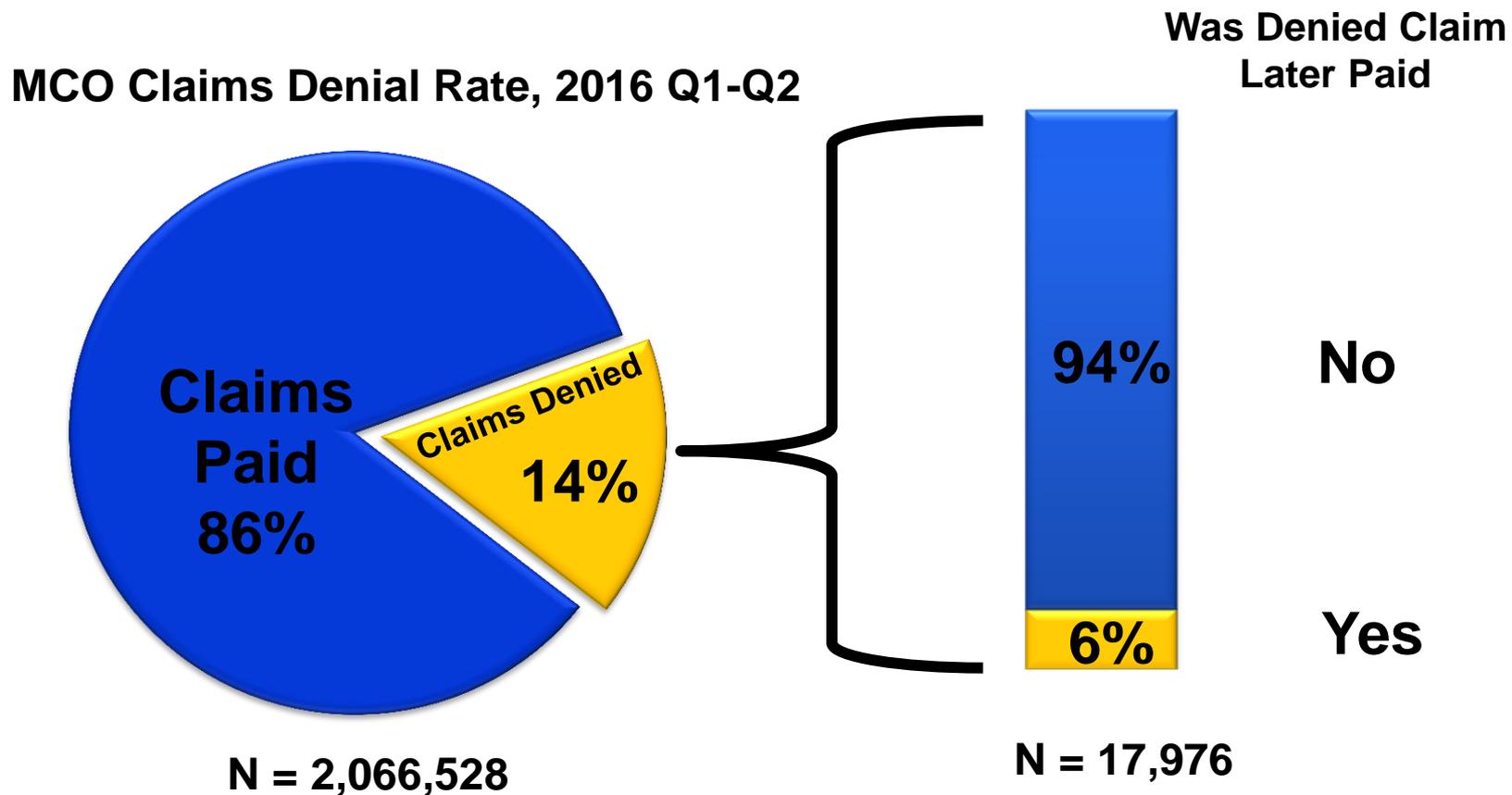
Denied Claims By Provider Type, CY2016 Q1-Q2

Provider type	Number of Total Claims	Claims Denial Rate By Provider Type
Nurse Practitioner	9,789	70%
FQHC	34,506	40%
FSMHC	19,995	40%
Home Health Agency	10,062	26%
Hospital	193,586	25%
Physician	298,937	24%
MHRS	15,939	14%

Note: FQHC denial rate is likely inflated due to paid Unity Health Care claims submitted under non-FQHC provider type.

Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2016

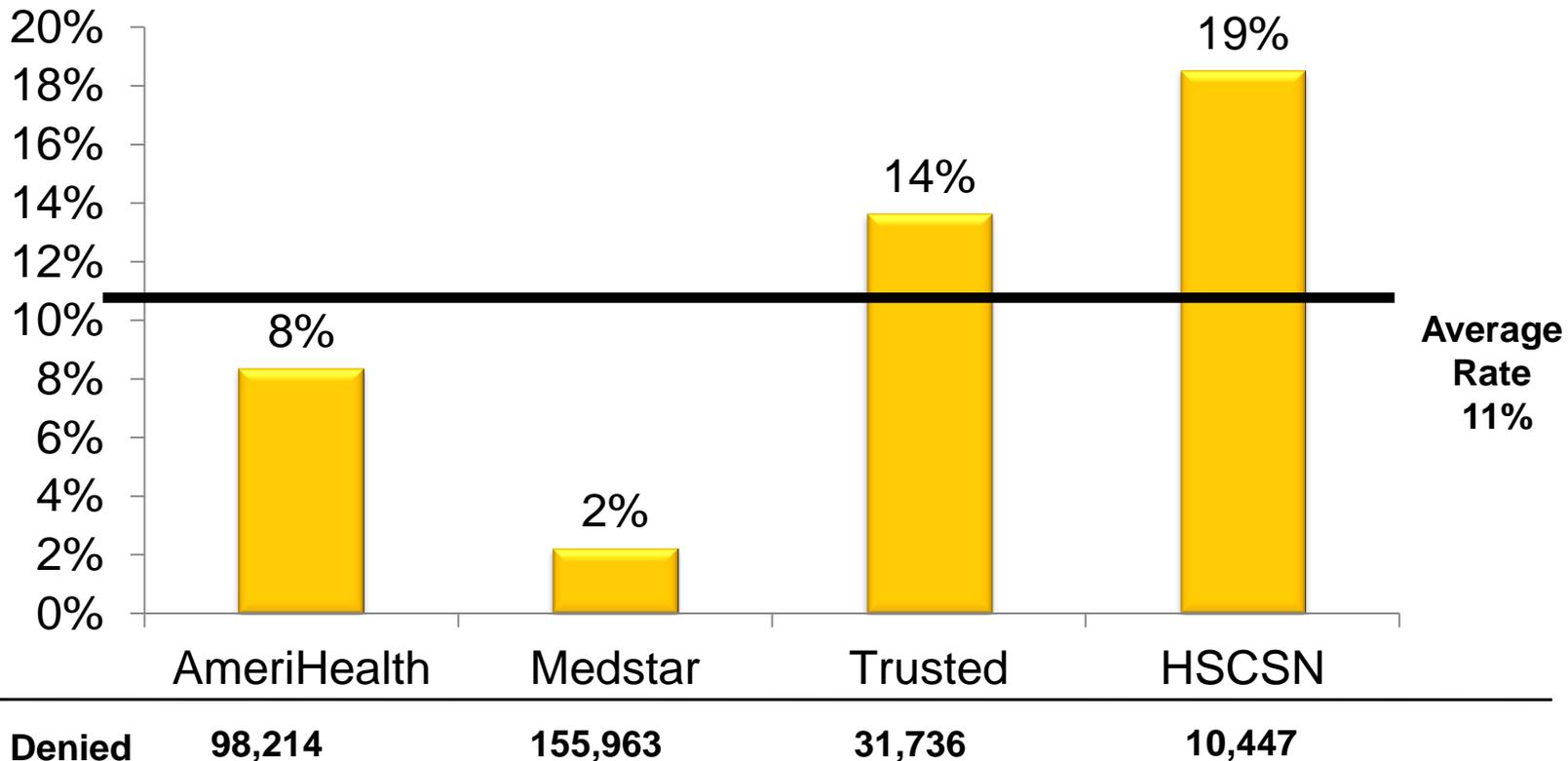
Only Six Percent of Claims Initially Denied Were Later Paid



Note: Patient encounters with 2016 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period. The claims run out period was August 2016.

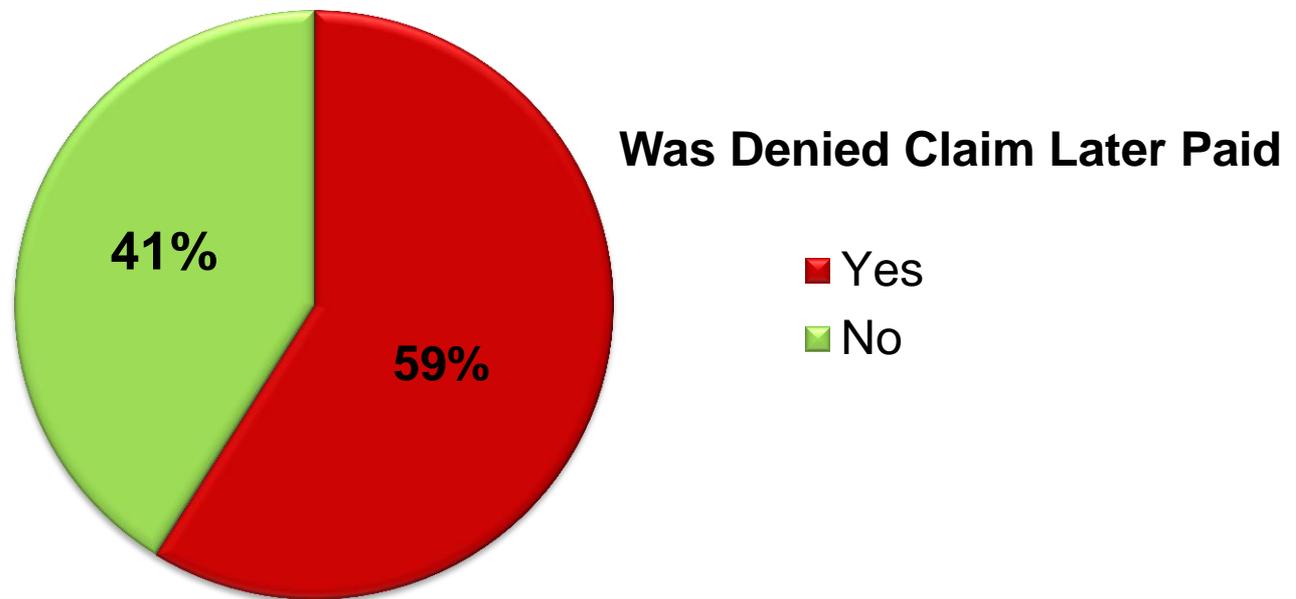
Claim Denials Are Generally Sustained By Each MCO With HSCSN Having The Highest Subsequent Pay Rate At 19 Percent

