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

(January 2016 – December 2016)

Department of Health Care Finance

April 2017
Washington DC

Presentation Outline

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

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 2016, more than 181,400 Medicaid beneficiaries and just over 15,500 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 nearly $1.1 billion on MCO services in FY2016. A little more $870 million of this amount funded the full risk-based contracts signed by AmeriHealth, MedStar, and Trusted, while approximately $175 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 costs
  - Home Health costs

- DHCF now includes the CASSIP program in this review in regular 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 5,580 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 is the end-of-year report for 2016. The following questions are addressed for each MCO.
  - What was the financial condition of the MCOs during 2016? Were the health plan revenues sufficient to cover claims and operating costs?
  - Did the MCOs successfully execute the administrative responsibilities required of a managed care plan – timely claims processing, robust member encounter systems, and appropriate use of claims denial procedures?
  - Did the full risk-based MCOs successfully meet the 85% 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 success -- as measured by performance against three established benchmarks -- did the full risk MCOs experience in coordinating care for its members in 2016?

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Summary Of Key Findings

Financial Conditions - Full Risk-Based Health Plans

- The District's three full-risk health plans finished 2016 in very good financial condition. Each plan reports Risk-Based Capital (RBC) positions that are above the required level of 200 percent, while posting profits ranging from 4 to 8 percent with ample cash reserves as protection against a sharp downturn in revenue or spike in costs.

  - The one caveat - Trusted's current position relative to December of 2015 is down sharply but company officials report that they are investing heavily in US treasuries and bonds. Although these investments have 90 day maturity dates, the notes can be converted to cash at any time so as not to adversely impact the company's liquidity, according to company officials.

Summary Of Key Findings
(Continued)

- After suffering huge losses in 2015, it appears that HSCSN's financial position as a risk sharing plan has stabilized owing, no doubt, to a DHCF cash infusion of $13 million effective January 2016. It remains to be seen whether this solid position can be sustained as a new management group has assumed control promising to better contain program cost without imperiling patient care.

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 in 2016:

  - The health plans have constructed comprehensive and diverse provider networks to ensure access to a full range of services as well as robust systems to report patient encounters;

Summary Of Key Findings
(continued)

- Three of the four health plans are in full compliance with the District's prompt pay requirements. However, HSCSN – due mostly to delays in federal payments – could only timely pay 67 percent of its claims according to required policy; and

- The aggregate claims denial rate for all four plans of 12 percent is consistent with prior rates and indicative of the fact that the health plans are not employing the claims adjudication process as a cash management strategy.

Medical Expenses: Full-Risk-Based Health Plans

- The MCOs in this program spend at least the required 85% of health plan revenue on beneficiary Medicaid medical expenses while generally avoiding spikes in their per-member, per-month costs. Specifically, the expense growth rate from 2015 to 2016 for adults was 4 percent while the cost for children was virtually flat.

Summary Of Key Findings

(continued)

- However the three full-risk plans witnessed double digit increases in Alliance per-member, per-month costs. The year-over-year growth was the most significant for AmeriHealth (28 percent) and reached 18% for MedStar. This growth was most certainly exacerbated by DHCF's need to move the pharmacy spending for the program off of the Department Of Defense Discount Program and into the MCO benefits.

- This had special implications for MedStar which has a beneficiary panel that seems to require a higher volume of more expensive medications. Consequently, MedStar's actual per-member, per-month Alliance expenses are at least 40 percent more than their nearest competitor at a figure of $341 per-member, per-month.

- HSCSN's 89 percent spending level on medical expenses for 2016 is in line with the threshold which provides the anchor for its rate. This relieved some pressure on the operating margins for the plan, obviating the need for DHCF to step in with risk corridor payments in 2016. The plan's cost growth rate settled in at 2% over last year following a major spike from the previous year.

Summary Of Key Findings
(continued)

- Mental health spending remains higher than levels that were routinely reported in 2013 – the first year of the MCO contract for the three full-risk plans. Specifically, among adults, the spending is three times those earlier levels and for children more than twice previously reported rates.

Beneficiary Utilization

- 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 children well-child visits, the three full-risk plans showed measurable improvement for a rate that has historically hovered around 50 percent. Surprisingly, however, this rate dropped precipitously for HSCSN, and has attracted the attention of DHCF's managed care team.

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 -- 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.

- In 2016, the health plans spent more than $53 million on patient care that may have been avoided through the use of more aggressive care coordination strategies.

- CMS has now approved DHCF's pay-for-performance program. Had this program been in effect for 2016, only one health plan – Trusted – would have successfully reached all three of the performance goals that have been customized for each plan.

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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 significantly higher surpluses

  - **Patient utilization management.** Relative differences across plans in the degree to which their enrollees unnecessarily access high end care as an alternative to less expensive treatment will drive variations in operating margins

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 an earlier report on the health plan's management of the denied claims process through the first half of 2016. This report updates those numbers using a complete year's worth of data.

For Medicaid Membership, MedStar Has Experienced A 54 Percent Growth Rate Since The Beginning Of The Five-Year Contract Period

MCO	Medicaid July 2013 Enrollment	Medicaid December 2016 Enrollment	Net Change (%)
AmeriHealth	91,585	95,283	4.0
MedStar	32,536	50,216	54.3
Trusted	26,204	30,483	16.3
HSCSN	5,595	5,482	-2.0

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 2016 Enrollment	Net Change (%)
AmeriHealth	98,019	101,424	3.4
MedStar	35,911	54,316	51.2
Trusted	28,803	33,608	16.6

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

Revenues Paid By DHCF To The Health Plans In 2016 Were Sufficient To Cover Both Claims And Administrative Cost While All Four Plans Posted Significant Profits

MCO Revenue and Expense Data for January 2016 to December 2016

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

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	$470.6M	$399.6M	$36.9M	$34.1M
MedStar	$256.7M	$224.9M	$15.5M	$16.2M
Trusted	$143.0M	$122.5M	$14.6M	$5.9M
HSCSN	$175.1M	$156.3M	$15.1M	$3.8M

Notes: *MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue.
**Total claims include incurred but not reported amounts for as of December 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.

