District of Columbia's Managed Care End-of-Year Performance Report

(January 2015 – December 2015)

Department of Health Care Finance

April 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
- ☐ 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 December 2015, more than 176,000 Medicaid beneficiaries and just over 15,500 Alliance members 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)
- Three of these health plans -- AmeriHealth, MedStar, and Trusted -- offer comprehensive benefits and operate under full risk-based contracts with the District and are the primary focus of this report
- In FY2015, the District spent more than $1 billion on MCO services

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 plan's performance in 2015. The following questions are addressed for each MCO:
  - What was the financial condition of MCOs during 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?
  - What was the estimated cost incurred by the MCOs that might otherwise have been avoided with more robust care coordination programs?

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Summary Of Key Findings

- This report summarizes the annual 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

- For the first time since DHCF awarded new contracts to the health plans in the program more than three years ago, each of the MCOs finished the year in a strong financial position. The health plans reported risk-based capital levels that are significantly higher than the threshold required by District regulations. Further, while showing profits ranging from 4 to 5 percent, the managed care plans possessed sufficient liquidity in 2015 to cover expenses for a significant number of days without having to use long-term assets.

- Critically important, the managed care plans all possessed the necessary cash reserves to pay claims that were incurred in 2015 but not submitted for payment during the calendar year.

Summary Of Key Findings
(continued)

Administrative Performance

- With 12 months of administrative data, the evidence indicates that the managed care plans continue to successfully execute the major administrative requirements of the program. Robust provider networks, timely payment of claims, and modest overall denial rates bear witness to the significant improvements the health plans have made in these areas since 2013.

- One area that Trusted can further improve concerns the submission of encounter claims. Gains have been made in terms of both completeness and accuracy, but Trusted's performance still lags behind the levels reported by the other two plans. DHCF is presently working on a policy that will impose financial sanctions on those plans whose performance in this area drops below desired levels

Summary Of Key Findings
(continued)

Medical Expenses

- As observed during the six month mark of 2015, the three health plans met the required spending level for medical expenses of 85 percent for the entire year. MedStar showed improvement in managing its member medical expenses but continues to have the highest cost beneficiaries on a per-member-per-month basis, while spending 90 percent of the plan's revenue on medical expenses.

- By comparison, AmeriHealth and Trusted are experiencing lower costs from last year with their adult Medicaid populations. However, for AmeriHealth, the plan's Medicaid medical expenses for children jumped by 4 percent from 2015. Trusted's cost for this population was relatively flat and MedStar experienced a sharp decline of seven percent.

- Both AmeriHealth and Trusted successfully aligned beneficiary cost with their members' risk levels in 2015. MedStar, however, continued with what is now a two year struggle with this issue. The sources of this problem is the managed plan's more rapid rate of beneficiary enrollment growth, much higher cost than the other plans for the more expensive forms of care - inpatient, outpatient, and pharmacy services – and a substantially higher rate of inpatient admissions.

Summary Of Key Findings
(continued)

Medical Expenses (continued)

- The positive trend in physician visit rates for adults and children in 2014 continued in 2015. 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 before the start of the next contract period - October 1, 2016

- The trend of every increasing health care cost for Alliance beneficiaries continues unabated for both AmeriHealth and MedStar with rates of growth from 2014 of 12 and 10 percent respectively. Trusted's Alliance cost actually declined but they manage care for a small number of beneficiaries

Summary Of Key Findings
(continued)

Care Coordination

- The was no real change in the care coordination struggles by the health plans in 2015 with failures in this area resulting in additional and avoidable medical spending of $36 million.

- Due to changes in the rate review process by CMS, DHCF delayed 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.

- This program will require the health plans to show measurable improvement 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%. 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 second report on the health plan's management of the denied claims process in April 2016 and the results are included in this document

For Medicaid Membership, MedStar Has Experienced The Highest Enrollment Growth -- 36 Percent Growth Rate -- Since The Beginning Of The Five-Year Contract Period

MCO	Medicaid July 2013 Enrollment	Medicaid December 2015 Enrollment	Net Change (%)
AmeriHealth	91,585	95,958	5%
MedStar	32,536	44,309	36%
Trusted	26,204	28,304	8%

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

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

MCO	Medicaid & Alliance July 2013 Enrollment	Medicaid & Alliance December 2015 Enrollment	Net Change
AmeriHealth	98,019	102,714	5%
MedStar	35,911	48,166	34%
Trusted	28,803	31,326	9%

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

The Revenue For All Three Health Plans Was Sufficient To Cover Both Medical Claims And Administrative Cost During 2015

MCO Revenue and Expense Data for January 2015 to December 2015

Revenue* — **Claims**** — **Administrative Cost***** = **Net Gain (Loss)**

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	$454.6M	$399.6.5M	$35.8M	$19.2M
MedStar	$219.4M	$198.2M	$13.0M	$8.2M
Trusted	$128.5M	$110.3M	$11.2M	$7.0M

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.

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

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

- The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether a health plan has the assets to pay claims

- MCOs conduct this complicated calculation annually for each health plan using end-of-year financial data (as well as some information that is not publically disclosed) which is provided to the Department of Insurance, Securities and Banking (DISB) for review

- Health plans with RBC levels that fall below 200% 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.

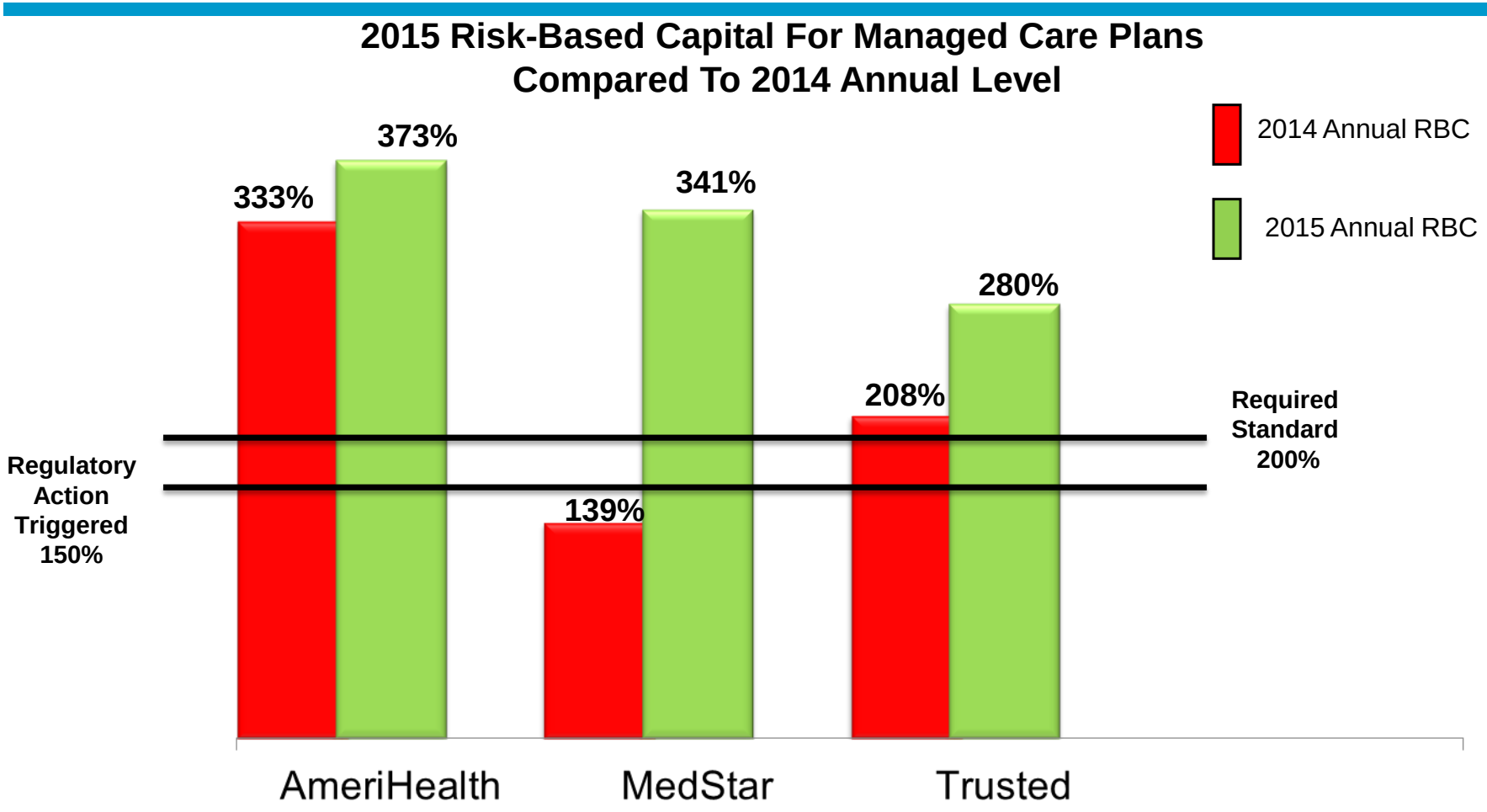
2. **Company Action Level** - Total Adjusted Capital of 150% to 200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.

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 Of 200 Percent



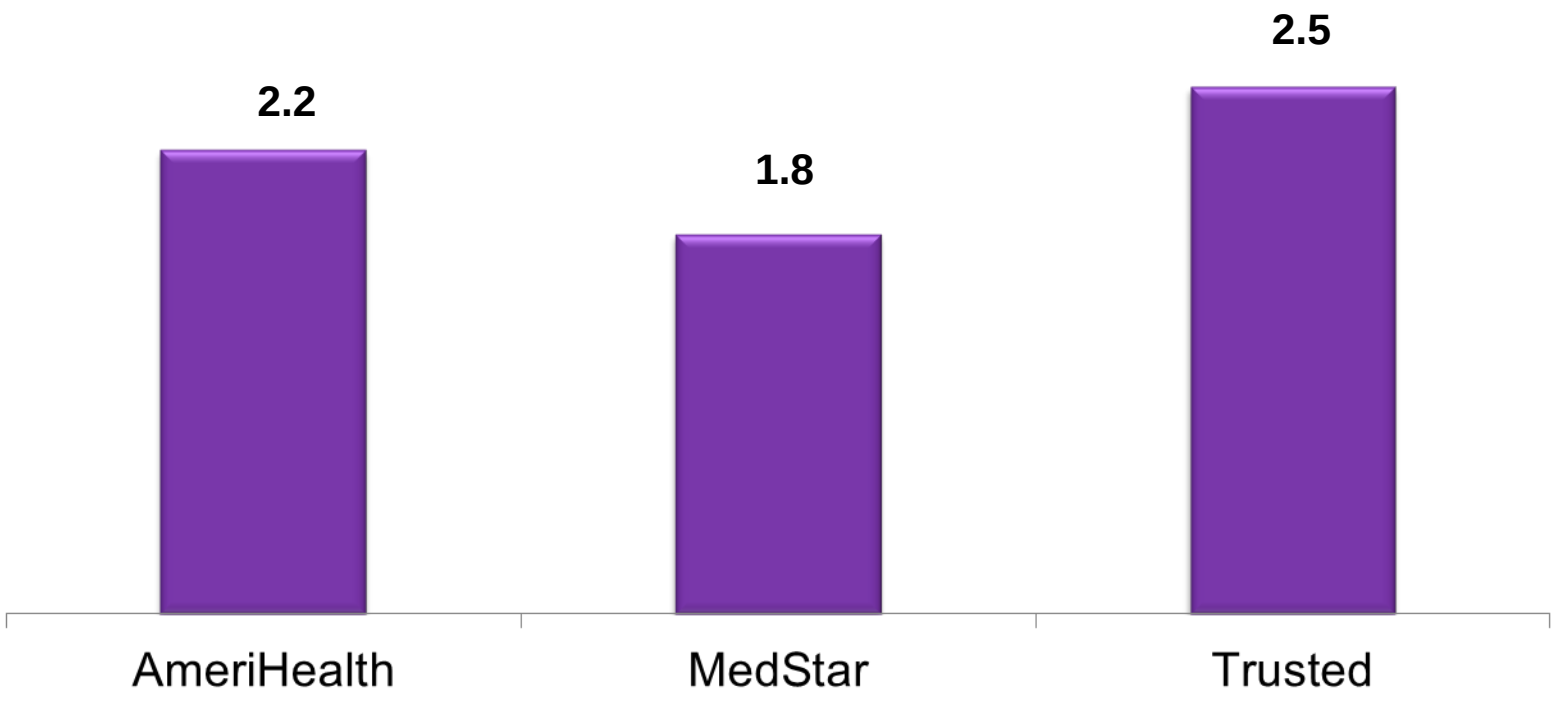
Source: Reported figures are from the MCO's annual 2014 and 2015 financial statements filed with DISB.