MCO Pay Rates For Claims Originally Denied, 2016 Q1-Q2



MCOs Paid Nearly Four of Ten Claims Approved After Appeal Within 30 Days

Percentage Of MCO Claims Approved After Appeal Paid Within 30 Days



N = 17,976

Denial Rates Have Remained Consistent Over Time But The Rate Of Denied Claims That Were Later Paid Within 30 days Has Declined

A Comparison of Claims Processing Outcomes From 2014 Through Two Quarters Of *2016

<u>Outcome</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>
Total Claims Processed	2.26M	4.06M	2.1M
Claims Denied (%)	18%	14%	14%
Highest Denial Rate By Plan	31% (MedStar)	22% (Trusted)	26% (MedStar)
Denied Claims Later Approved	18%	6%	6%
Denied Claims Later Approved And Paid Within 30 Days	79%	43%	59%

Note: 2014 paid claims do not include pharmacy data.

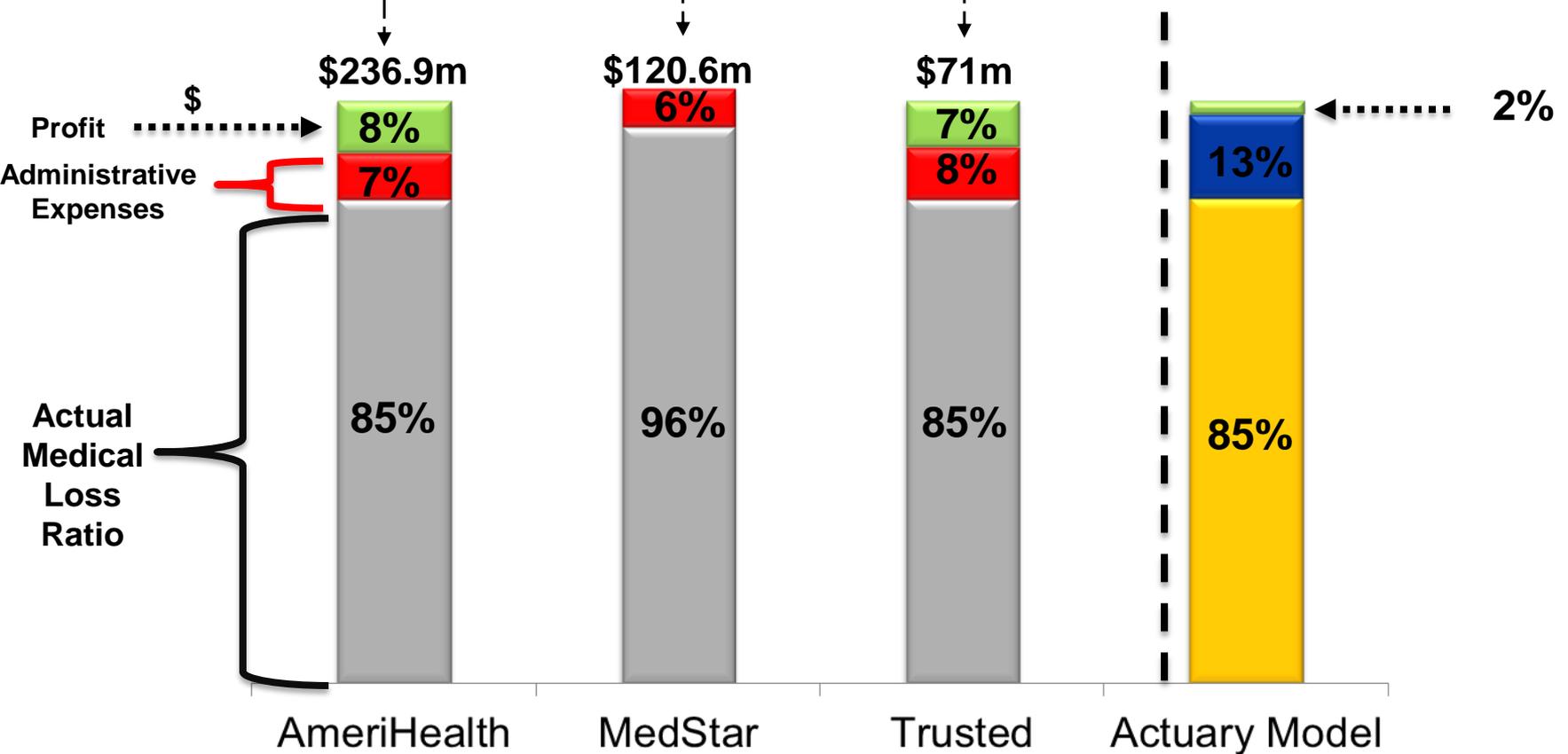
*For the period January 2016 through June 2016

Presentation Outline

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

Two Of The Full Risk Plans Spend A Least 85 Percent Of Revenue On Member Medical Expenses Without Experiencing A Loss, While MedStar's 96 Percent Rate Puts The Plan In A Fiscally Challenging Position

Actual MCO Revenue At Target Rate For January 2016 to June 2016



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

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

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

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

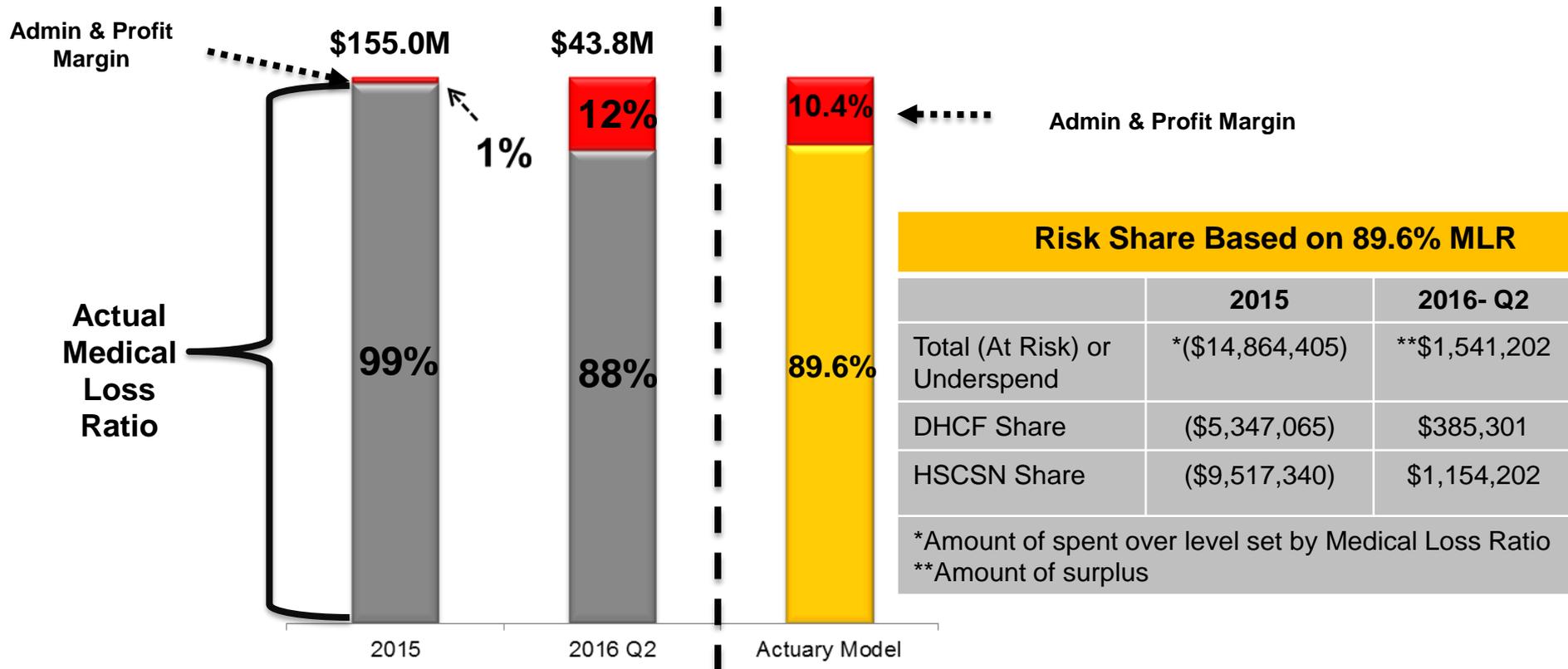
- ❑ The Table below shows the risk corridors for this contract and how financial gains or losses are shared between the HSCSN and the District

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

- ❑ For this first quarter of this period, HSCSN medical expenses as a percent of its revenue (88 percent) was less than its Medical by Loss Ratio of 89%, meaning the District and the health plan shared equally in the savings