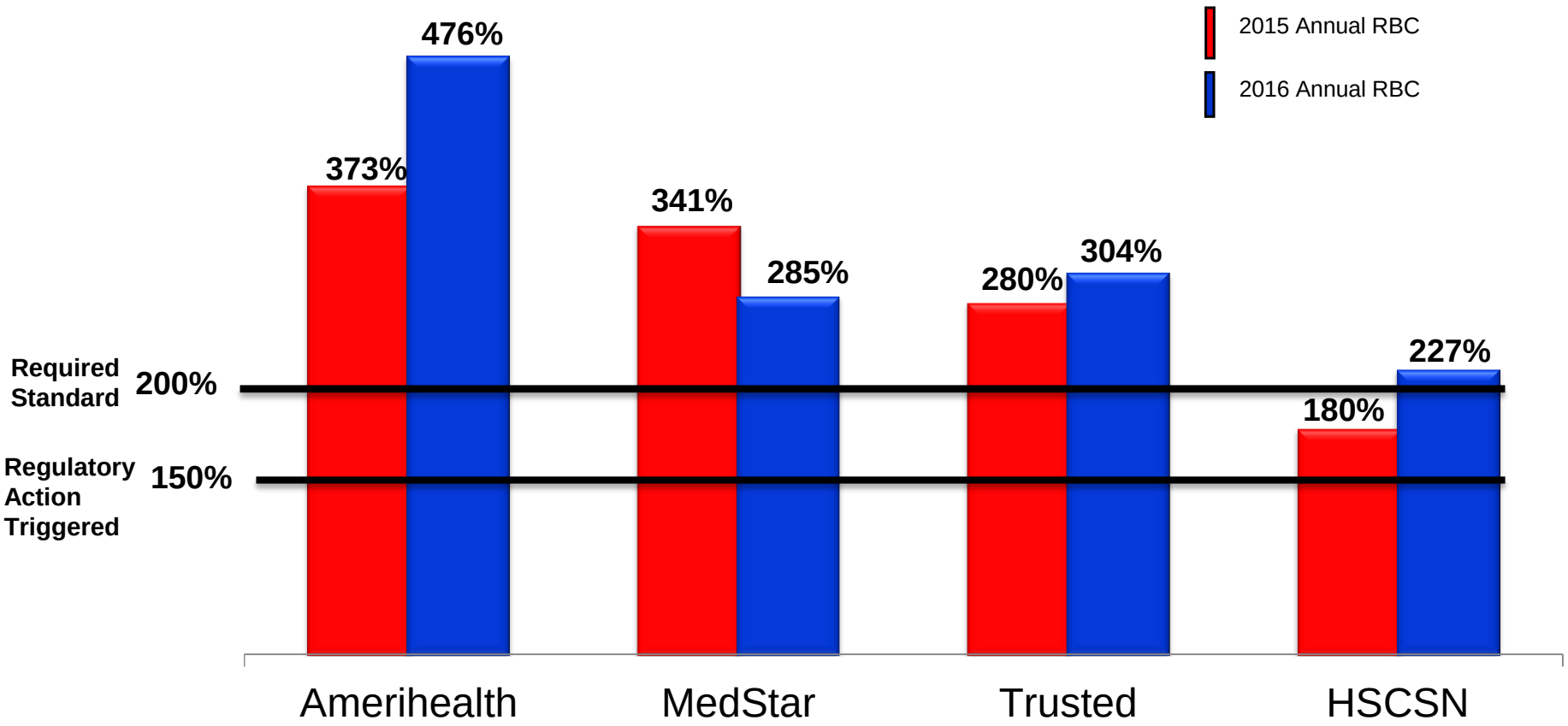
3. **Regulatory Action Level** - Total Adjusted Capital of 100 to 150 percent of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems

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).

The Three Full Risk Health Plans And HSCSN Maintained Risk Based Capital Levels That Exceed Recommended Standards

Annual 2016 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 calculated for this report.

Source: Reported figures are from the MCO's annual 2015 and 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.