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 (IBNR) Claims

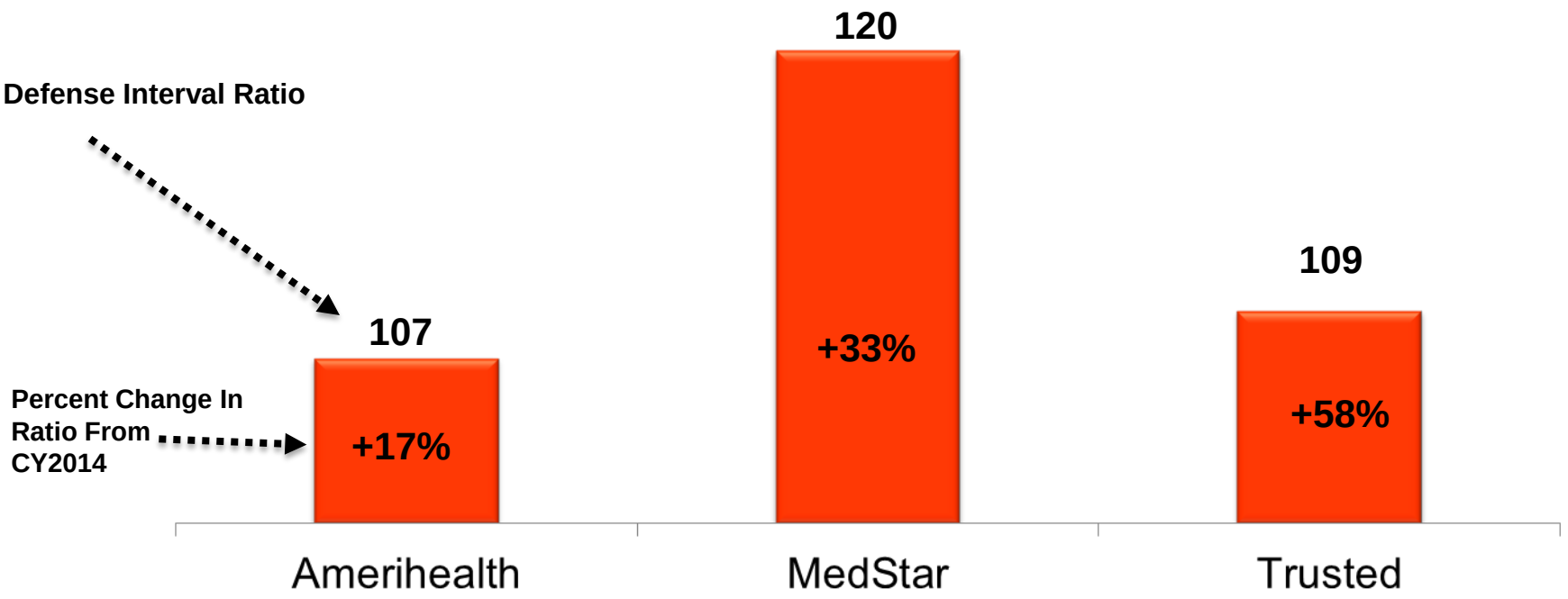
Estimated Number Of Months Reserves Compared To Average Monthly Incurred Claims For The Period Covering January 2015 to December 2015



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

All Three MCOs Have Sufficient Cash On Hand To Operate Without Having To Access Long-Term Care Assets

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 December 2015



Note: Mercer calculated the Defensive Interval Ratio as cash and equivalents divided by daily operating expenses for the period from January to December 2015 (measured by 91.25 days per quarter) to indicate the numbers of days the company can operate without having access to long-term assets.

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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 December 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	68	**548**	47	**706**	62	**347**
MedStar FP	32	**681**	14	**393**	19	**440**
Trusted	20	**542**	9	**172**	12	**444**

Source: This information is self-reported and attested by the MCOs as of December 31, 2015 and verified by Department of Health Care Finance and the Enrollment Broker through a sampling of providers.

The Health Plans Have Successfully Constructed Encounter Data Files But Trusted And, To A Lesser Degree, AmeriHealth Must Improve The Accuracy Of Its Submissions

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

MCO	Average Monthly Enrollment	Total Encounters	Average Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	107,952	1,514,384	14.0	92%
MedStar	47,333	478,408	10.1	97%
Trusted	31,750	347,852	10.9	89%

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

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

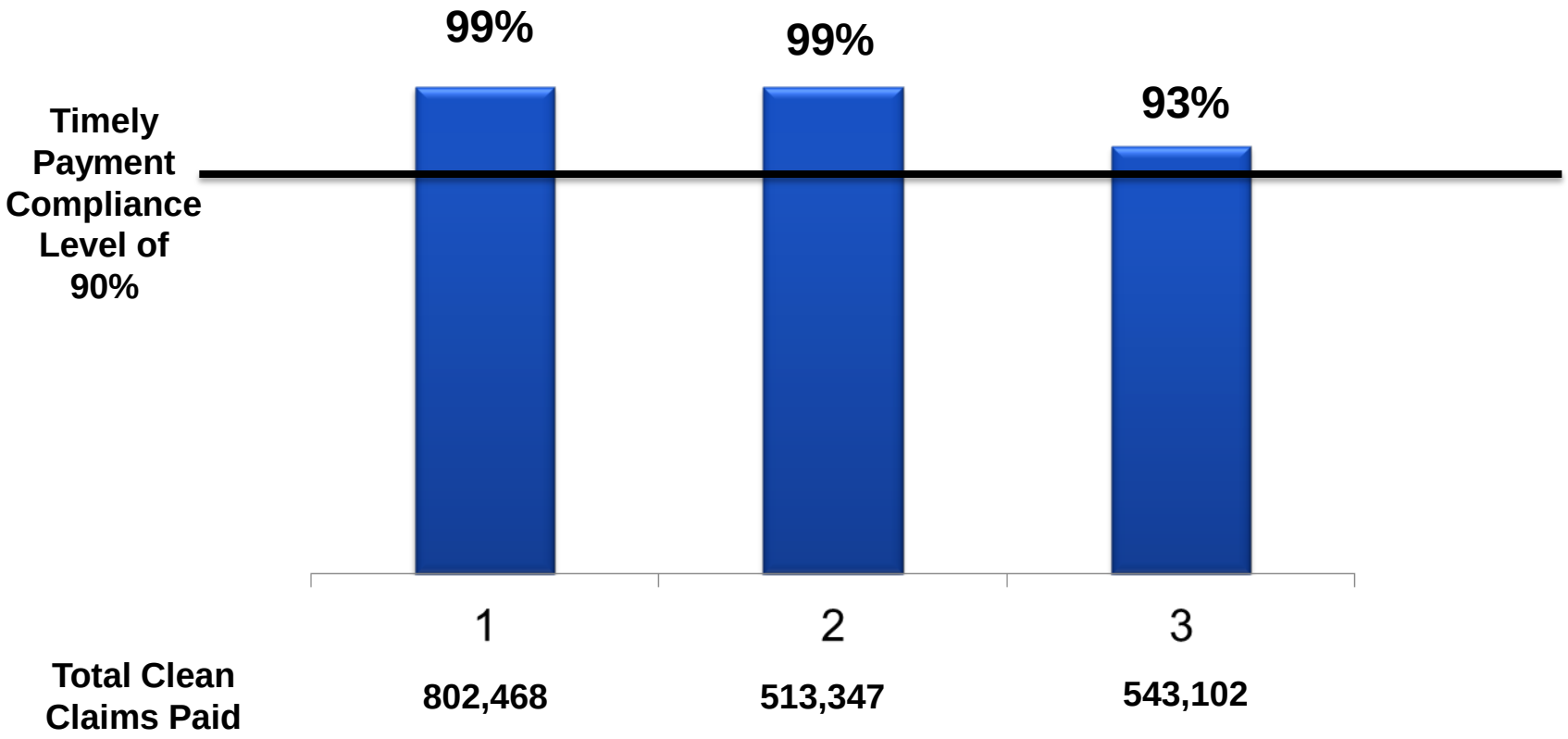
- Through electronic claims processing, the District's three managed care organizations are required to pay or deny clean claims within 30 days to satisfy timely filing requirements

- 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

In 2015, The Three Health Plans Continued 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 December 2015



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

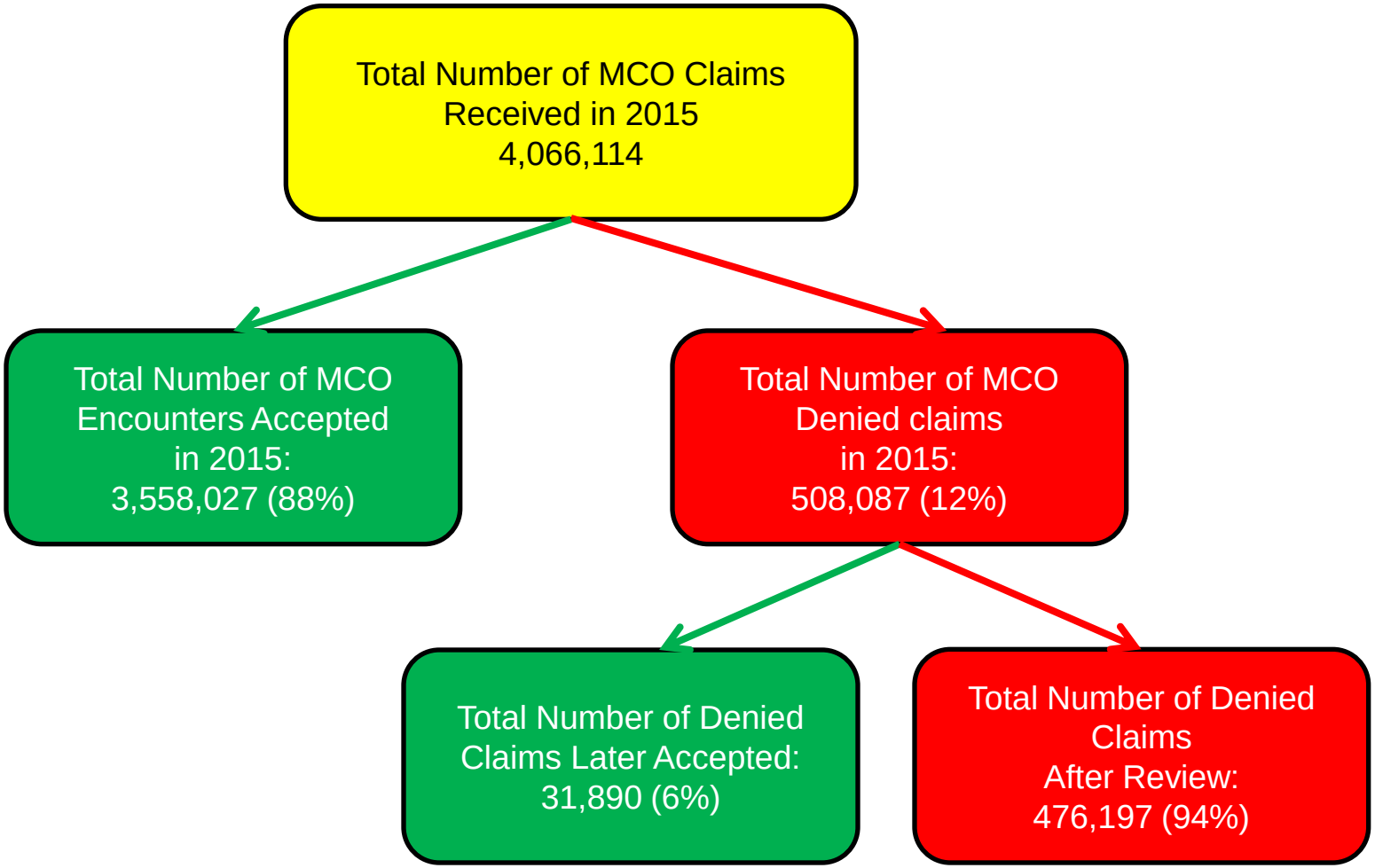
The Issue of Claims Denial -- Which Focuses On Whether The Managed Care Companies Are Acting In Good Faith -- Must Also Be Evaluated

- 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

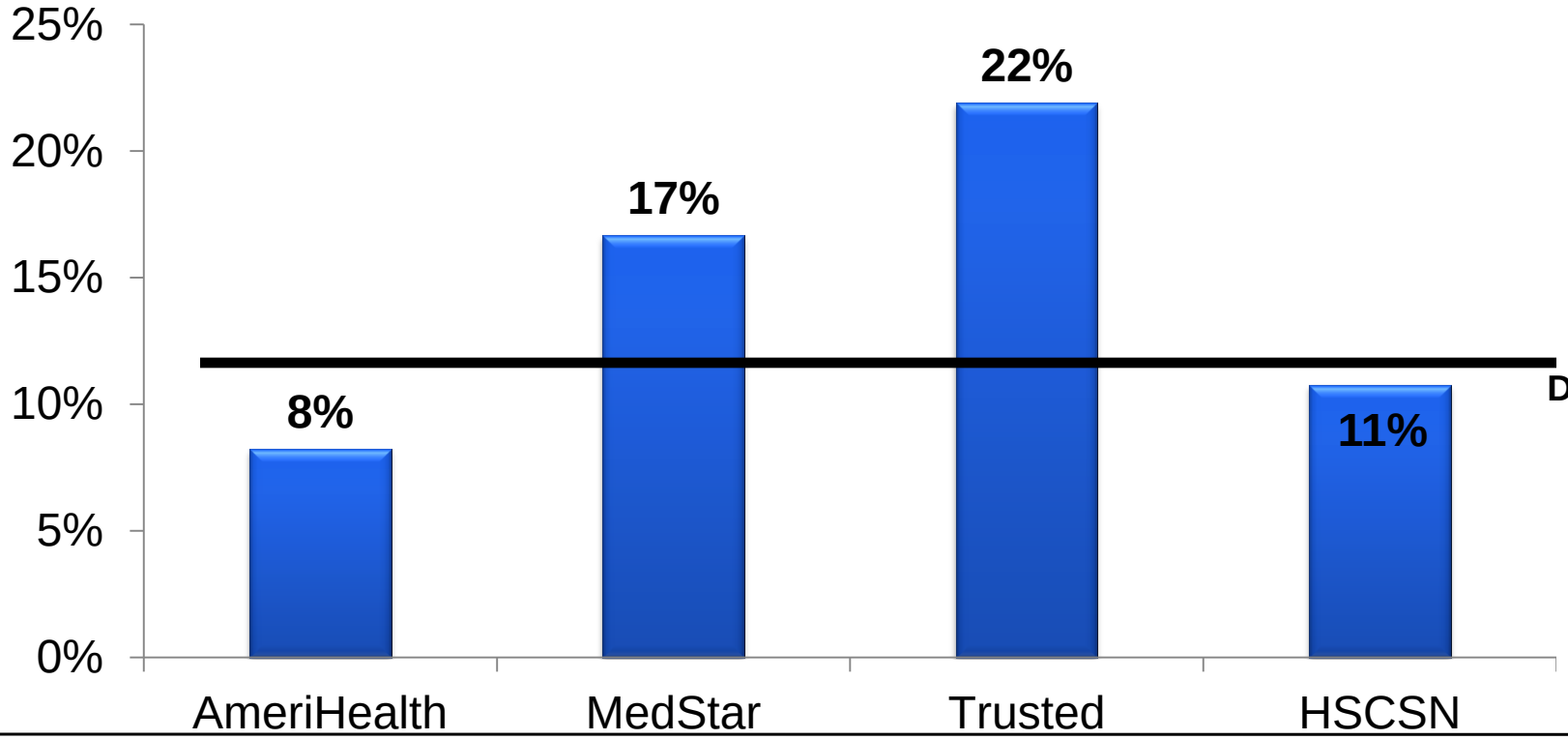
MCOs Had An Average Denial Rate of 12 Percent in CY 2015



Note: Patient encounters with 2015 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 February 2016.