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

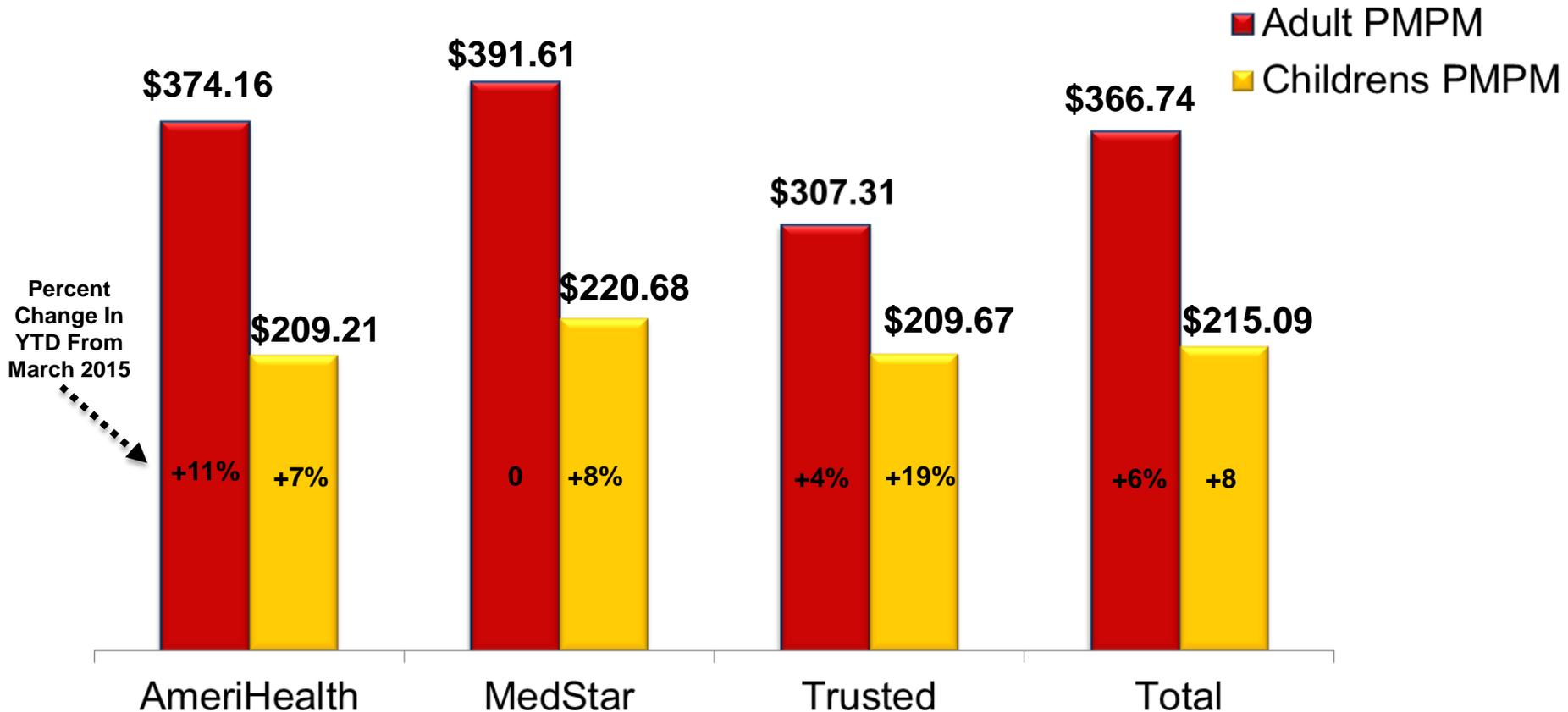
HSCSN Revenue And Claims Cost For 2015 and January 2016 to June 2016



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. These numbers do not reflect the impact of payments made to HSCSN September 2016.

Compared To The Second Quarter Of 2015, The Growth In Per-Member Per-Month Medicaid Expenses For Adults (6%) And Children (8%) Has Been Significant But Did Not Reach Double Digits

Medicaid Adult And Children Medical Expenses Per-Member, Per-Month, January 1, 2016 to June 30, 2016

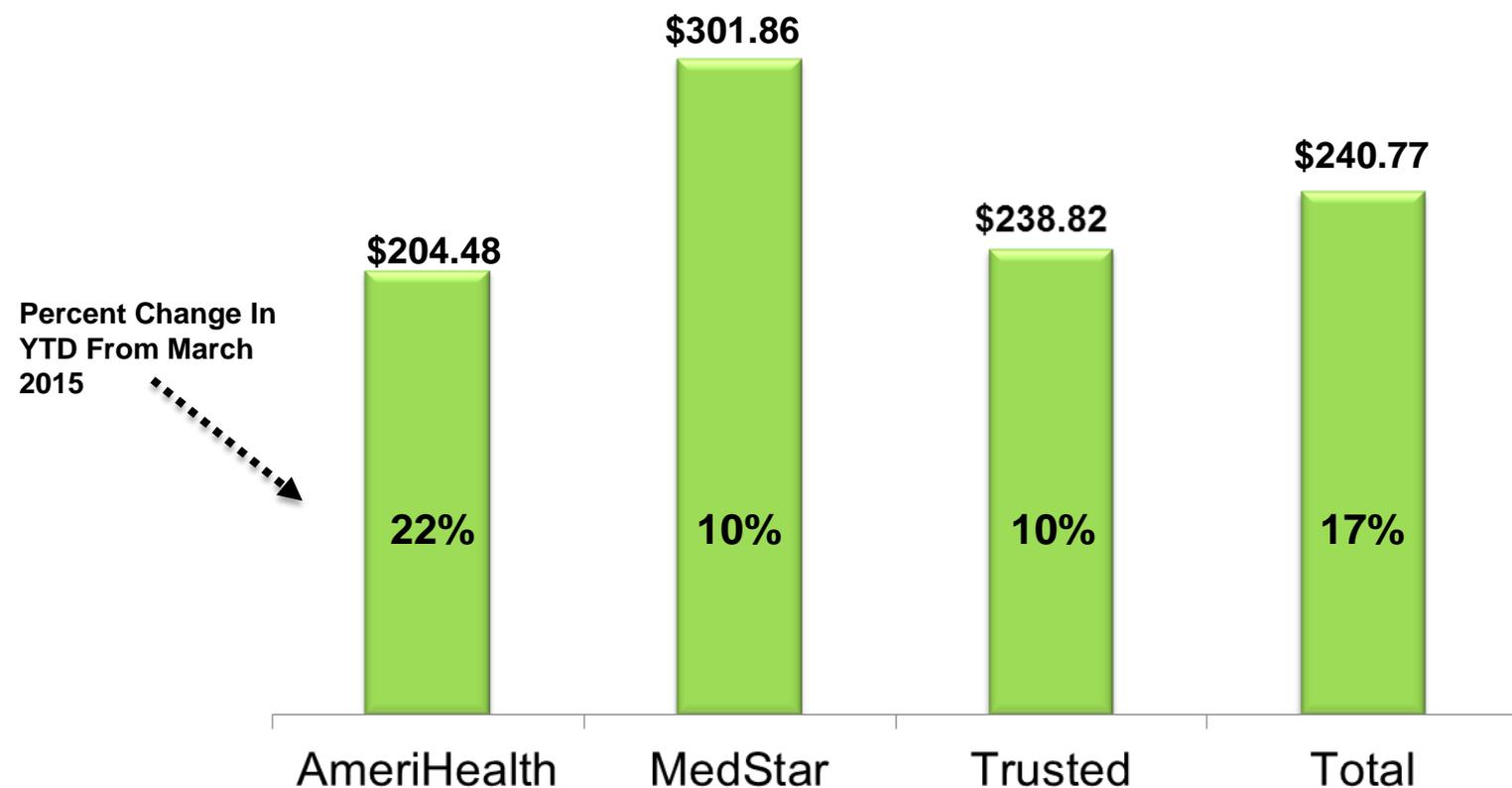


Notes: Expenses incurred from January 1, 2016 to June 30, 2016 and paid as of September 31, 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOSs.

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

Alliance Witnessed Double Digit Growth Compared To Expenses From The Same Quarter in 2015 With The Sharpest Increase Observed For AmeriHealth

Alliance Adult Medical Expenses Per-Member, Per-Month, January 1, 2016 to June 30, 2016

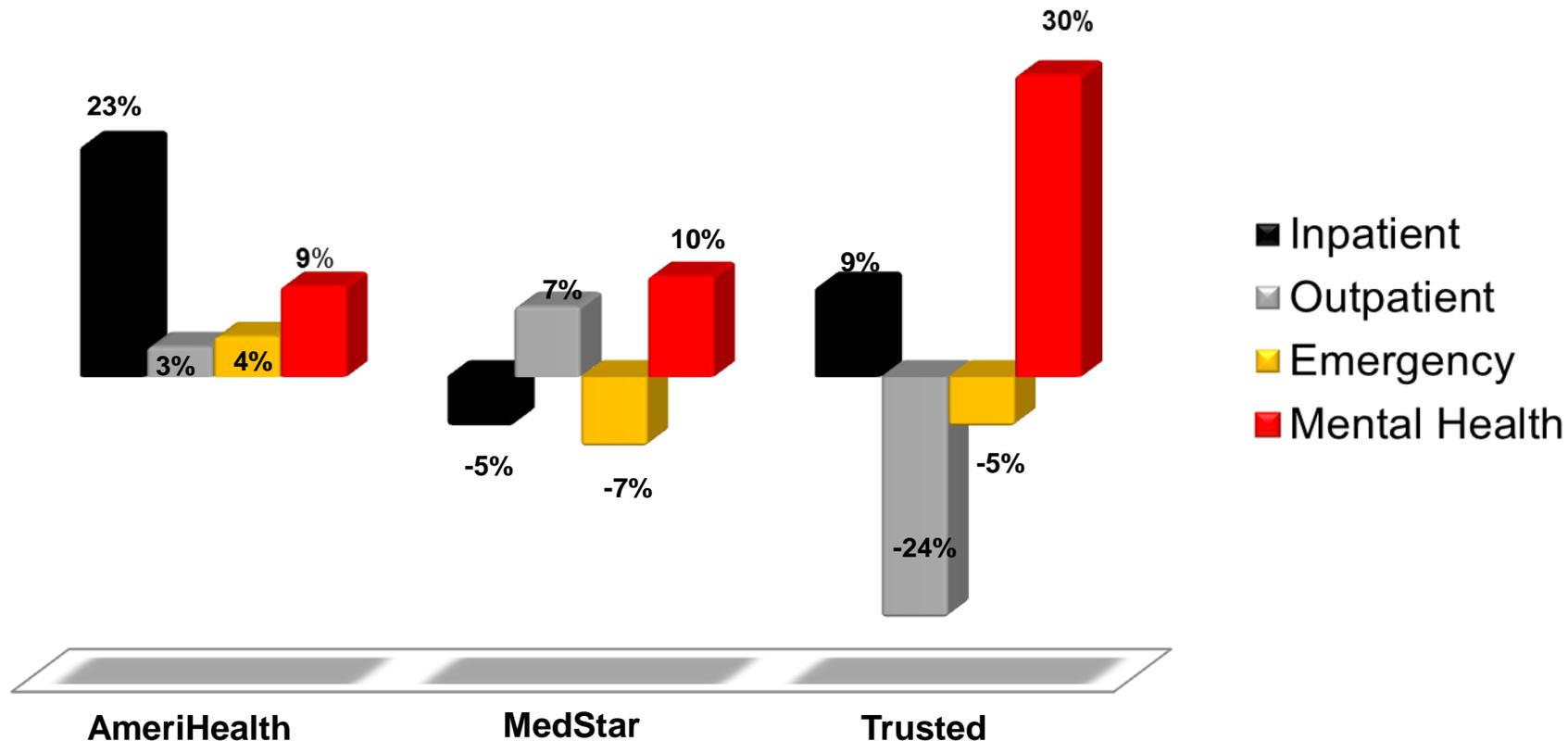


Notes: Expenses incurred from January 1, 2016 to June 30, 2016 and paid as of August 31, 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis.