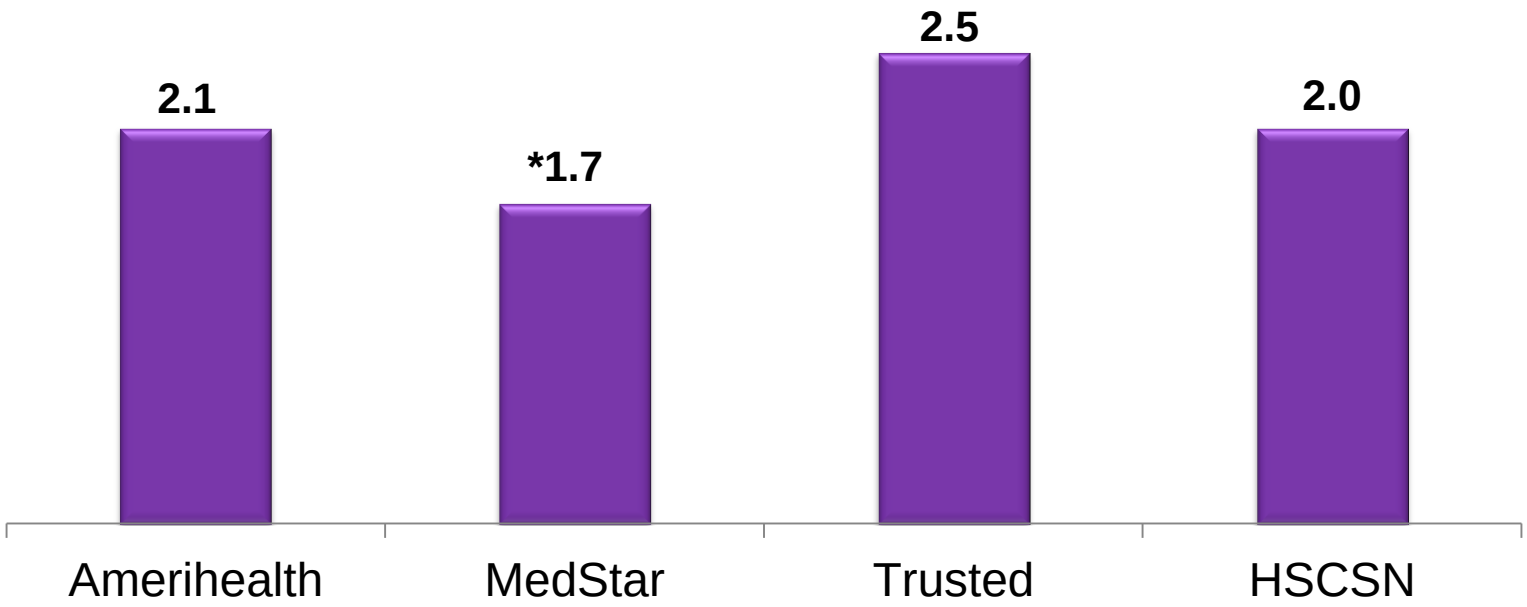
- Typically, MCOs are expected to retain a reserve equal to between one to two months' worth of claims, depending on how quickly claims are processed.

- In this report, DHCF reports that the MCO's have reserves available to satisfy incurred but not reported claims. This analysis is based on calculations provided by Mercer using data on the monthly claim's experience for each plan to calculate the reserves on hand.

- We also provide an analysis of the number of days the health plans can operate without accessing long-term assets. This is described as a Defensive Interval Ratio which is, in essence, a liquidity measure -- the degree to which the MCOs can survive on liquid assets without having to make use of either investments from the market or by selling long term assets.

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

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

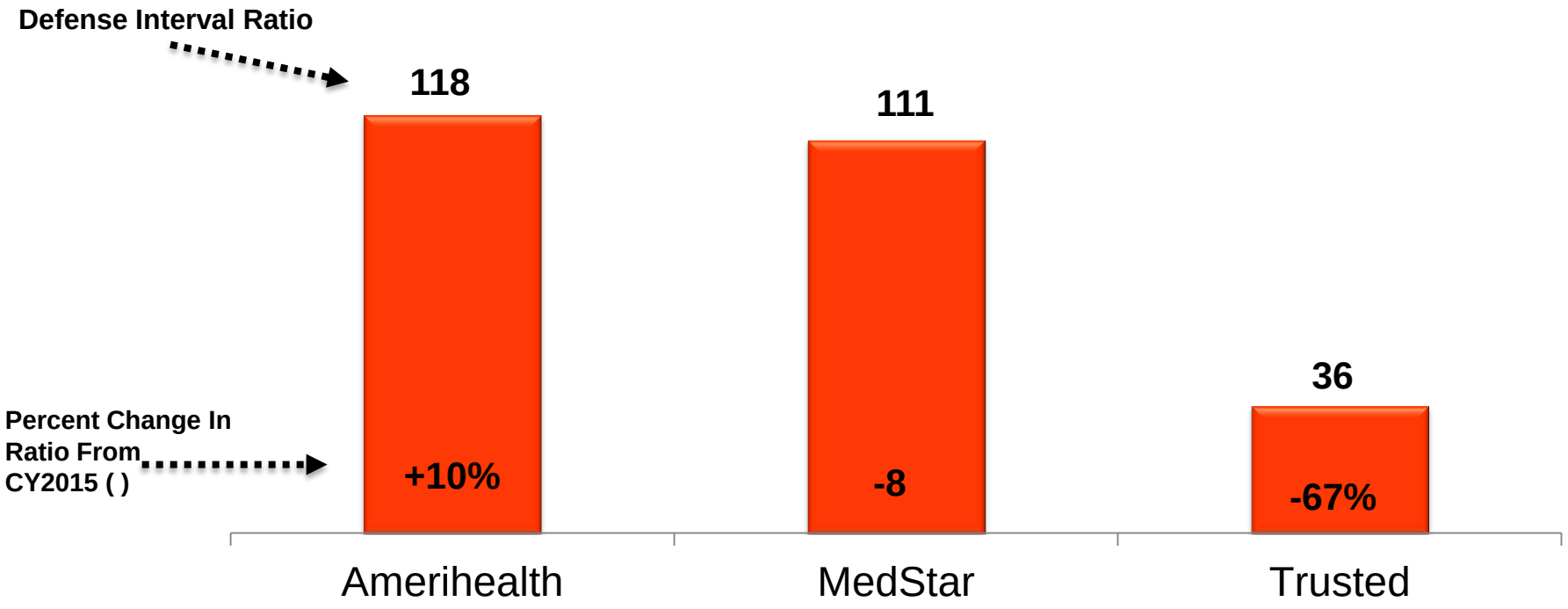


*Note: MedStar officials report that its monthly reserve figure includes data from its operations in other states and is also adversely impacted by the manner in which it pays the required Affordable Care Act fees. MedStar has been asked to provide a District specific monthly reserve figure going forward.