The Claims Denial Rate For Trusted Was Nearly Twice As High As The Average For All Plans

Claims Denial Rates For Each Health Plan, 2015

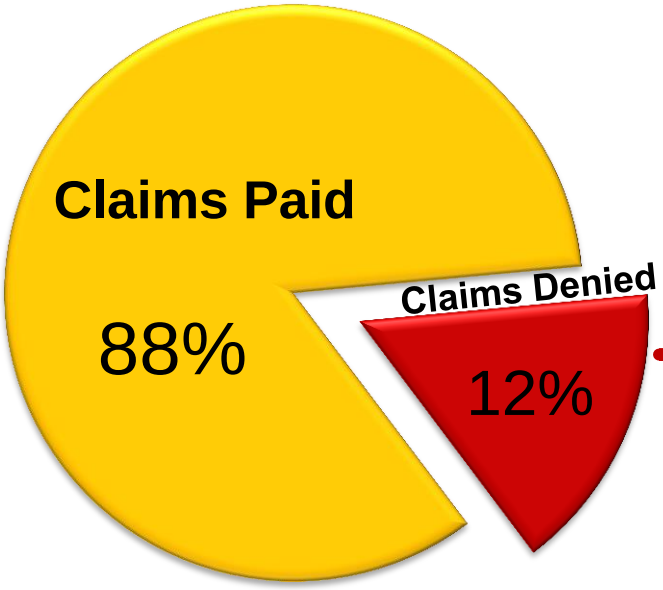


	AmeriHealth	MedStar	Trusted	HSCSN
Total Claims Adjudicated	**2,169,367**	**1,052,130**	**569,218**	**275,339**

Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2015.

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

MCO Claims Denial Rate, 2015



N = 4,066,114

Denial Reason	Total Claims	Percent of Total Claims Denied
Service coverage issue*	122,890	28%
Incomplete or improper billing	61,579	14%
Duplicate claim**	58,204	13%
Member not eligible	31,810	7%
Untimely filing	13,576	3%

Paid Denied

Note: *This can include missing prior authorization, services not being covered, or exceeded units.
**Approximately 11% of duplicate claims were submitted more than once.
Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2015

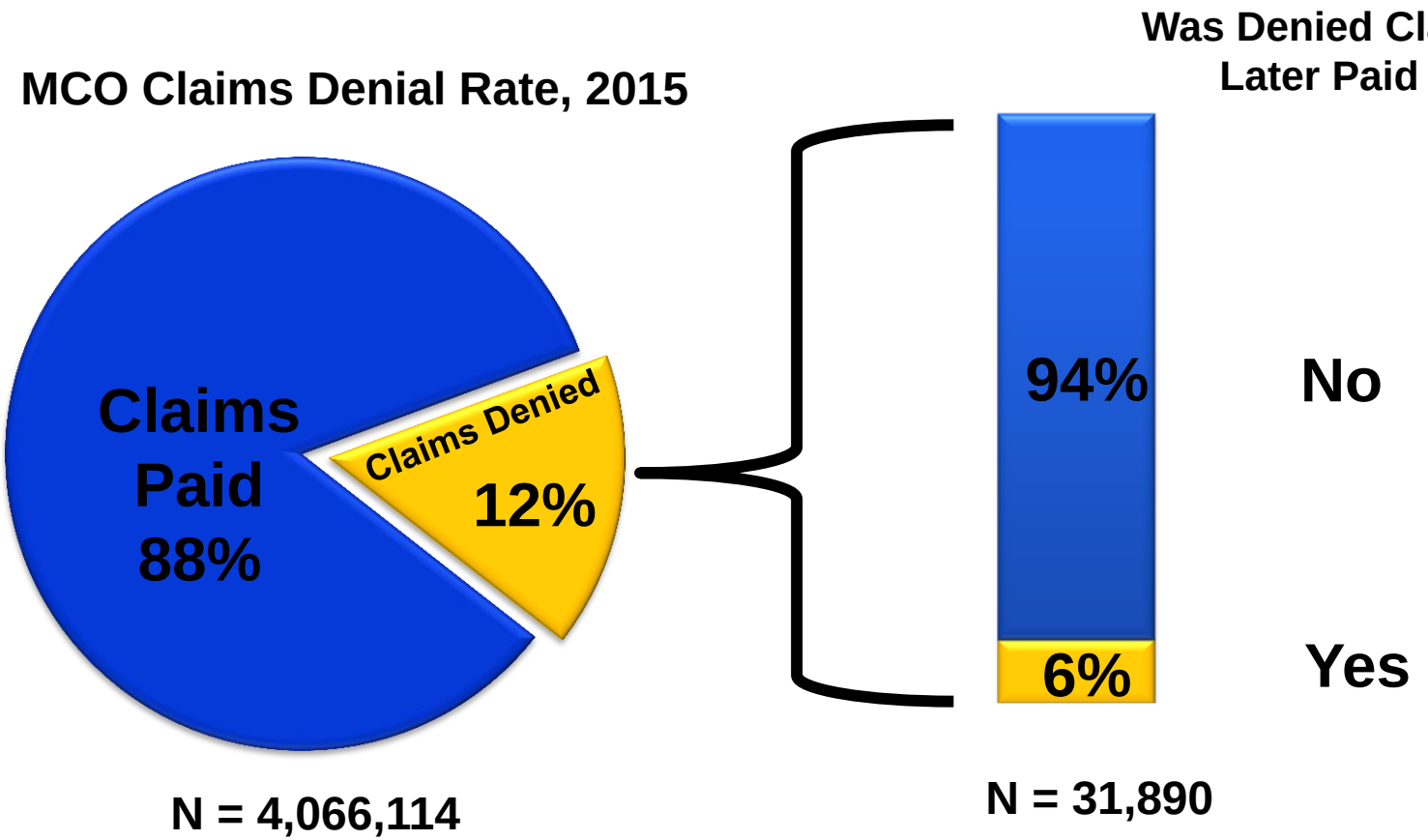
The Claims Denial Rates Are Highest For Low Volume Providers – This Calls Into Question A MCO Cash Management Motive

Denied Claims By Provider Type, CY2015

Provider type	Number of Total Claims	Claims Denial Rate By Provider Type
Nurse Practitioner	27,799	76%
FQHC	64,767	31%
Hospital	377,403	27%
Mental Health Clinic	30,330	26%
Physician	666,301	26%
Dentist	177,139	14%
Independent Lab	170,033	11%

Note: *Approximately 11% of duplicate claims were submitted more than once.
Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2015

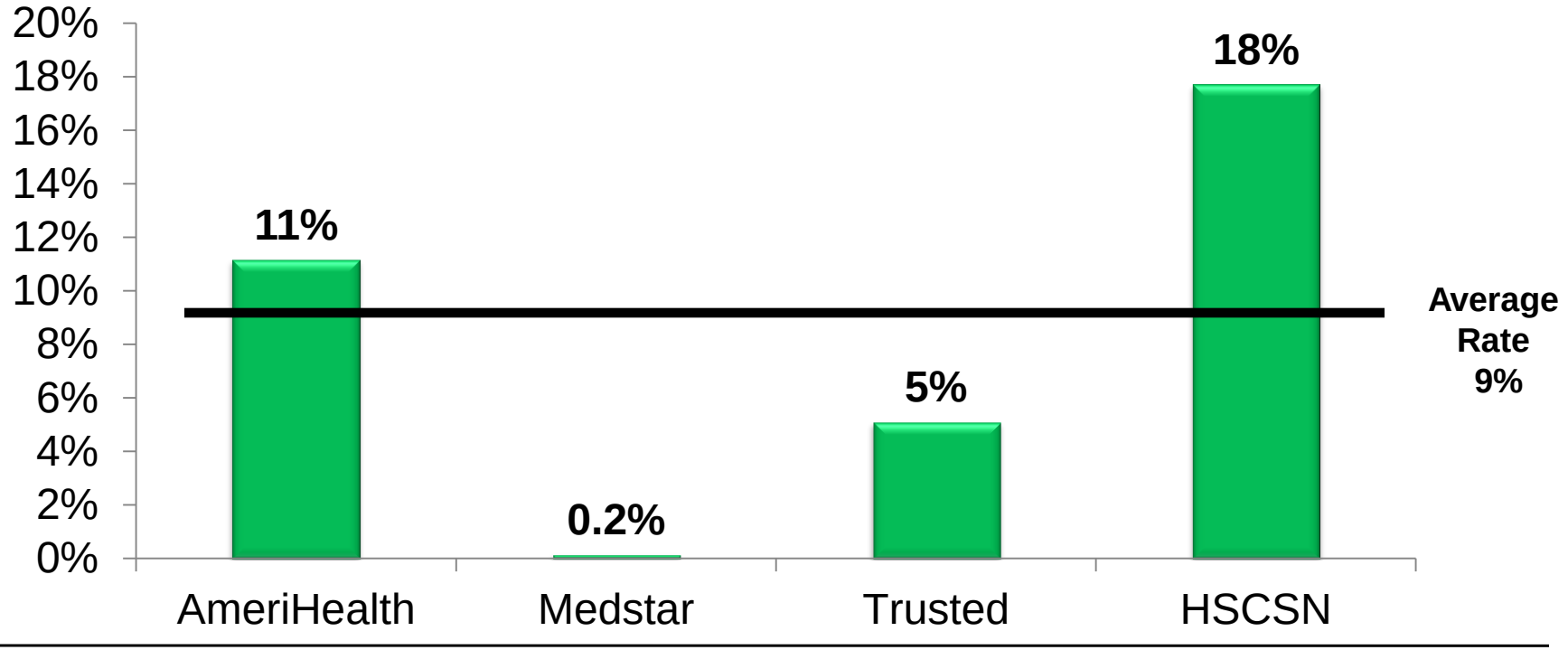
Only Six Percent of Claims Initially Denied Were Later Paid



Note: Patient encounters with 2015 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 February 2016.

AmeriHealth And HSCSN Ultimately Paid The Largest Share Of Their Initially Denied Claims

MCO Pay Rates For Claims Originally Denied, 2015

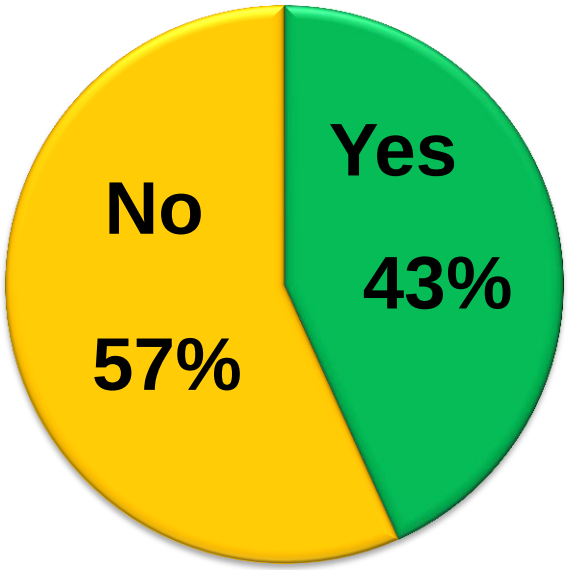


	AmeriHealth	Medstar	Trusted	HSCSN
Total Claims Denied	**178,479**	**175,343**	**124,629**	**29,636**

Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2015.

MCOs Paid Four of Ten Claims That Were Initial Denied Within 30 Days

Percentage Of MCO Claims Previously Denied Then Paid Within 30 Days



N = 31,890

Note: Patient encounters with 2015 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 February 2016.