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

Relative To The 1st Quarter Of 2015, Both Positive And Negative Swings Were Observed In Spending On Adult Inpatient Services, Outpatient Care, And Mental Health

Percent Change in Expenses In 1st Quarter 2016 Compared To 2nd Quarter 2016

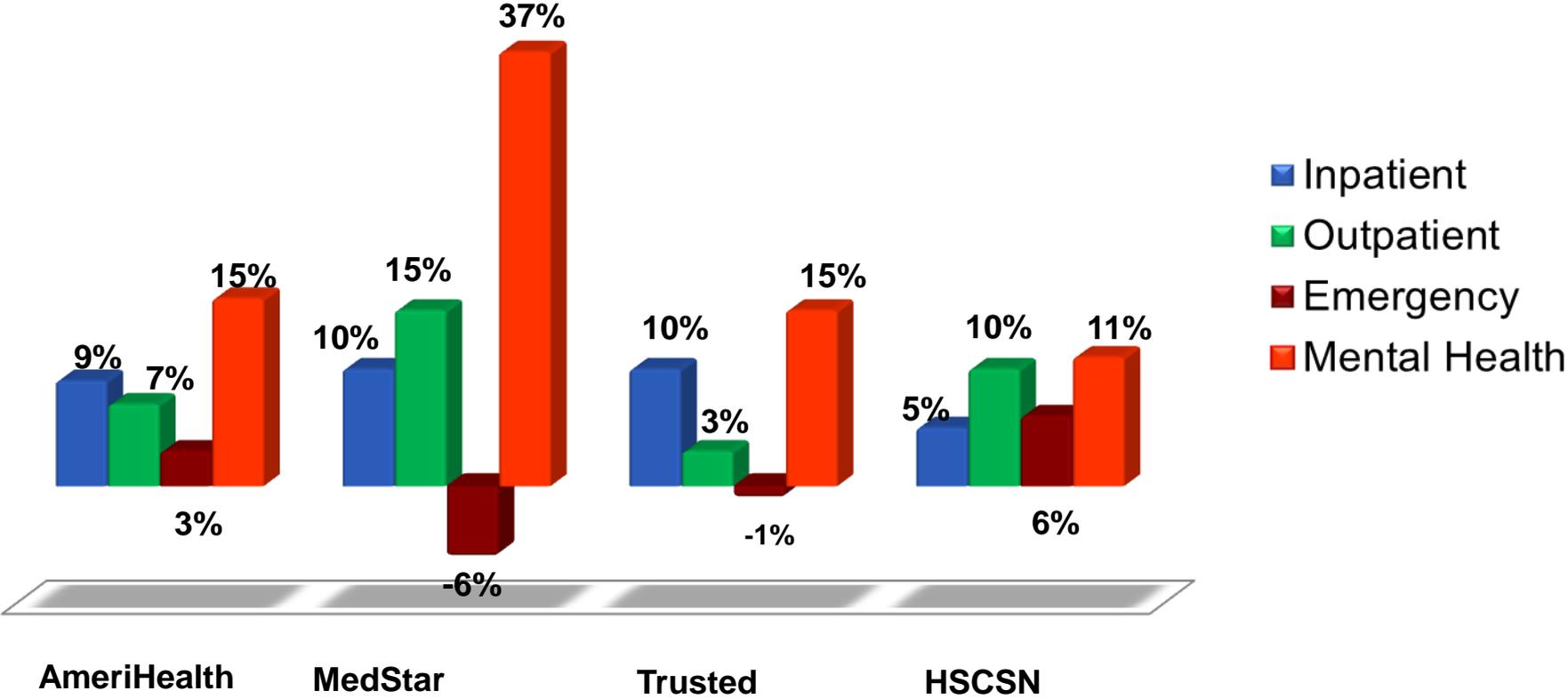


Note: *The expenses do not reflect adjustments to account for IBNR

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

For Children In All Four Health Plans There Was Double Digit Growth In The Expenses For Mental Health Services

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



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

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

MedStar Medical Expenses For The Adults And Children Does Not Match Their Assigned Risk Scores

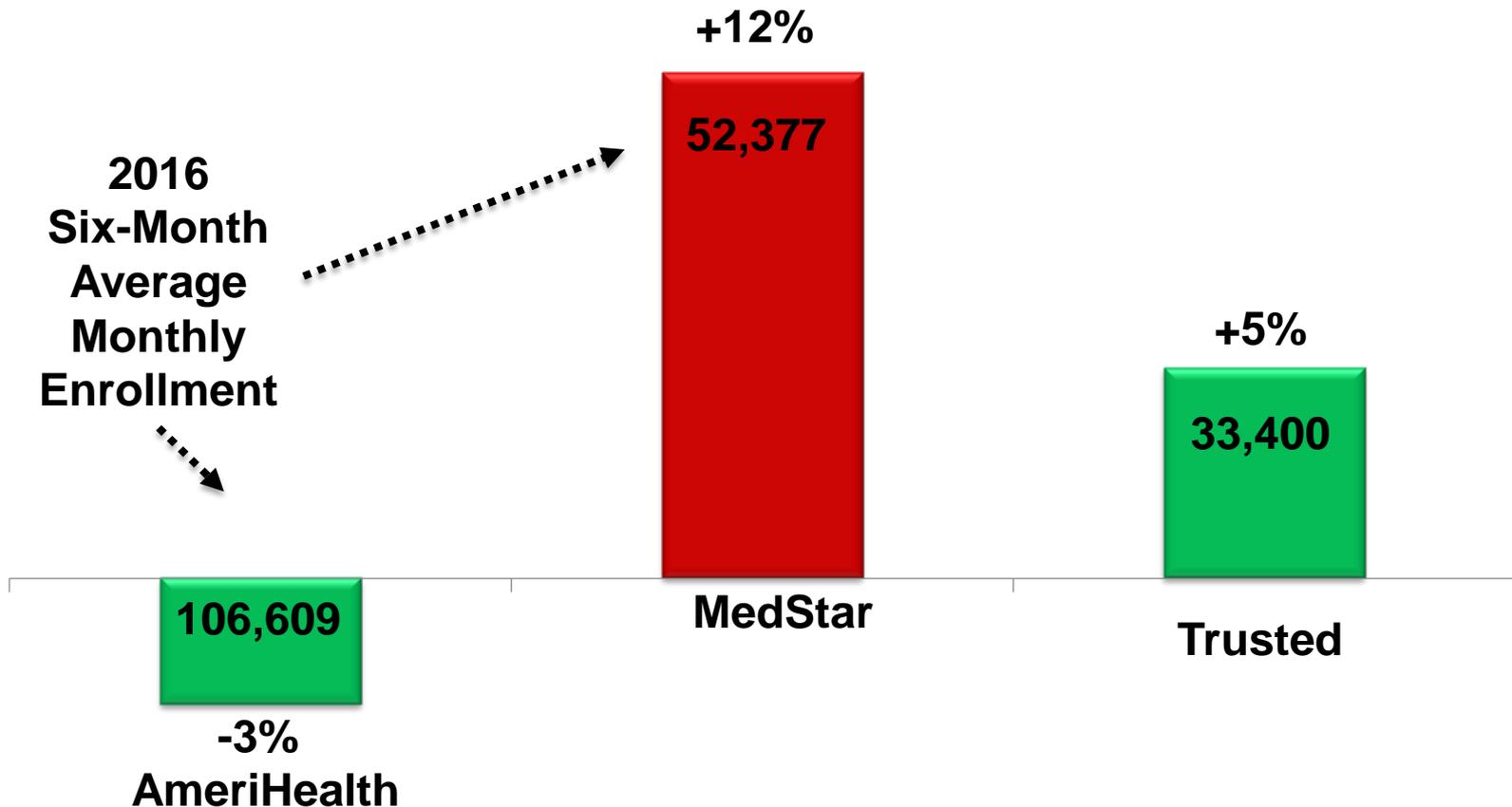
Ranking On Enrollee Risk Scores As Of October 2016

		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 January 1 2016 to June 30 2016 and paid as of August 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis. Health plans' risk scores are derived from pharmacy data. *A large volume of claims denied by Trusted using new procedures have likely impacted Trusted's ranking a as low-cost plan for adults on Medicaid .
 Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