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 For AmeriHealth And MedStar Appear Significantly Stronger Than Those Observed For Trusted Which Invests Its Cash Reserves Into Treasuries And Bonds

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 December 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. Cash and equivalents data for HSCSN was not available in time for this report.

Source: Mercer calculated the Defensive Interval Ratio as cash and equivalents divided by daily operating expenses over for the period from January to December 2016.

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

- As a part of its core mission, MCOs must accomplish the following:

1. Build an adequate network of providers and pay health care claims to service providers on time and through an electronic claims process with documentation to facilitate reconciliation of payments

2. Create an accurate electronic record of all patient health care encounters and transmit the files containing this information to DHCF with a minimal error rate

3. Establish a system of care management and care coordination to identify health plan enrollees with special or chronic health care issues and ensure that these enrollees each receives access to appropriate care, while managing the delivery of health care services for all enrollees

Contractual Requirements Exist To Ensure Adequate Health Care Provider Networks

- The five-year MCO contracts contain specific provisions to ensure Medicaid and Alliance enrollees have reasonable access to care. The health plans must have:
  - 1 primary care physician for every 1,500 enrollees
  - 1 primary care physician with pediatric training for children through age 20 for every 1,000 enrollees
  - 1 dentist for every 750 children in their networks
- Additionally plan networks must include:
  - At least 2 hospitals that specialize in pediatric care
  - Department of Behavioral Health core service agencies
  - Laboratories within 30 minutes travel time from the enrollees' residence
- For pharmacies, each plan must have:
  - 2 pharmacies within 2 miles of the enrollees' residence
  - 1 24-hour, seven (7) day per week pharmacy
  - 1 pharmacy that provides home delivery service within 4 hours
  - 1 mail order pharmacy

All Health Plans Have Impaneled Substantially More Physicians Than Required By Contract Standards

The Number of Providers In The MCO Networks Compared to Contract Requirements, as of December 31, 2016

Health Plan	Primary Care Doctors Required In Network (1:1500)	Primary Care Doctors In The MCO Network	Primary Care Doctors With Pediatric Specialty Required In Network (1:1000)	Doctors With Pediatric Specialty In Network	Dentist For Children Required In Network (1:750)	Dentist For Children In Network
AmeriHealth	67	**576**	45	**766**	59	**381**
MedStar	36	**731**	17	**408**	22	**425**
Trusted	22	**781**	10	**1742**	14	**416**
HSCSN	--	**896**	--	**2945**	--	**200**

Note: In 2016, HSCSN did not have contractual requirements mandating physician ratios per member. That issue has been addressed for FY2017.

Source: This information is self reported by the MCOs to the District's Enrollment Broker as of December 31, 2016 and verified by the Department of Health Care Finance through a sampling of providers.

The Health Plans Have Successfully Constructed Encounter Data Files But MedStar And Trusted Continue To Struggle With The Accuracy Of Submissions

Number of Recorded Encounters And Accuracy Transfer Rate, January 2016 to December 2016

MCO	Average Monthly Enrollment	Total Encounters	Average Total Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	100,305	1,396,034	13.9	97%
MedStar	50,878	728,396	14.3	87%
Trusted	32,258	396,331	12.3	88%
HSCSN	5,518	275,368	49.9	93%

Note: For MedStar, there were two months in 2016 where its dental vendor, DentaQuest impacted the health plan's overall encounter rate by submitting 30,000 plus encounters that all rejected. This significantly impacted our accuracy rate. We have since worked with the vendor and placed them on a corrective action plan, and improving MedStar's encounter data accuracy.

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

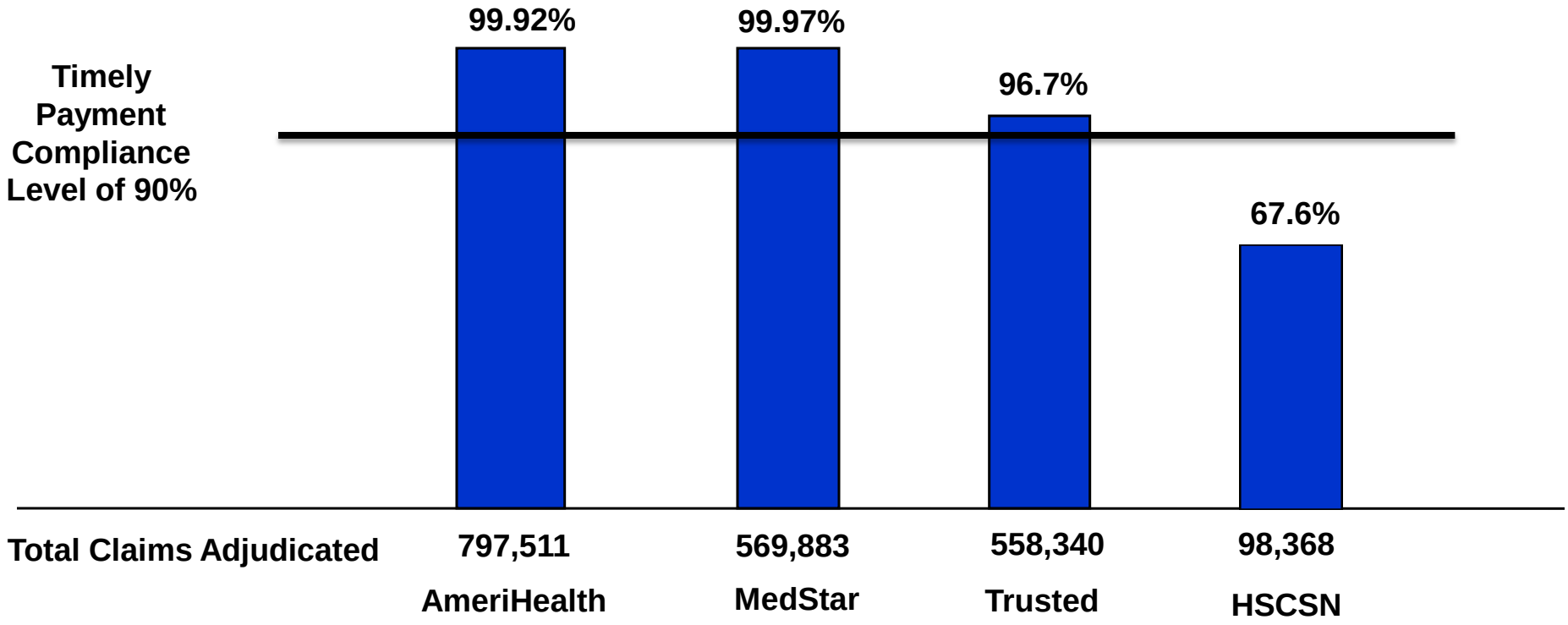
- Through electronic claims processing, the District's three managed care organizations are required to pay or deny clean claims within 30 days to satisfy prompt pay requirements.