Amount Of Time To Pay Previously Denied Claims Varies By Provider Type

Provider type	Average Number Of Days From Initial Denial To Acceptance
Nurse Midwives	12
Optometrist	30
Home Health	45
Private Clinic	48
Physician	50
Nurse Practitioner	50
FQHC	65
Dentist	85
Nursing Facilities	105

Note: Patient encounters with 2015 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 February 2016.

Compared To CY2014 MCOs Processed More Claims And Denied A Smaller Percentage, But, Resolved Fewer Of The Denied Claims With A Payment And Took More Time To Do So

A Comparison of Outcomes From CY2014 And CY2015		
Outcome	**CY2014**	**CY2015**
Total Claims Processed	2.26M	4.06M
Claims Denied (%)	18%	12%
Highest Denial Rate By Plan	31% (MedStar)	22% (Trusted)
Denied Claims Later Paid	18%	6%
Denied Claims Later Paid And Paid Within 30 Days	79%	43%

Note: Paid pharmacy claims are excluded from CY2014 data.

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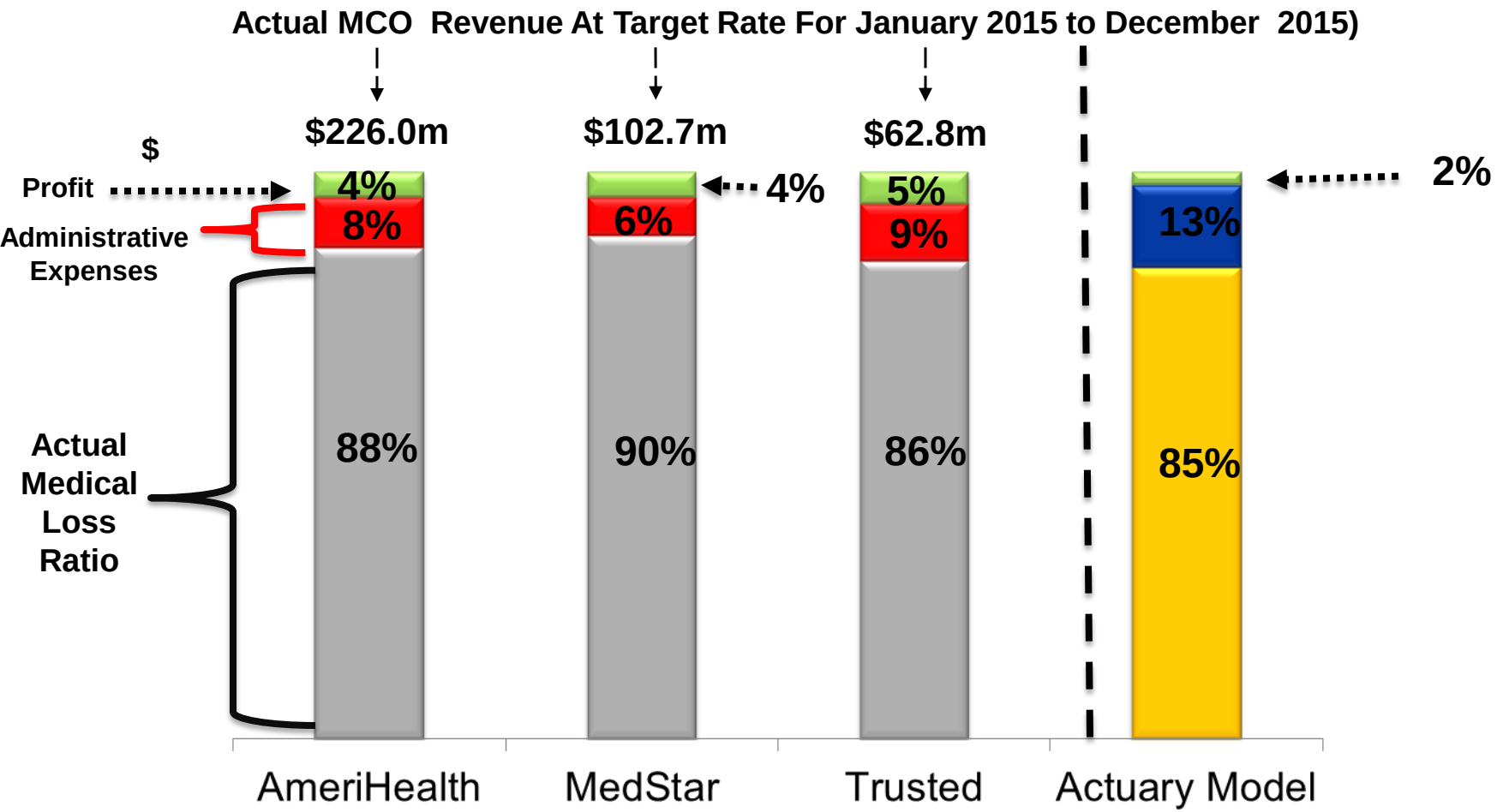
All Three Health Plans Spent The Required Amount On Beneficiary Medical Expenses, Responsibly Managed Administrative Cost, And Earned Profits Beyond The Rate Assumed In The Actuary's Model

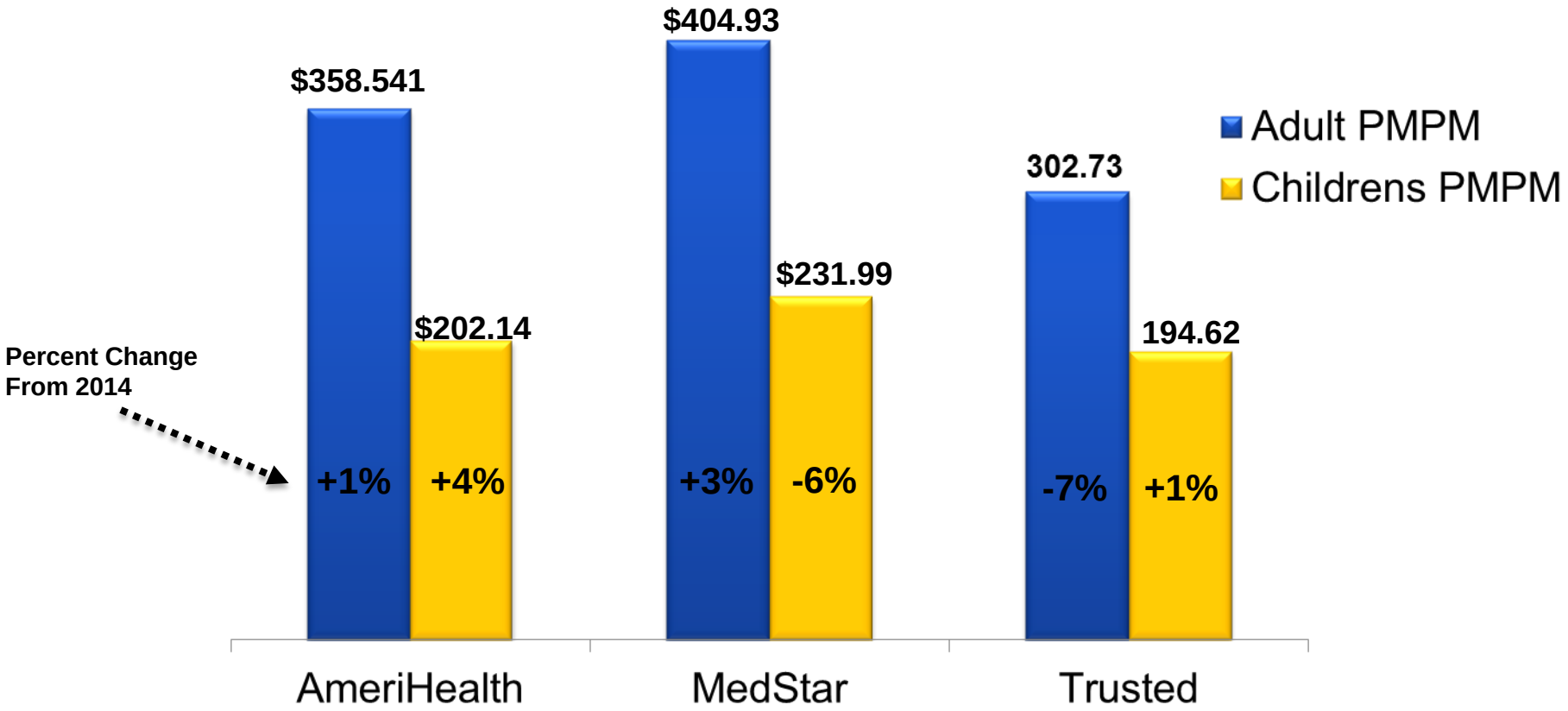


Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.

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 Growth Rates In Each Plan Were Either Modest or Declined

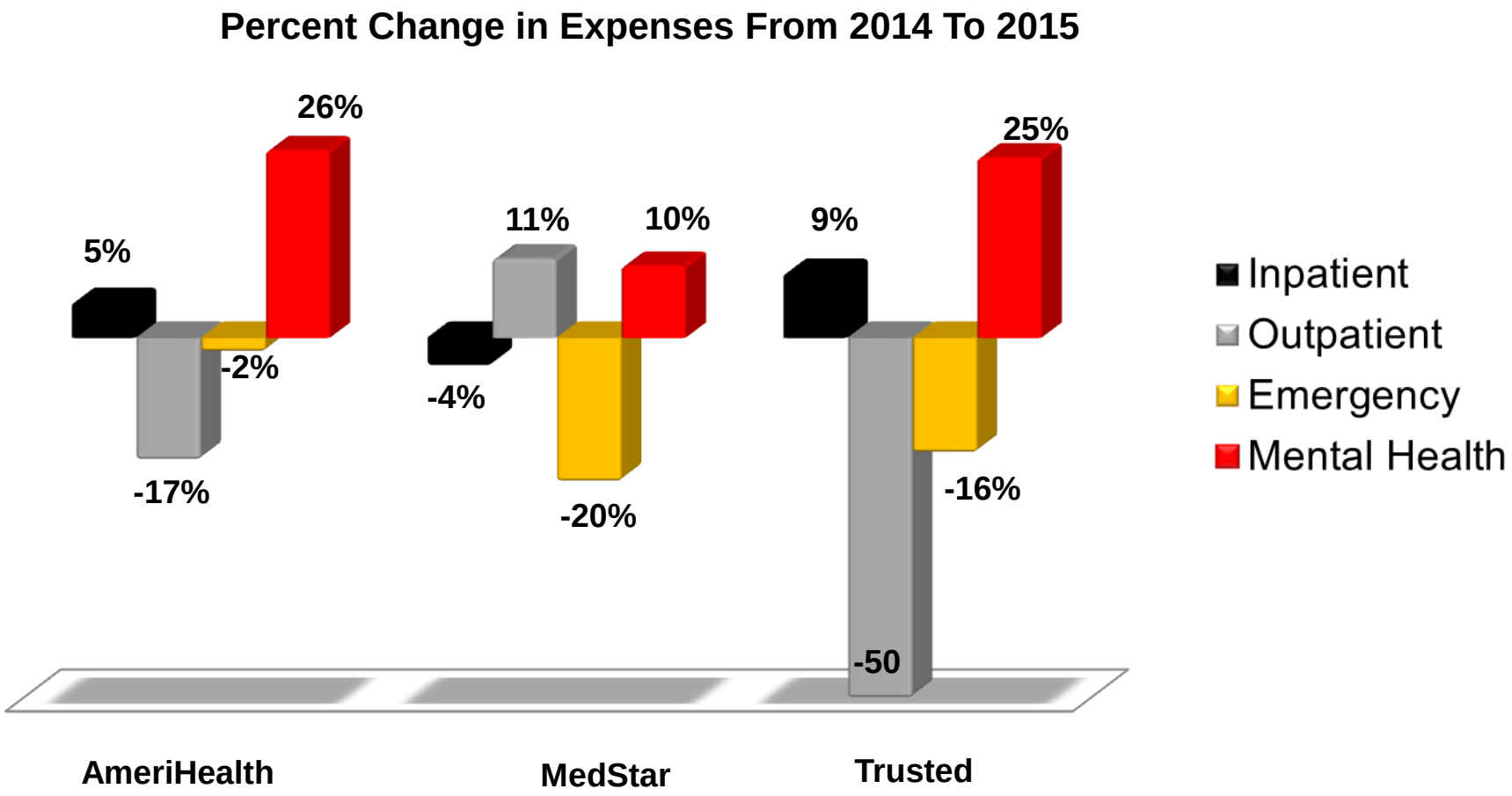
Medicaid Adult And Children Medical Expenses Per-Member, Per-Month, January 1, 2015 to December 31, 2015



Notes: Expenses incurred from January 1, 2015 to December 30, 2015 and paid as of January 2016. The expenses do not reflect adjustments to account for INBR claims. Children defined as person up to age 21 in this analysis.