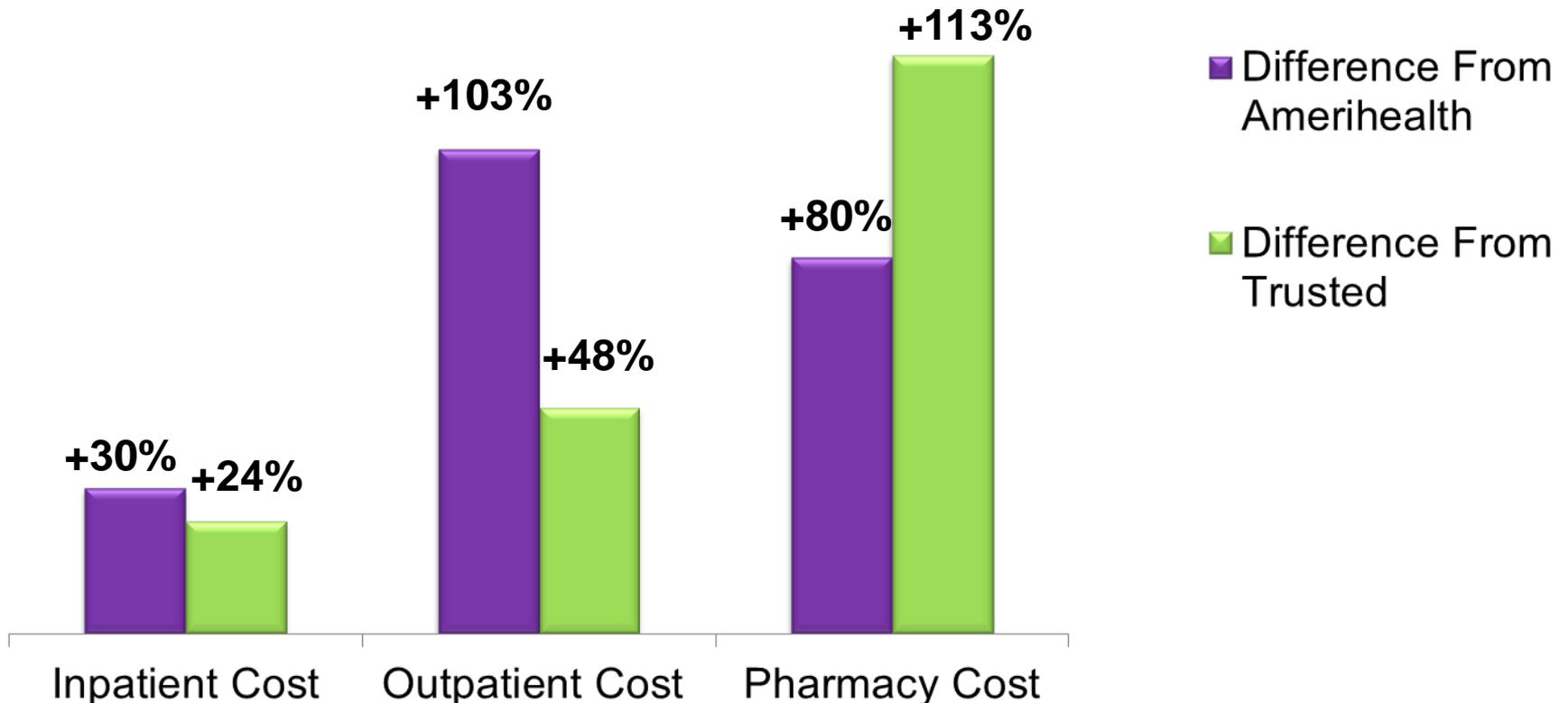
Why? Relative To The First Two Quarters Of 2015, MedStar Experienced More Enrollment Growth Than Both AmeriHealth -- Whose Enrollment Declined -- And Trusted

Change In Enrollment Levels From Relative To First Two Quarters Of 2015



Over First Six Month Of 2016 MedStar's Adult Costs For Three Major Services Were Also Substantially Higher Than The Other MCOs

MedStar's Cost Differences Relative To AmeriHealth And Trusted, As Of June 30, 2016

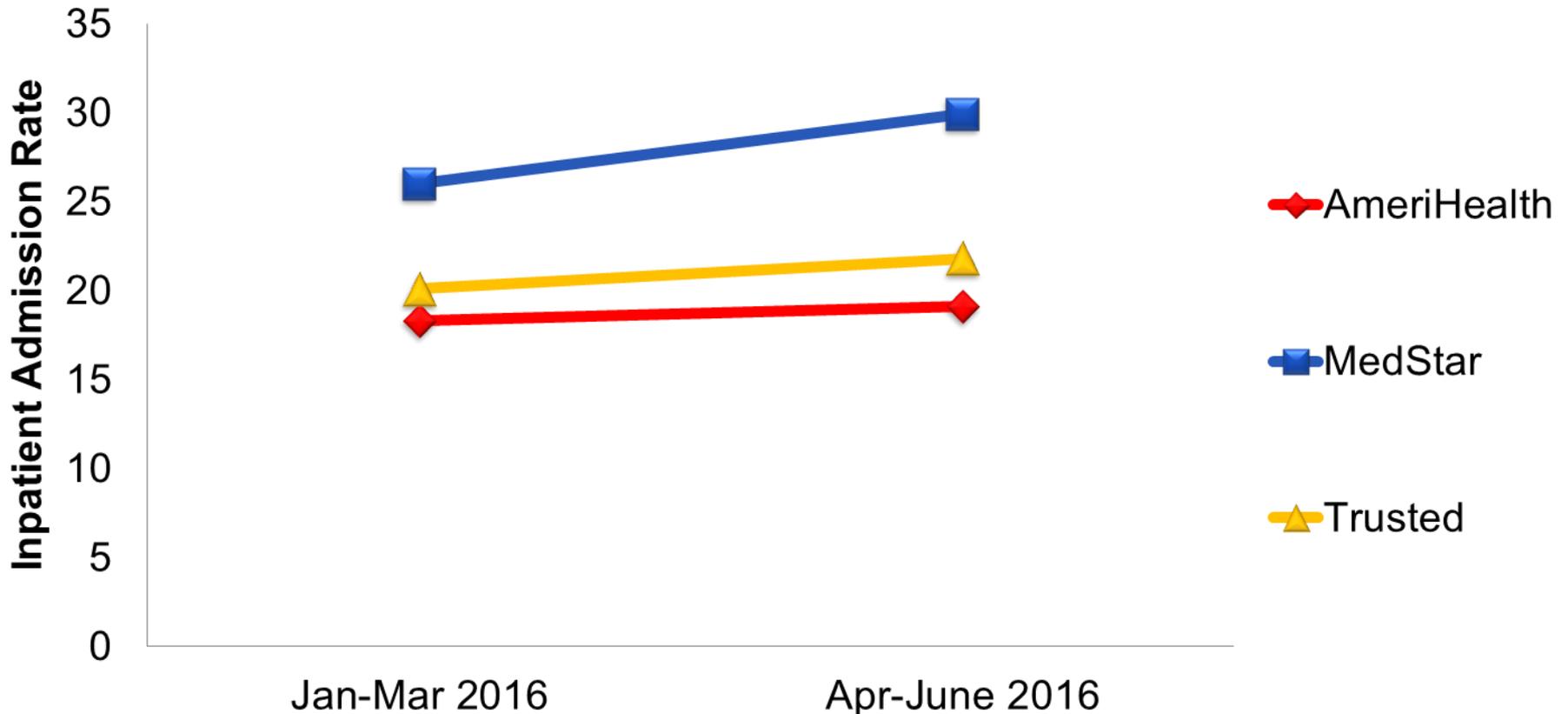


Notes: Expenses incurred from January 1 2016 to June 2016 paid as of August 31, 2016. The large difference in pharmacy cost is partly attributed to the fact the MedStar serves a higher proportion of beneficiaries who use the expensive Hepatitis C medications.

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

Finally, For The Second Consecutive Quarter -- And Continuing A Historical Trend -- MedStar Has A Higher Rate Of Inpatient Admissions Than The Both AmeriHealth And Trusted

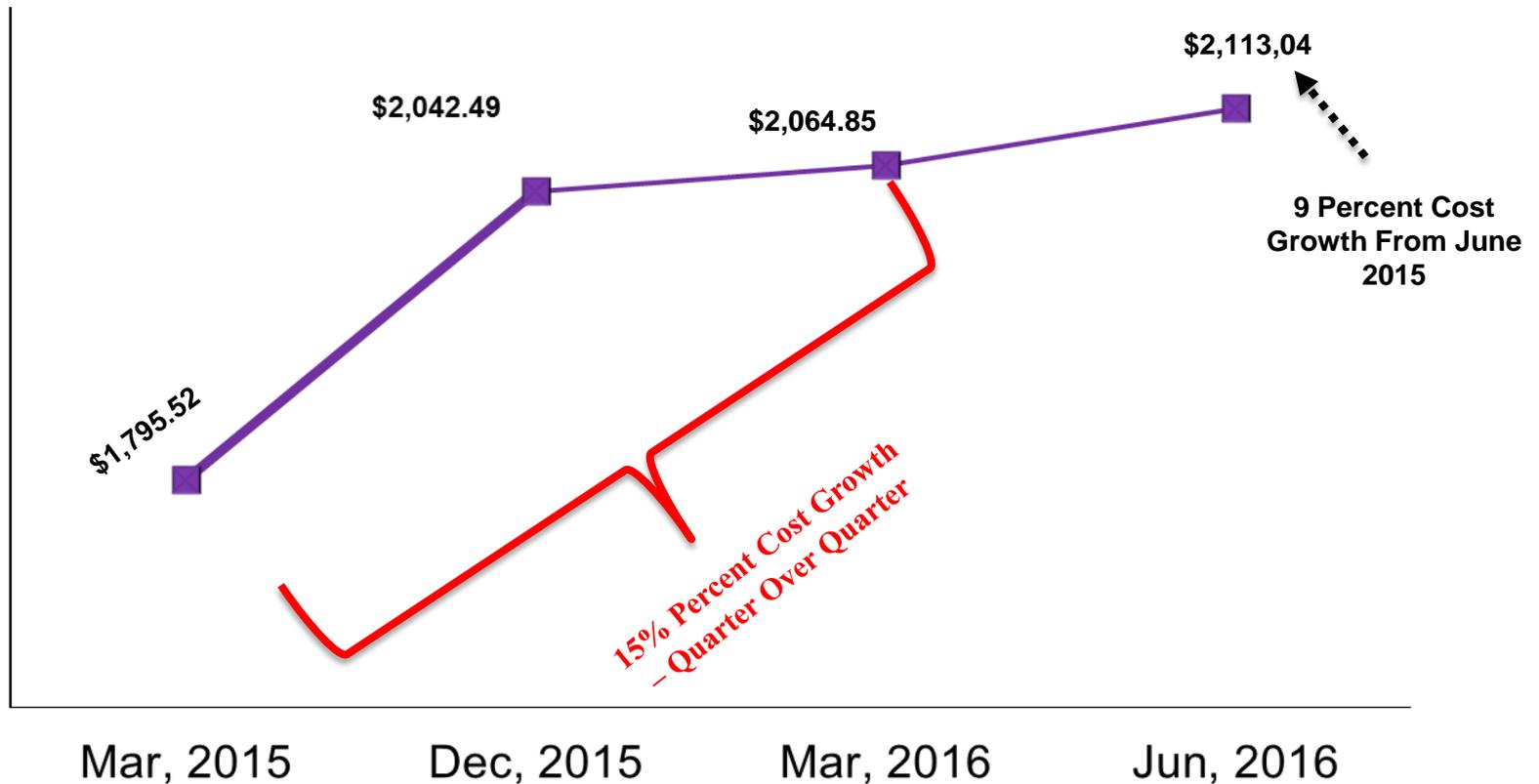
MCO Quarterly Inpatient Admission Rates For The 1st Two Quarters Of 2016



Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis. Admission rates are calculated per 1,000 members.,

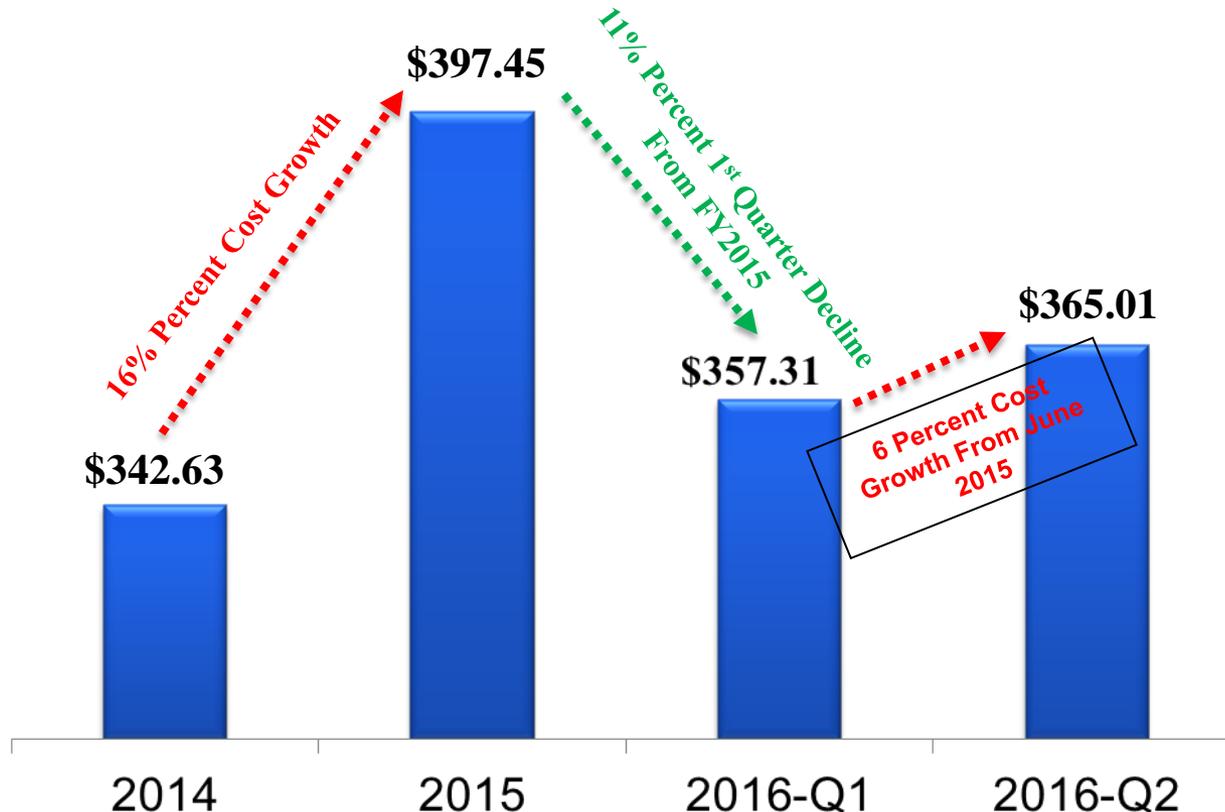
For HSCSN The Sharp Growth In Its Per-Member, Per-Month Medical Expenses For Children Occurring From March 2015 to March 2016 Appears To Be Leveling Off

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



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

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

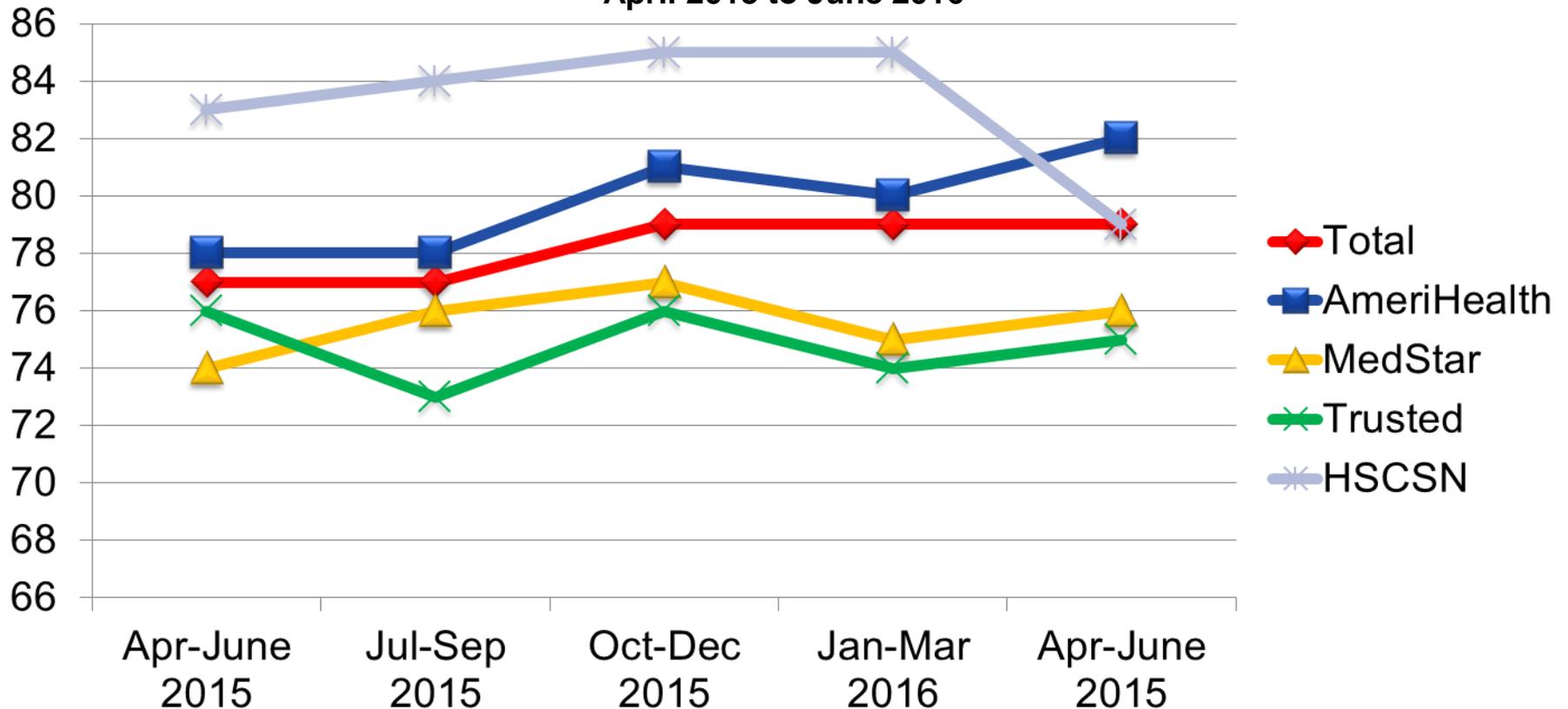


Notes: Expenses incurred from January 1, 2016 to June 30, 2016 and paid as of August 31, 2016. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOs and 26 for HSCSN 61

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

Notwithstanding A Decline For HSCSN, Physician Visit Rates For Children Remain High Across All Plans