- 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

With The Exception Of HSCSN The MCOs Exceeded The District's Timely Payment Requirement In 2016

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



Note: The 30 day timely payment requirement only applies to "clean claims" that meet the requirement for payment. HSCSN delayed payments to providers in 2016 due to federal delays in the approval of the updated payment rates.

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

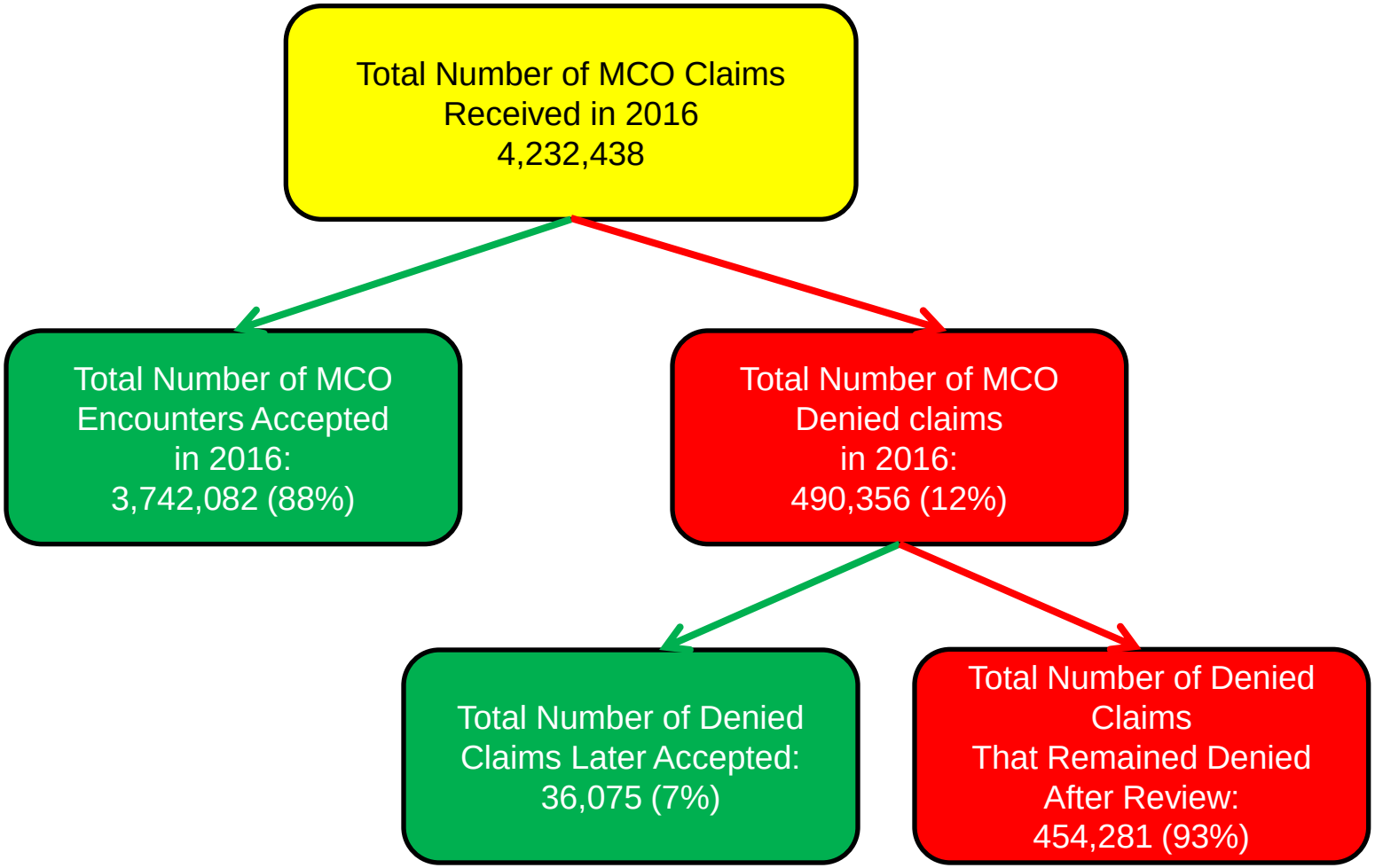
- Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the health plans networks, and potentially cause access to care issues

- 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 December 31, 2016 were obtained from the District's four MCOs and established as the master dataset. This data extraction yielded approximately 4.2 million 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 2016 and December 31 2016 were extracted yielding more than four 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.