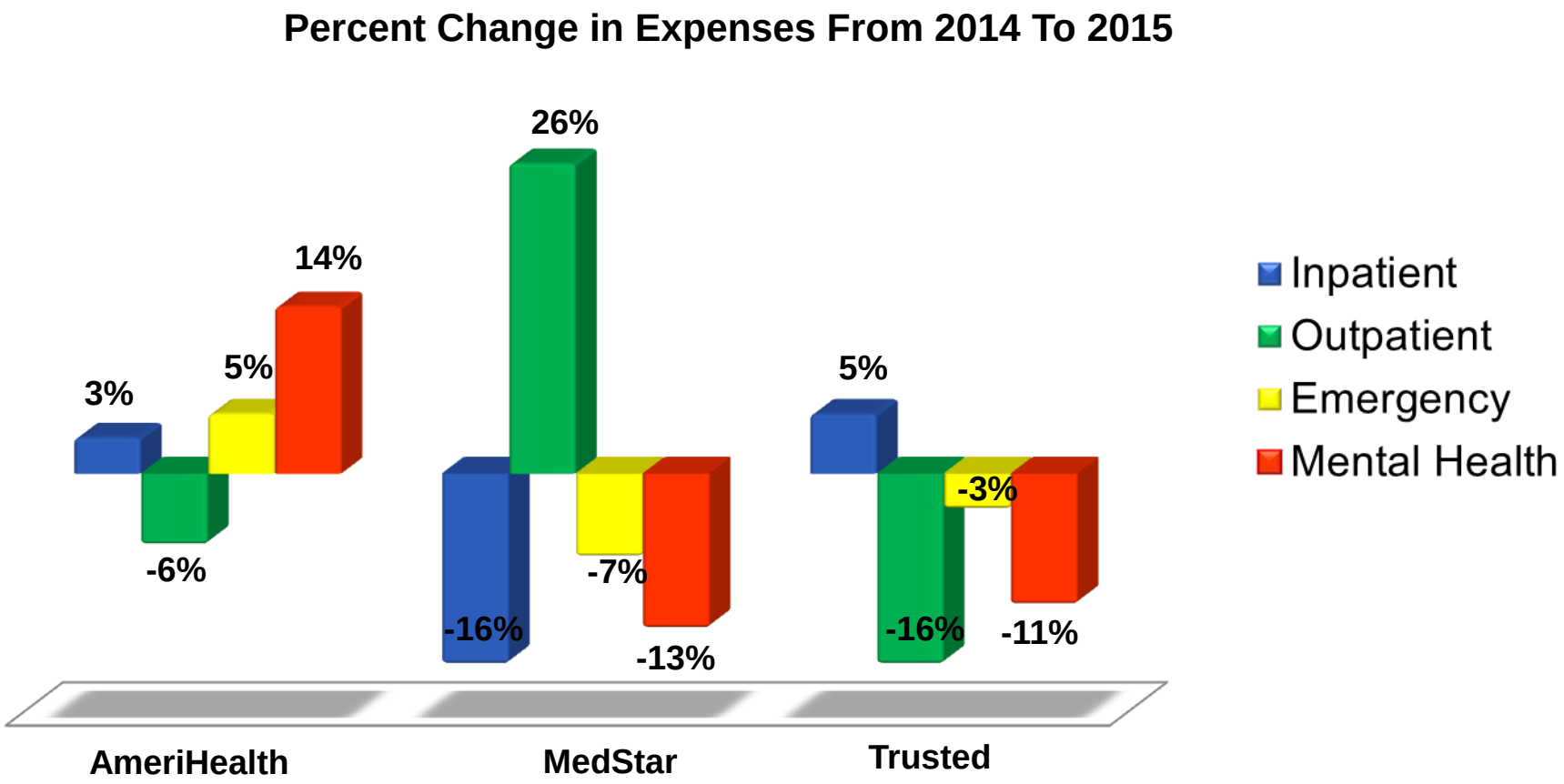
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

The Health Plans Report Sharp Changes In Spending For Adults From 2014 With Especially Stark Differences In Outpatient Cost From 2014



Note: Expenses incurred from January 1, 2015 to December 30, 2015 and paid as of January 31, 2015. The expenses do not reflect adjustments to account for INBR.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

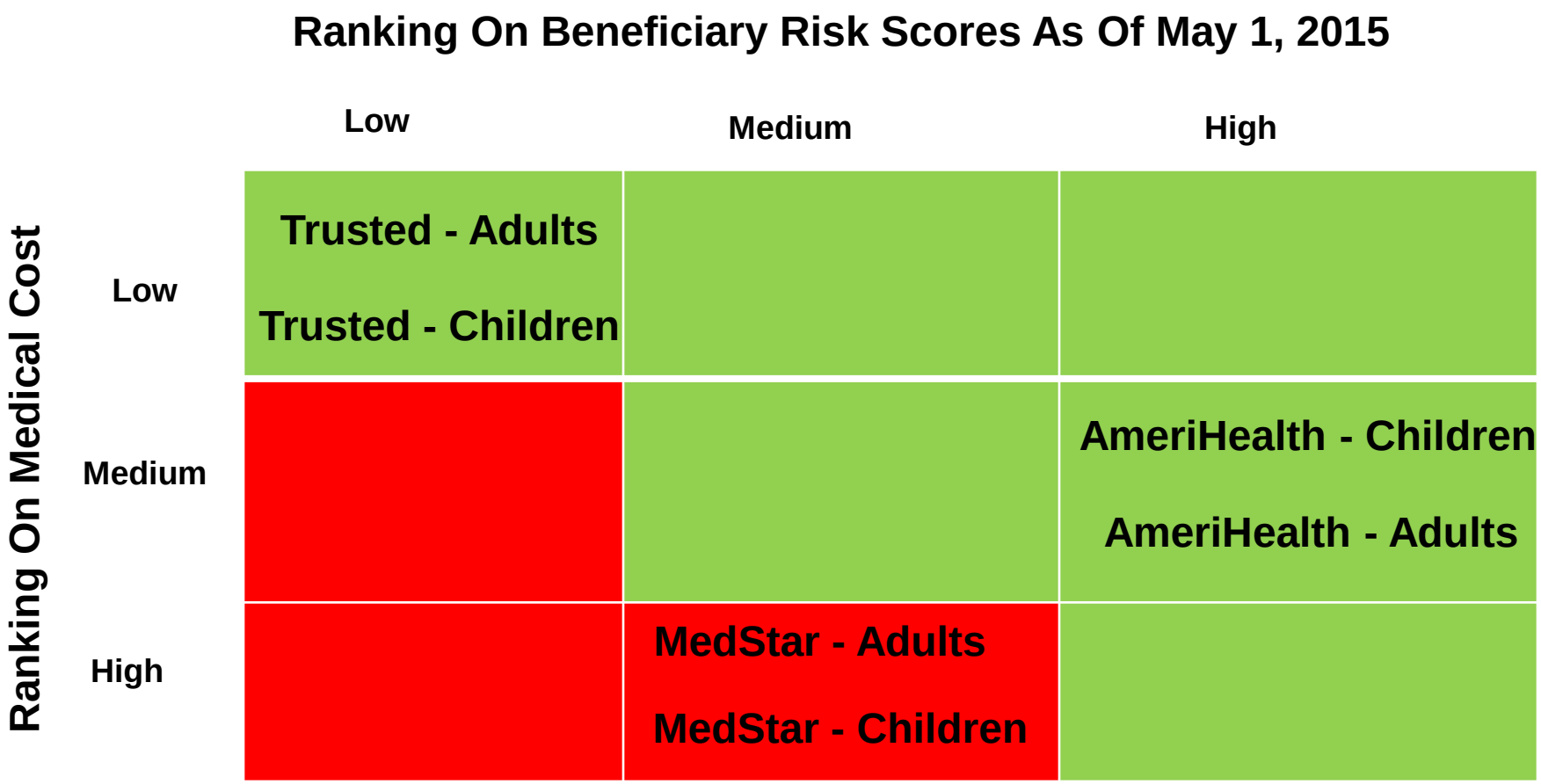
For Children, The Health Plans Experienced Significant Swings In Cost From 2014 As Well



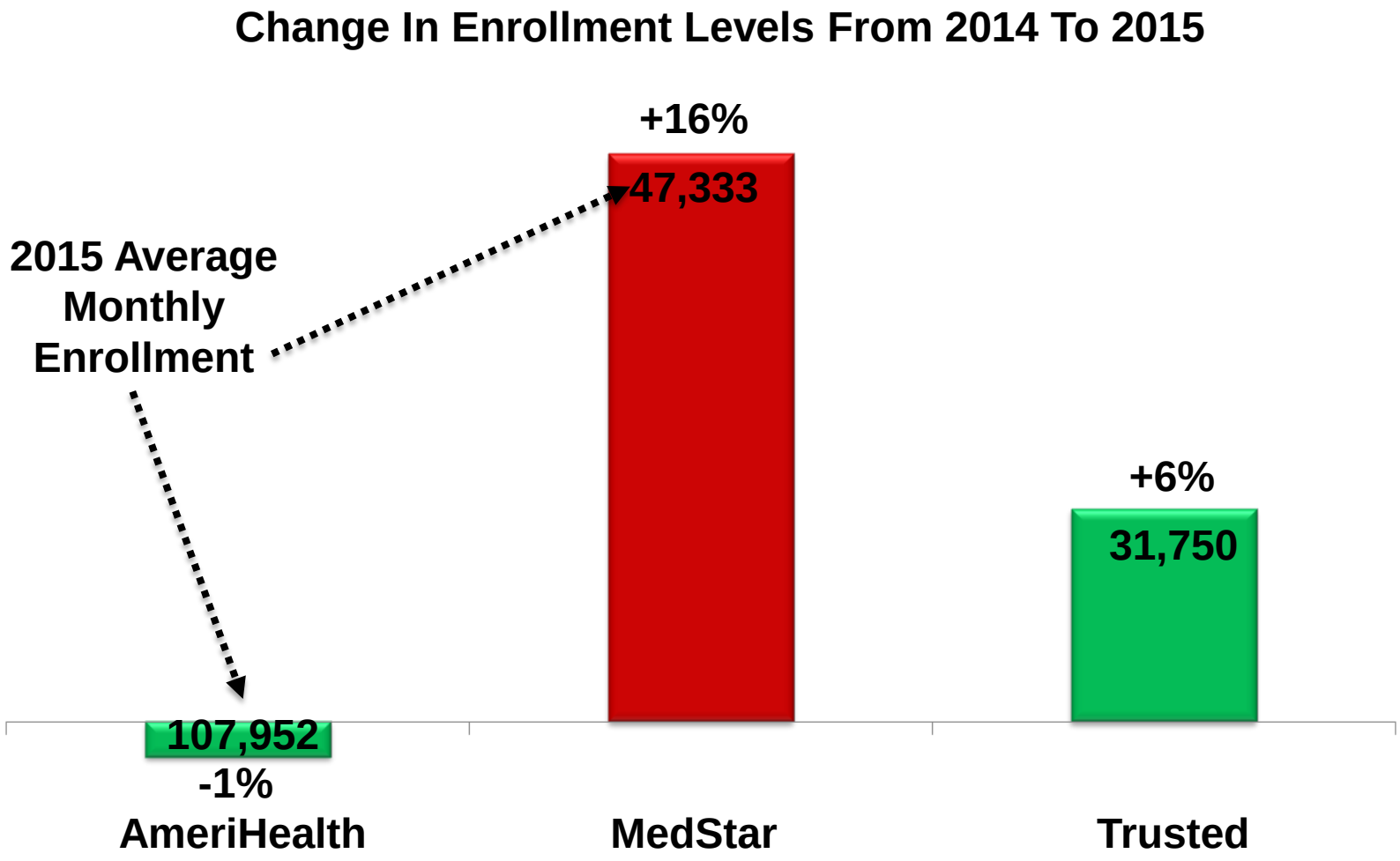
Notes: Expenses incurred from January 1, 2015 to December 30, 2015 and paid as of January 31, 2015. The expenses do not reflect adjustments to account for INBR claims.

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



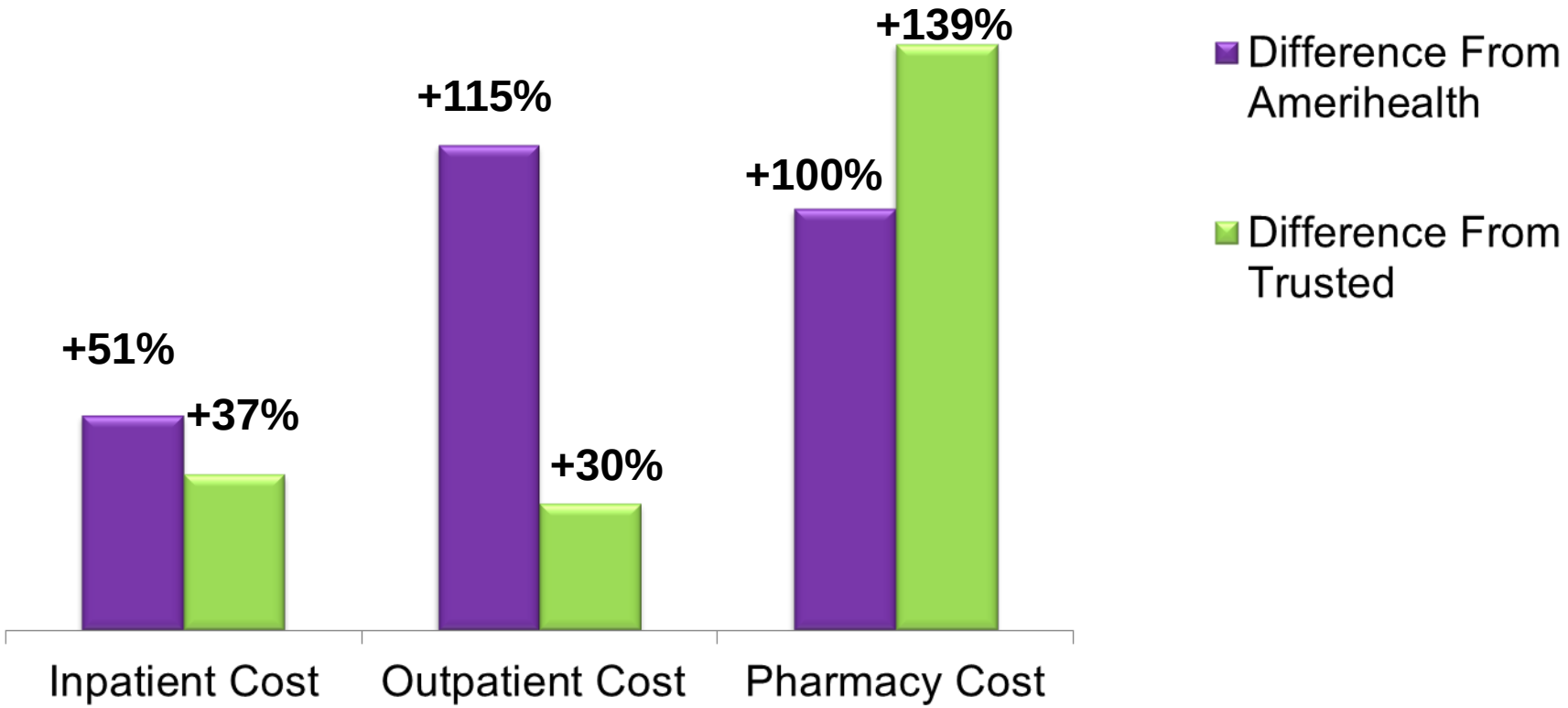
Why? MedStar Experienced More Enrollment Growth in FY2015 Than Both AmeriHealth – Whose Enrollment Declined – And Trusted