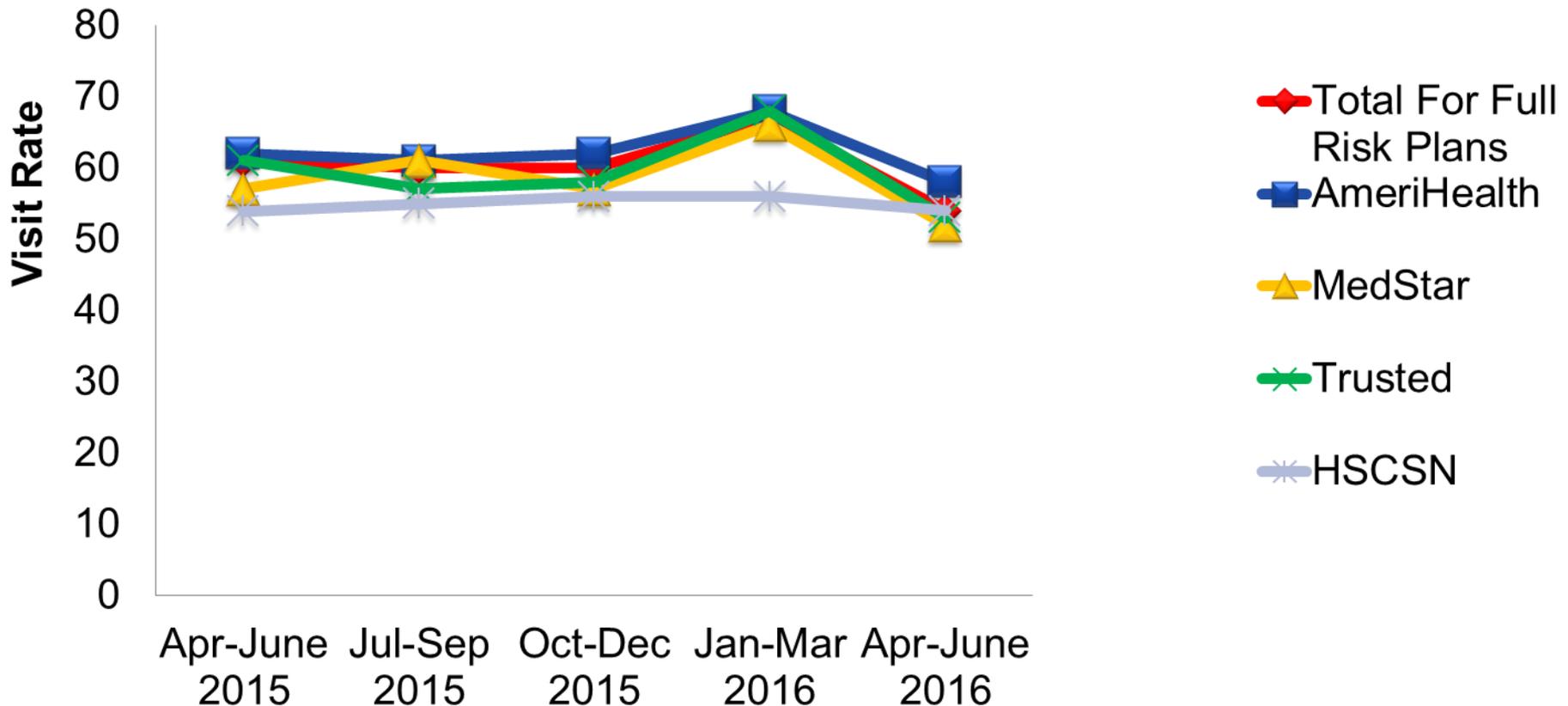
Medicaid Quarterly Physician Care Visit Rates For Children Who Were Enrolled In Managed Care, April 2015 to June 2016



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

The Physician Visit Rate For Children With An Added Well-Child Component Revealed Significant Declines For The Three Full Risk Health Plans And A Moderate Decrease For HSCSN

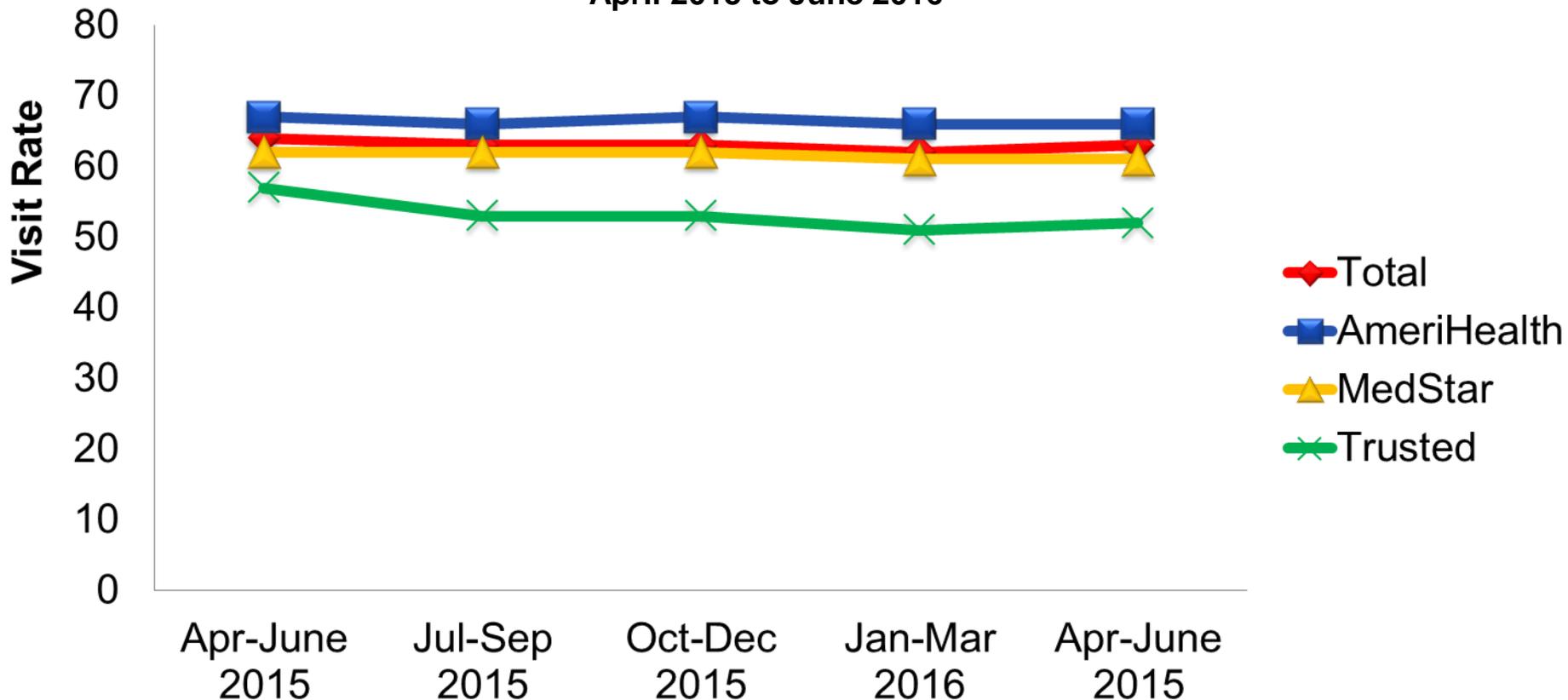
Medicaid Quarterly Physician Care and Well Child Visit Rates For Children Who Were Enrolled In Managed Care, April 2015 to June 2016



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

The Physician Visit Rate For Adults Is Largely Unchanged From The Previous Quarter

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

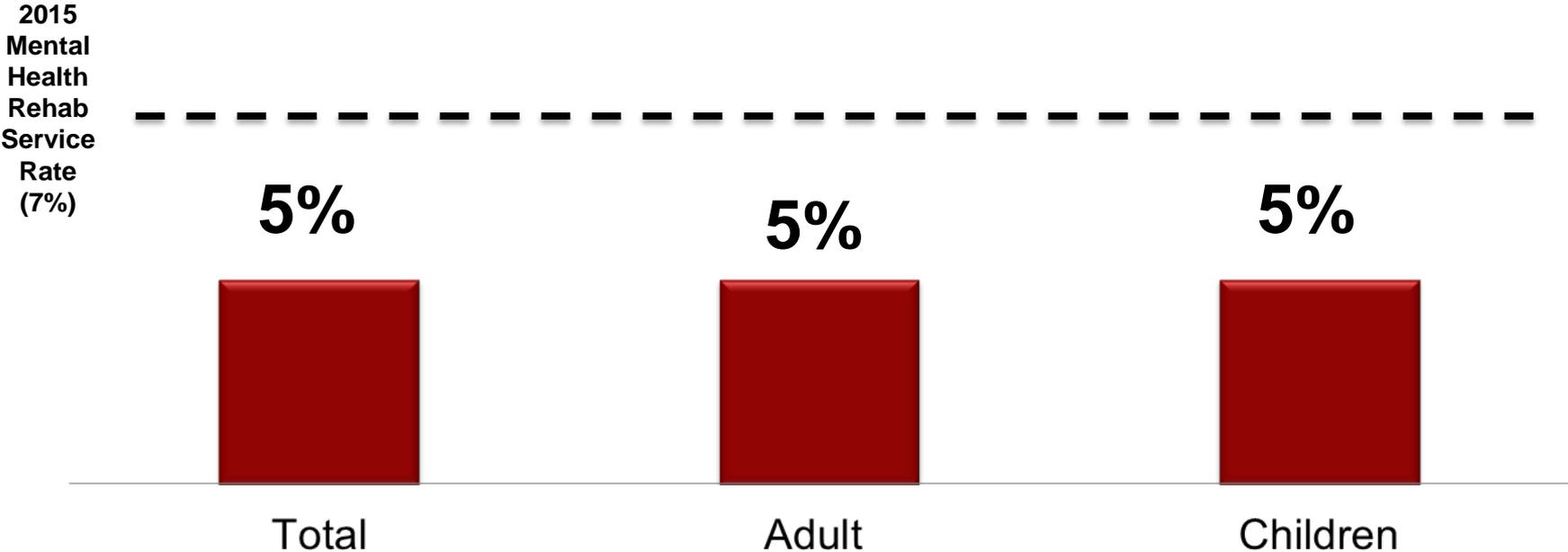


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

Understandably After Two Quarters, The Utilization Rate For Medicaid-Funded Mental Health Rehabilitation Services Is Below Last Year's Rate