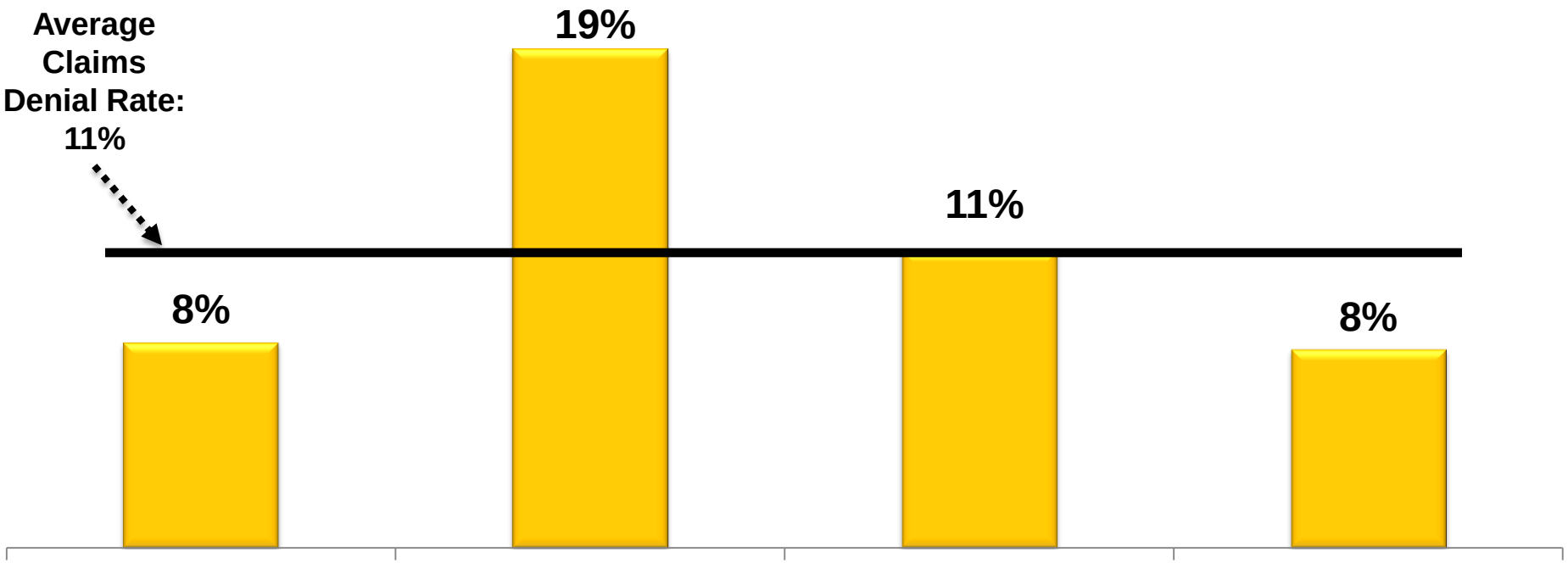
MCOs Had an Average Denial Rate of 12 Percent in CY 2016



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 February 2017.

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

Claims Denial Rates For Each Health Plan, 2016



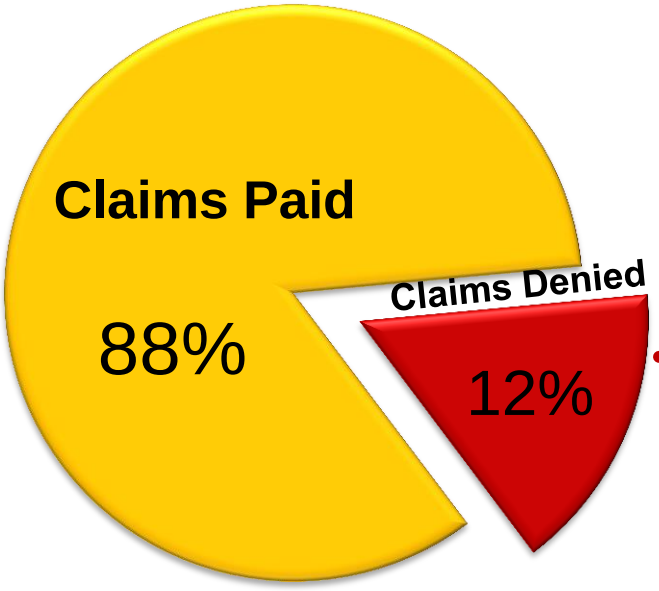
	AmeriHealth	MedStar	Trusted	HSCSN
Total Claims Adjudicated	2,150,037	1,264,865	559,204	258,332

Note: MedStar continues to work with its Pharmacy Benefits Manager, CareMark, to better understand their pharmacy adjudication process and what is truly considered a pharmacy claim denial as this is driving the plan's high overall denial rate.

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

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

MCO Claims Denial Rate, 2016



N = 4,232,438

Paid Denied

Five Most Common Denial Reasons	Number of Denied Claims	Percent of Total Denied Claims
Service coverage issue*	184,476	39%
Improper drug refill	42,175	9%
Duplicate claim	34,896	7%
Incomplete or improper billing	27,857	6%
Member not eligible	27,015	6%

N = 490,356 total denied claims

Note: *This can include missing prior authorization, services not being covered, or exceeded units.
Source: Department of Health Care Finance, Medicaid Management Information System (MMIS), 2016.