Source: Enrollment data based on quarterly self-reported financial data submitted by the MCOs to DHCF

MedStar's 2015 Costs For Three Major Services Were Also Substantially Higher Than The Other MCOs

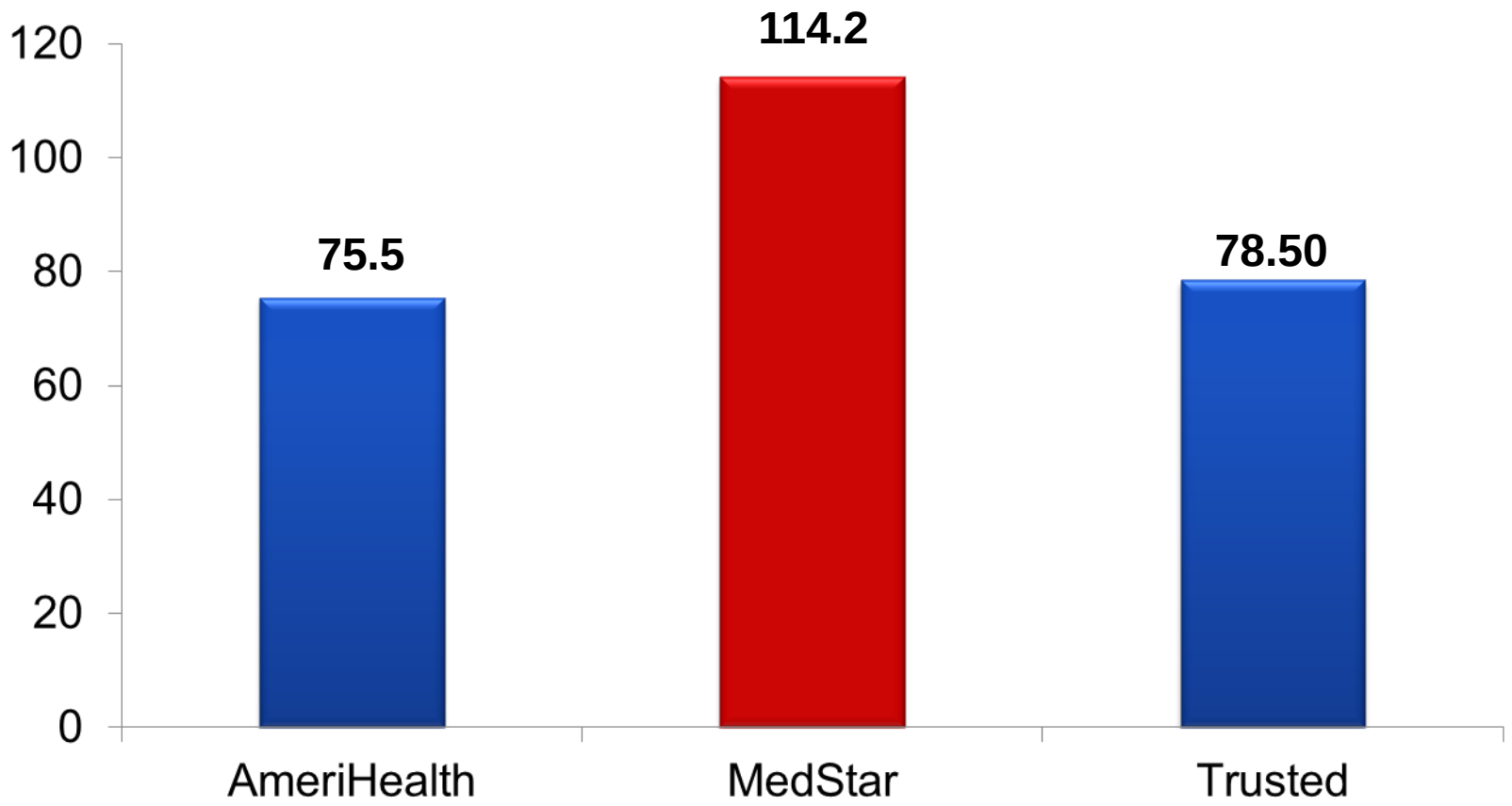
MedStar's Cost Differences Relative To AmeriHealth And Trusted, 2015



Notes: Expenses incurred in 2015 and paid as of January 31, 2016.
Source: Expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

Finally, MedStar's Higher Inpatient Cost In 2015 Was Fueled By A Much Larger Rate Of Inpatient Admissions Than Observed For The Other Plans

Total Number Of Inpatient Admissions In 2015 Per 1000 Members

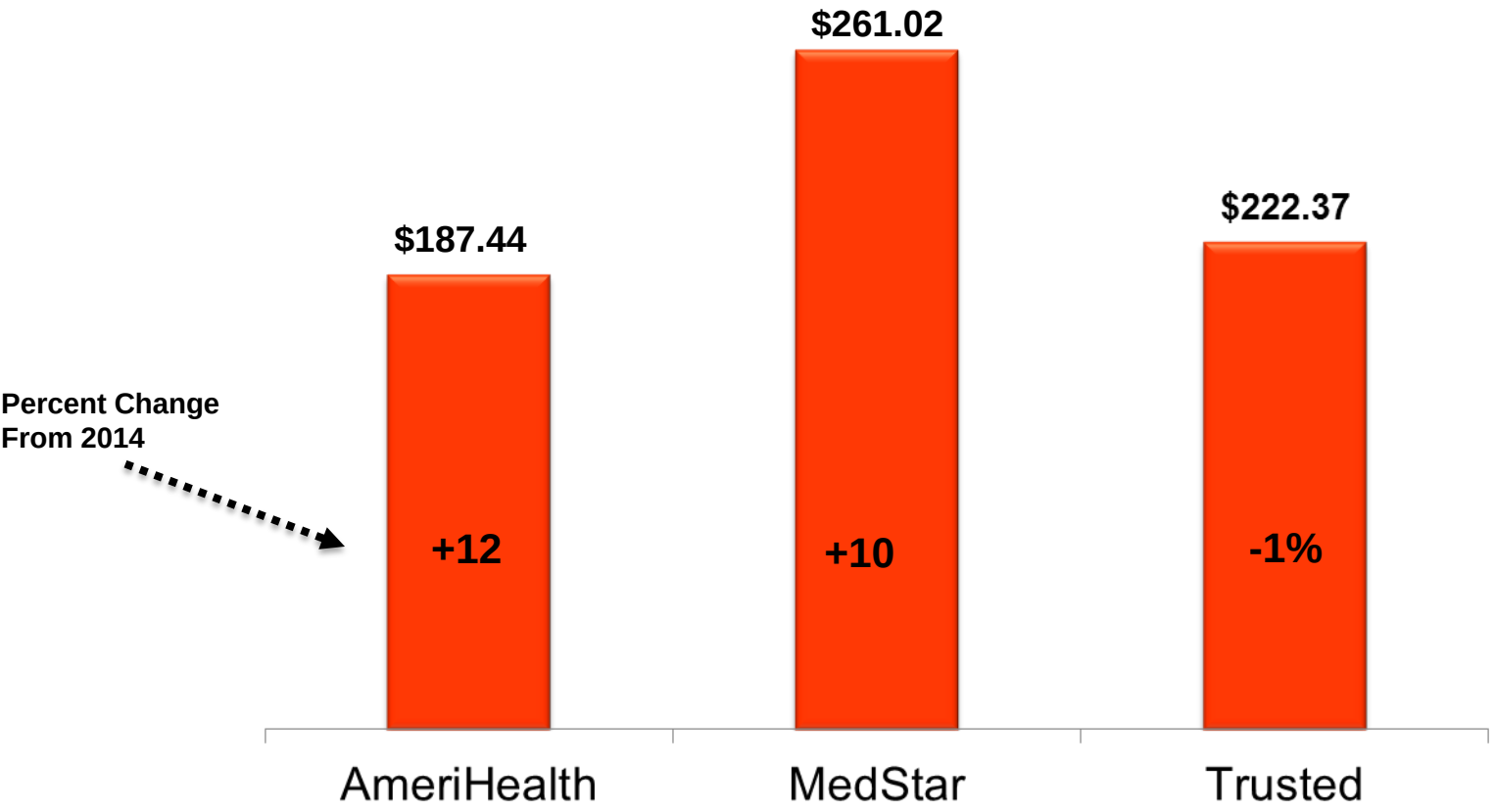


Notes: The current frequency of Index Admissions analysis for the period January 2015 to December 2015 includes encounters that are stamped by DHCF's MMIS both "Paid and Denied" encounters

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

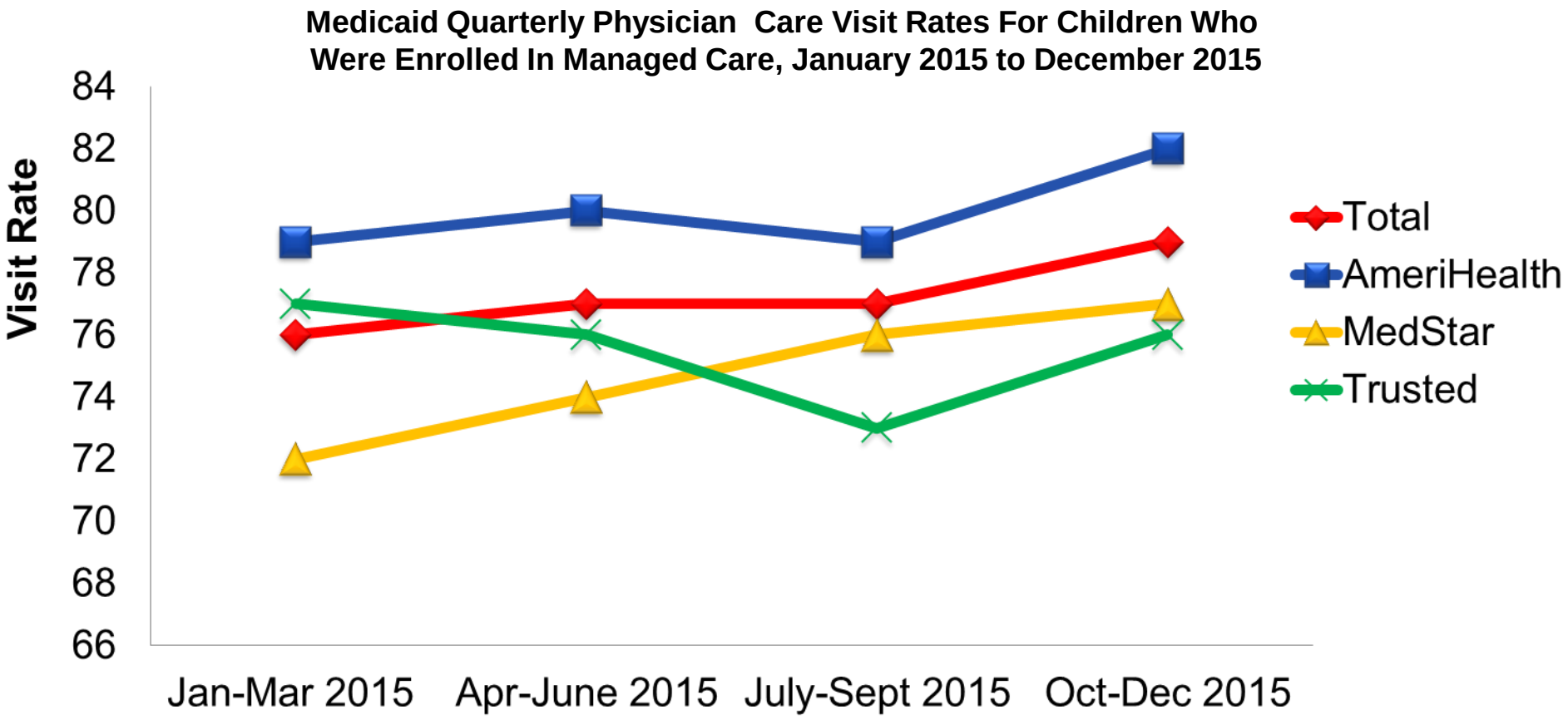
Alliance Medical Expenses For Adults Spiked In Two Of The Three Health Plans