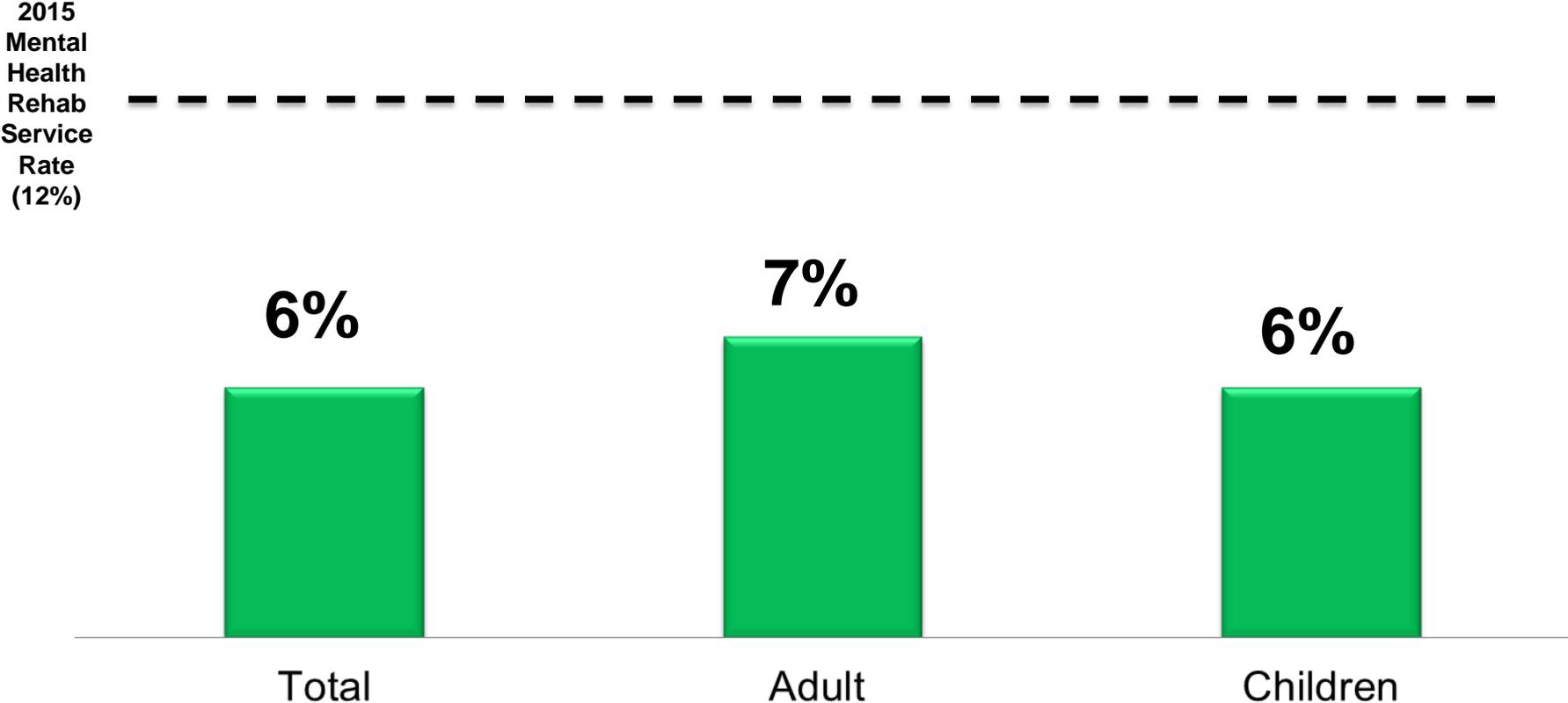
Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans January 2016 to June 2016



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

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

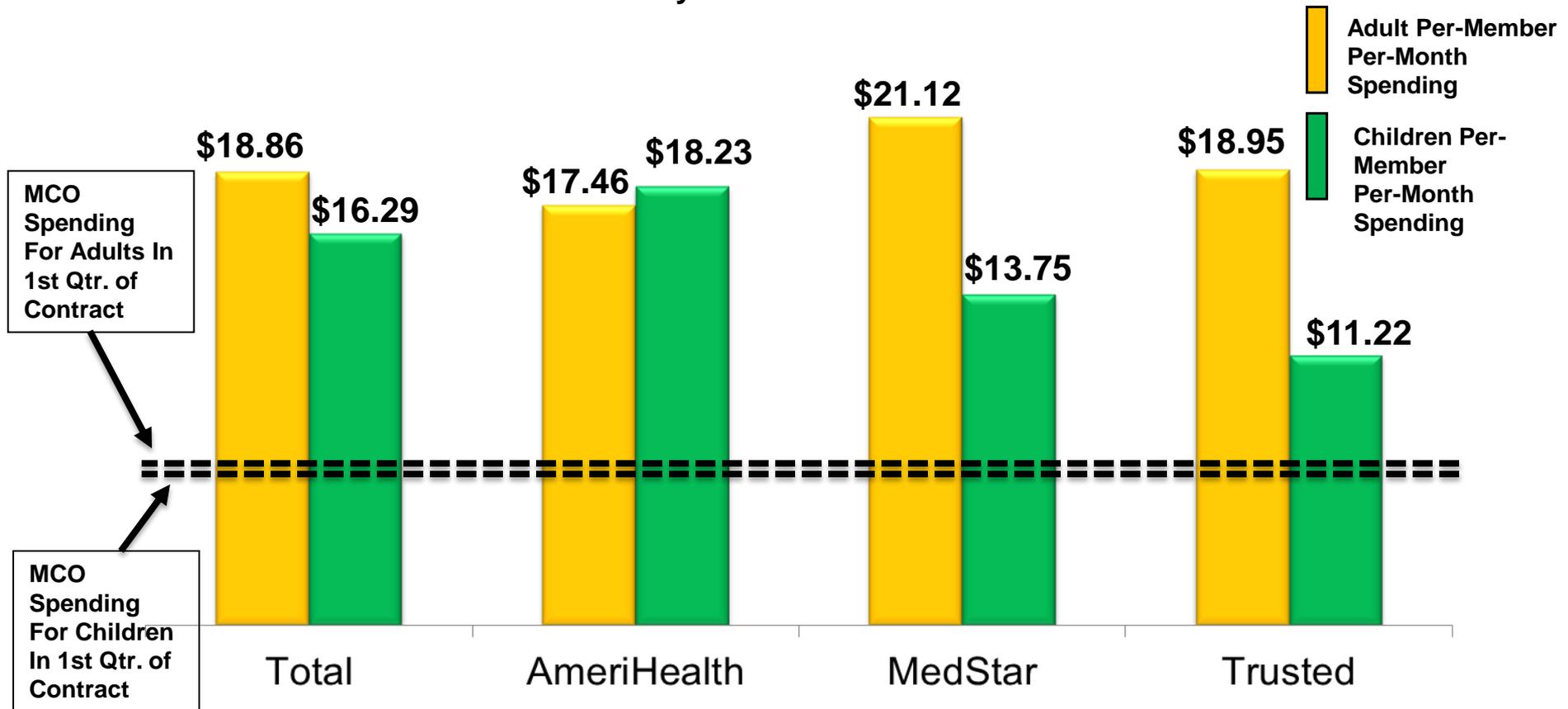
Percent of MCO Members Receiving Any Mental Health Services Through The Health Plans January 2016 to June 2016



Note: The data presented above are based on MCO capitated payments for the 2nd Quarter of 2016.
Source: Encounter data submitted by MCOs to DHCF.

Compared To 1st Quarter Of The Managed Care Contract (October to December 2013) -- On A Per-Member Per-Month Basis -- MCOs Continue To Spend At Significantly Higher Levels On Medicaid-Funded Mental Health Services For Both Children And Adults

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



Notes: The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis.

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

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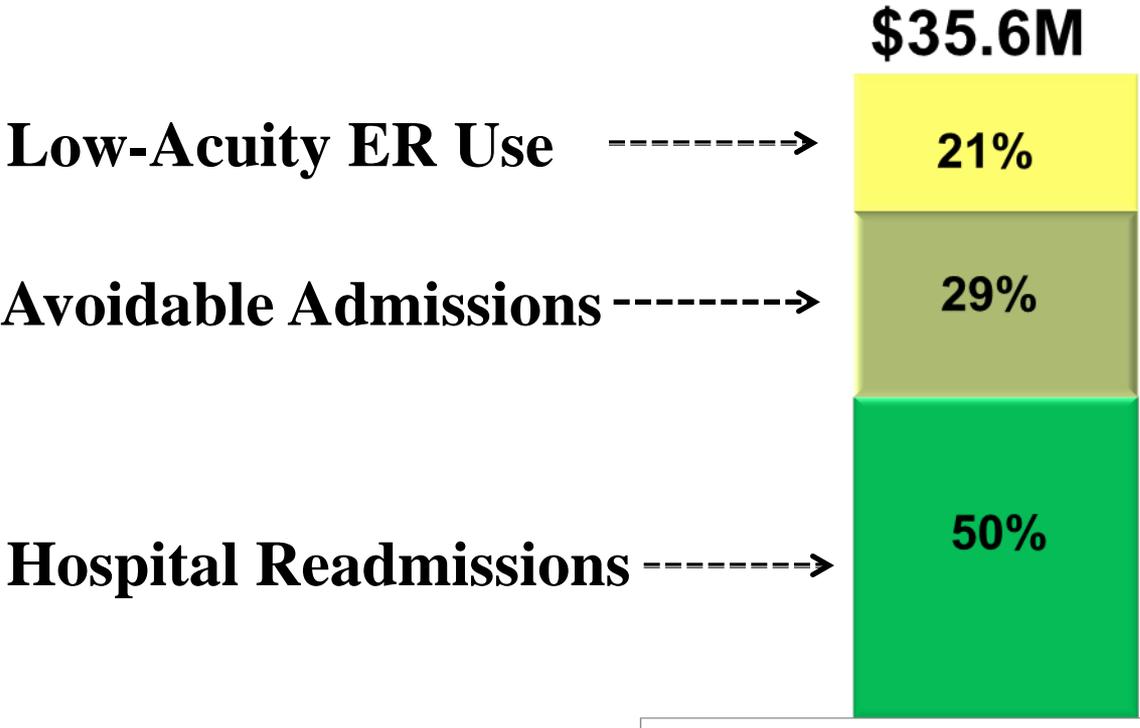
DHCF Relies Upon Several Metrics To Quantitatively Assess The Efforts By The Health Plans To Coordinate Enrollee Care

- ❑ Achieving high value in health care for Medicaid and Alliance beneficiaries is a preeminent goal of DHCF's managed care program.
- ❑ The District's three managed care plans are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management.
- ❑ With more than one year's worth of data, DHCF can now more closely examine the following performance indicators for each of the District's three health plans:
 - Emergency room utilization for non-emergency conditions
 - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care
 - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days -- hospitalization

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

Managed Care Expenses Due To Lack of Care Coordination, 2015

Patient Metrics



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

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

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

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

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

Program Structure Is Based On Cash Withhold

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

Weighting And Scoring System For Pay-For-Performance

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

- ❑ LANE and PPAs will be weighted at 33% of the capitation withhold. The MCOs have an opportunity to earn back the full 33% based on performance as follows:
 - 5% reduction in LANE Emergency Department (ED) utilization and PPAs from the baseline will result in the MCO earning 100% of the 33% withhold attributed to each of these measures
 - 3.5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 75% of the of the 33% withhold attributed to these measures
 - 2% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 50% of the 33% withhold attributed to these measures
 - If reduction in LANE utilization and PPAs are less than 2% from the baseline, the MCOs 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 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.