For MedStar, Pharmacy Claims Adjudication and Service Coverage Issues Are Primary Reasons For The Health Plan's High Denial Rate

Denied Claims By Provider Type For MedStar, 2016

Provider type	Number of claims	Percent of total denied
Pharmacy	140,999	59%
Hospital	23,803	10%
Physician	16,455	7%
FQHC	11,917	5%

Most Common Denial Reasons For MedStar, 2016

Denial reason	Number of claims	Percent of total denied
Service coverage issue	91,246	41%
Improper drug refill	42,175	19%
Duplicate claim	11,406	5%

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

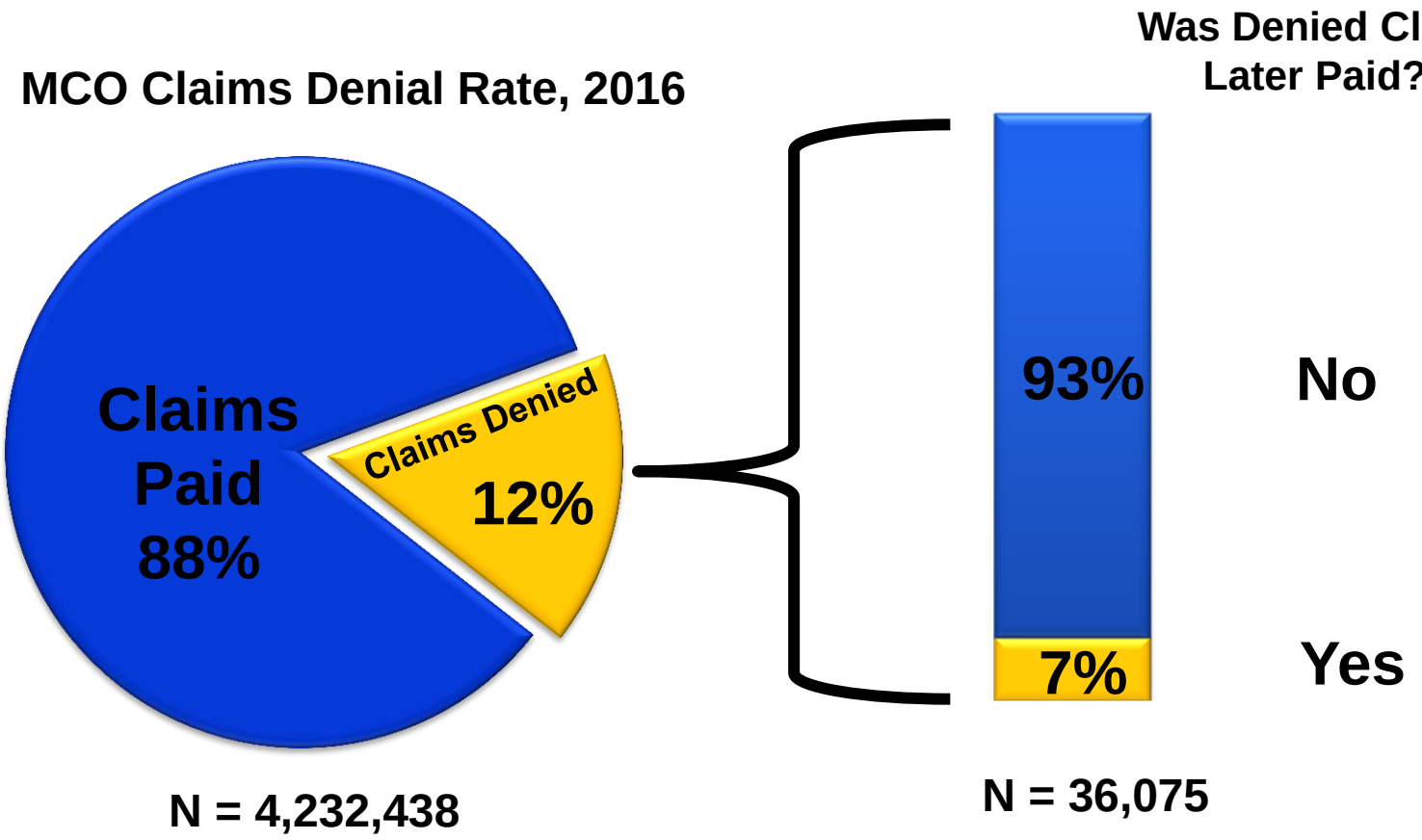
MCO Claims Denial Rates Vary Widely By Provider Type and May Indicate Need for Provider Education

Claims Denial Rate By Top Five Provider Types, 2016

Provider type	Number of denied claims	Number of Total Claims	Claims Denial Rate
Nurse Practitioner	11,549	20,615	56%
FSMHC	17,978	40,752	44%
Home Health Agency	4,503	19,620	23%
Hospital	76,396	379,929	20%
Physician	88,140	478,219	18%