Alliance Adult Medical Expenses Per-Member, Per-Month, January 2015 to December 2015



Notes: Expenses incurred from January 1, 2015 to December 30, 2015 and paid as of January 31, 2015 and do not reflect IBNR claims .
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 In 2015

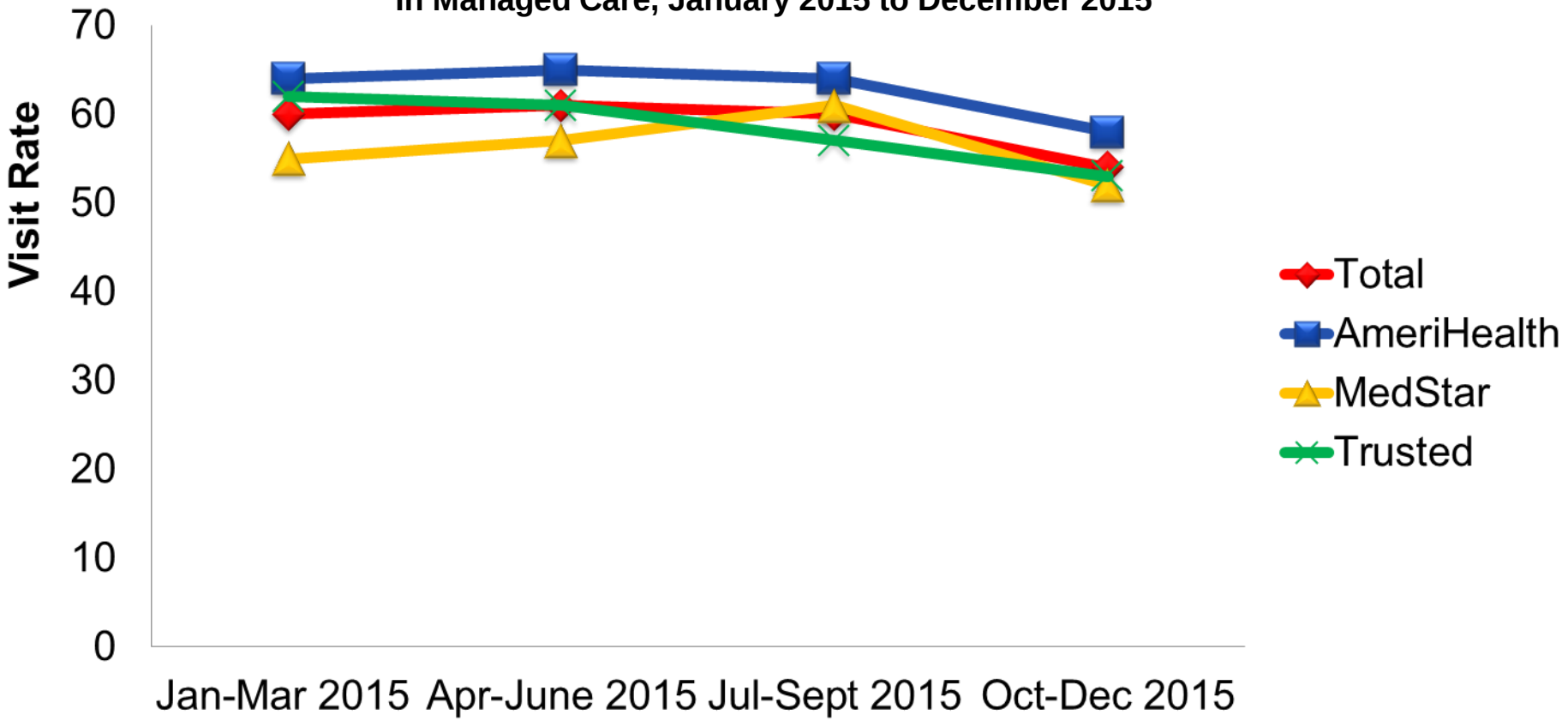


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The Physician Visit Rate For Children With A Well Child Component Declined In The Last Half Of 2015 For All Three Plans, Ending The Year Below 60 Percent

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

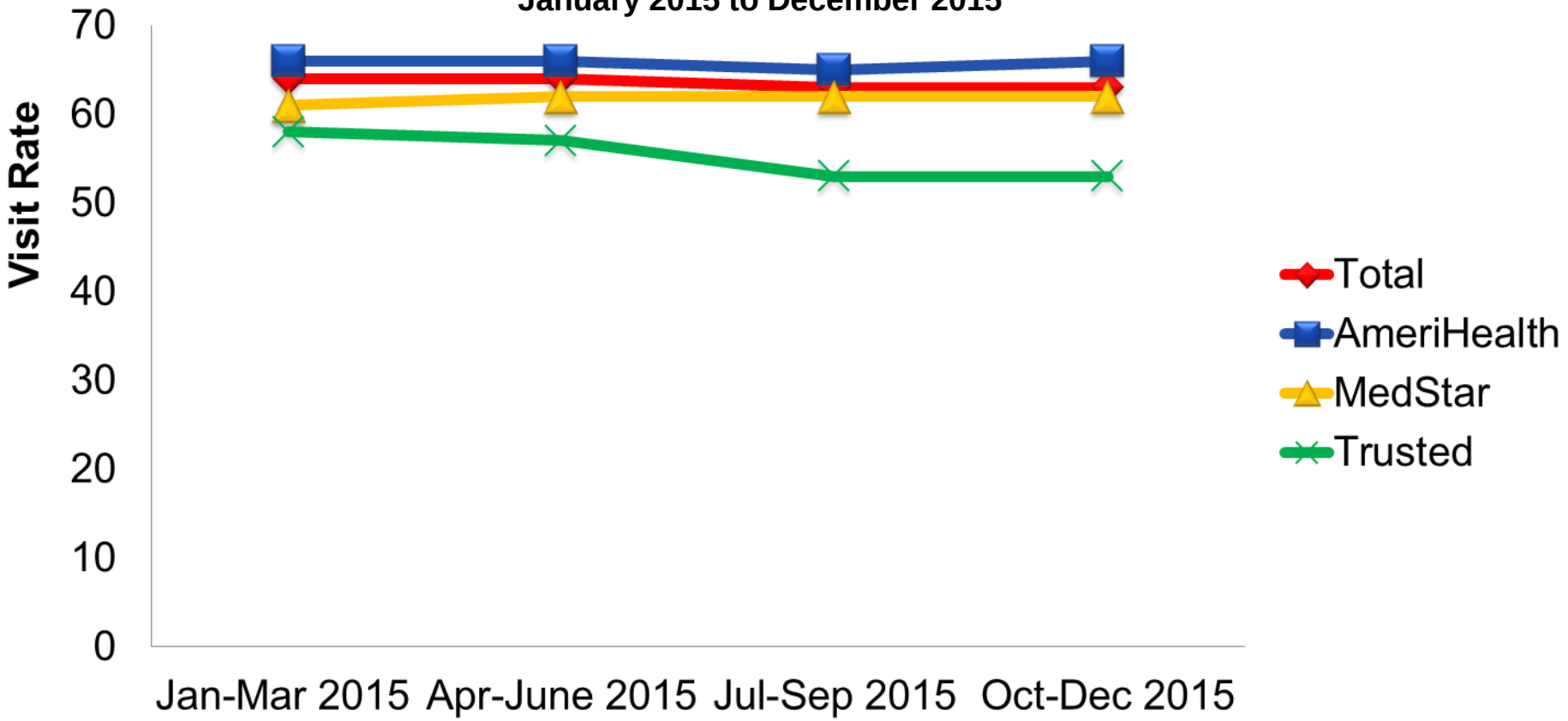


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

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

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

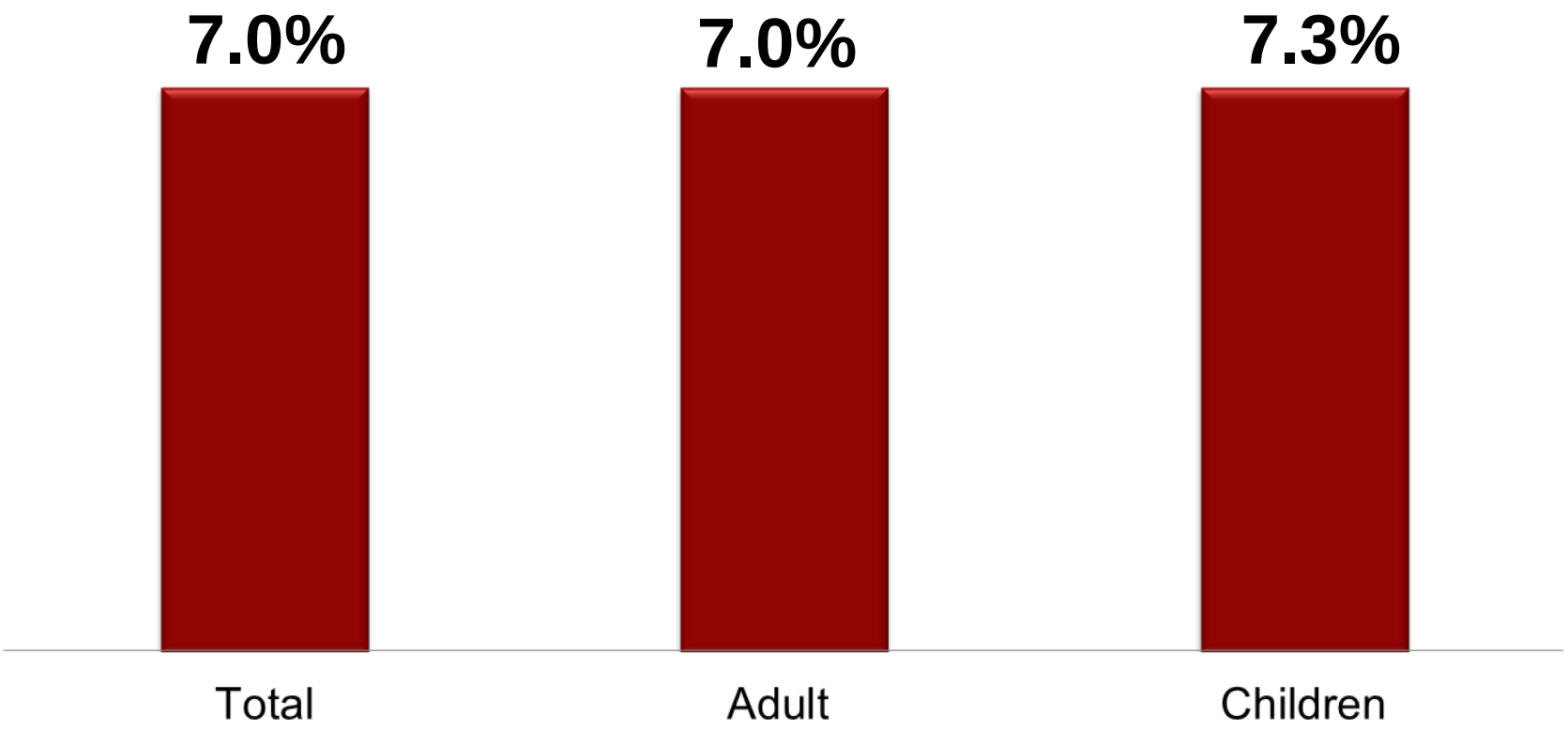


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The MCO Penetration Rate For Medicaid-Funded Mental Health Rehabilitation Services Was The Same For Both Children And Adults In 2015

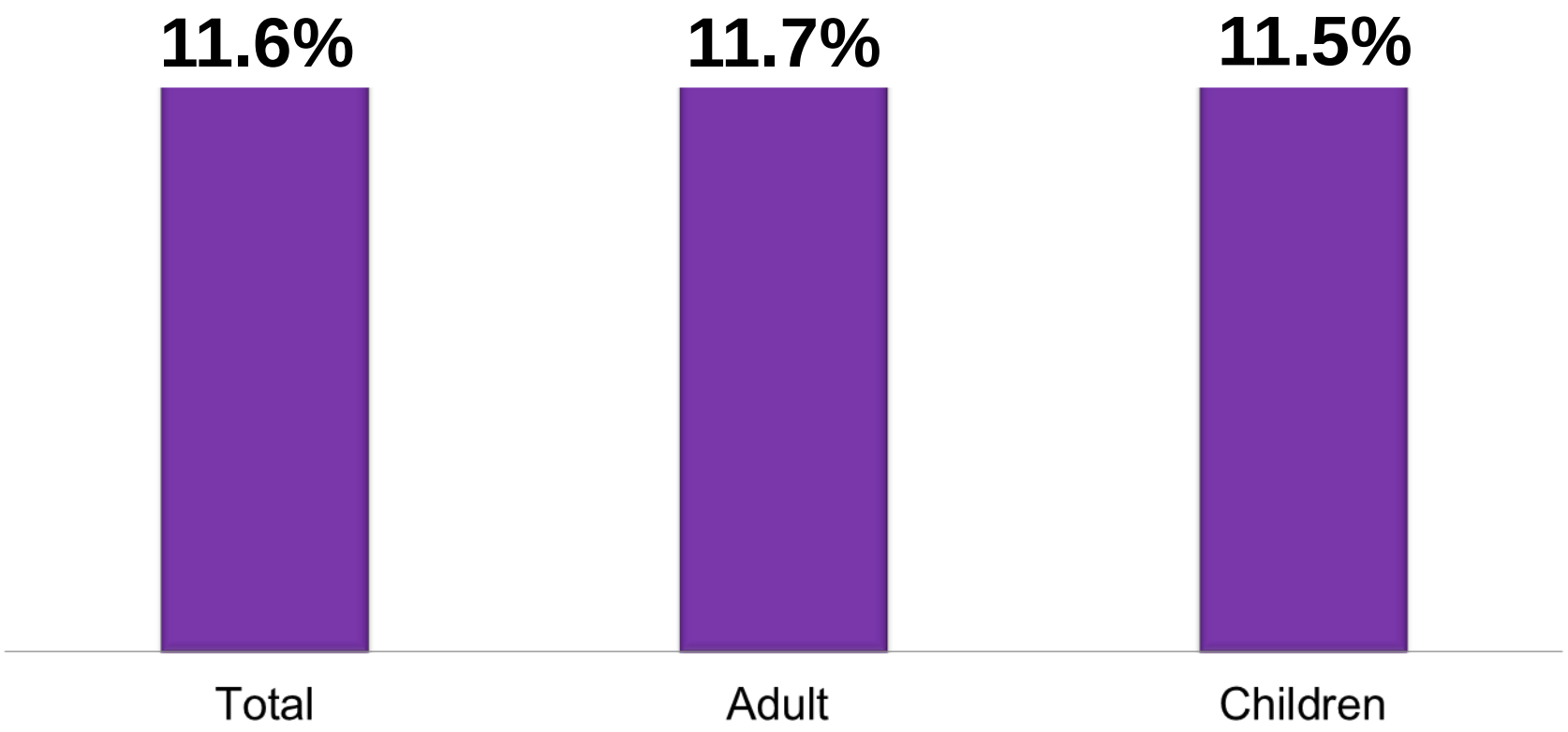
Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans, 2015



Source: Encounter data submitted by MCOs to DHCF.

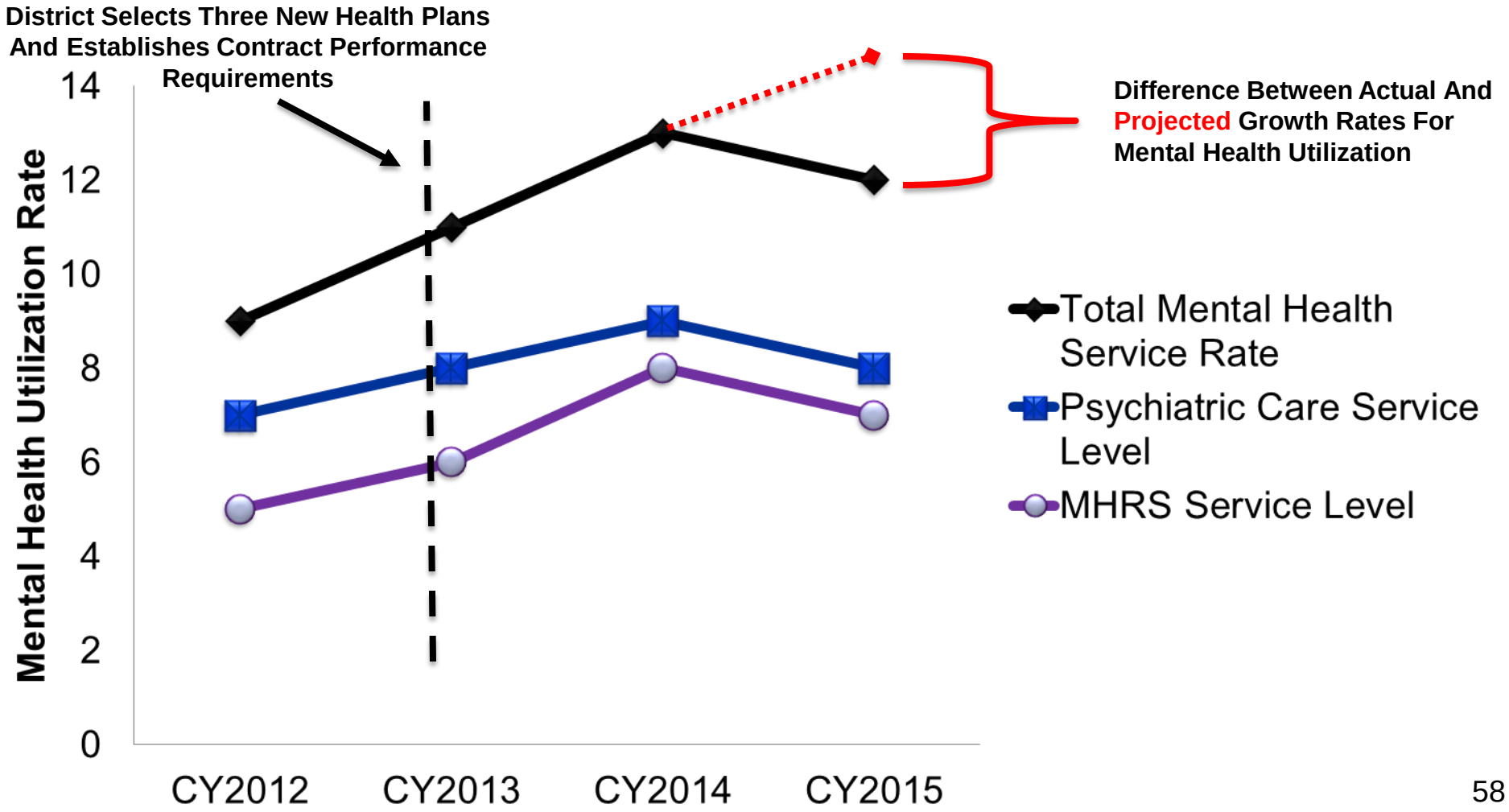
When Utilization For Any Mental Health Treatment Is Determined, The MCO Total Mental Health Penetration Rate Increases Overall And For Both Adults And Children On Medicaid

Percent of MCO Members Receiving Mental Health Treatment Services Through The Health Plans January 2015 to December 2015



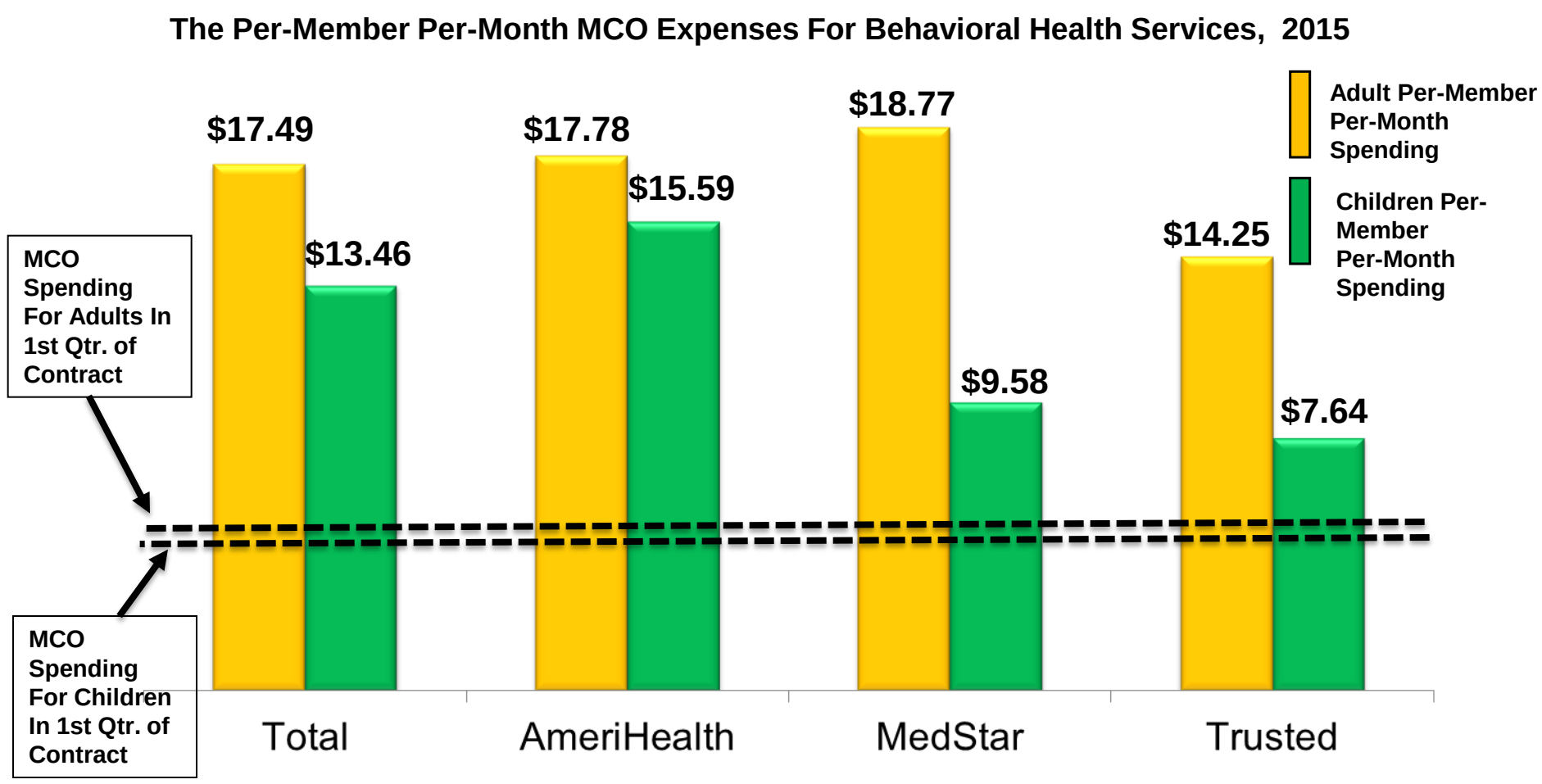
Note: The data presented above are based on MCO capitated payments from the period of January 2015 through June 2015.
Source: Encounter data submitted by MCOs to DHCF.

However When Compared To Previous Years, The Growth In Mental Health Utilization Slowed In 2015



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 Significantly Increased



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
- ☑ **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

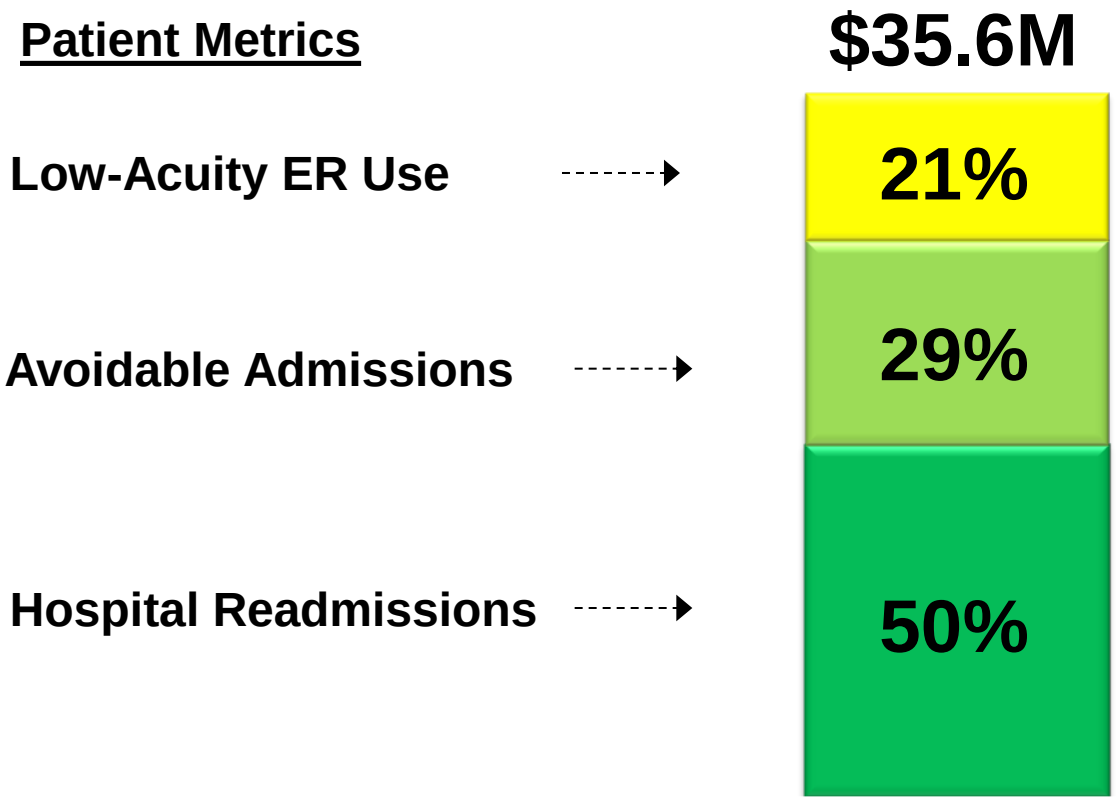
  - Potentially preventable hospitalizations – admissions which could have been avoided with access to quality primary and preventative care

  - Hospital readmissions for problems within 30 days of a previous 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



Source: DHCF and Mercer analysis of MMIS claims data.

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 or potentially as much as $16 million.

- 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.