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

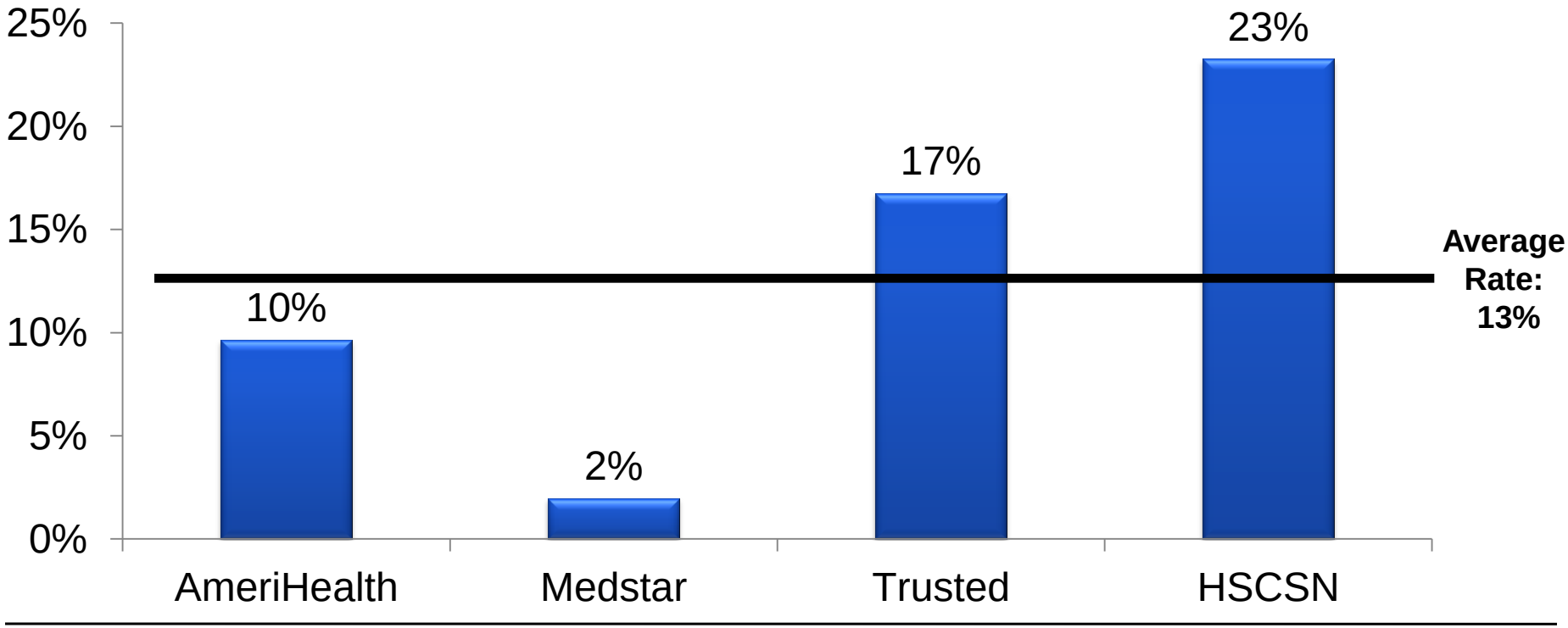
Only Seven Percent of Claims Initially Denied Were Later Paid



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 February 2017.

Claims Denials Are Generally Sustained By Each MCO With the Exception of HSCSN And To A Lesser Degree Trusted

MCO Rates of Payment For Originally Denied Claims, 2016

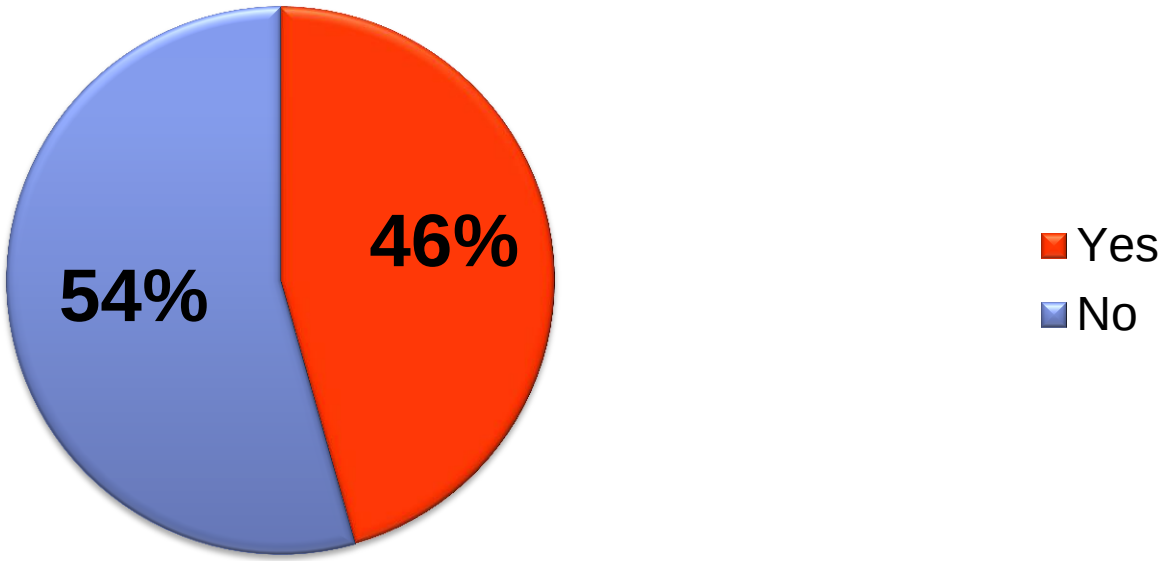


	AmeriHealth	Medstar	Trusted	HSCSN
Total Claims Denied	**167,956**	**239,727**	**63,160**	**19,513**

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

Nearly Half of All Appealed Denied Claims Approved After An Appeal Were Subsequently Paid Within 30 Days

Percentage Of MCO Claims Approved After Appeal That Were Paid Within 30 Days, 2016



N = 36,075

Note: Patient encounters with CY 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 February 2017.

Number of Days to Pay Approved Appealed Claims Varies By Provider Type

Average Number Of Days To Payment For Appealed Claims, 2016

Ten Select Provider Types	Average Number Of Days From Initial Denial To Payment
Hospice	25
Dentist	42
Psychiatric Residential Treatment Facility	43
Hearing Aid Dealer	44
Independent Lab	45
Free-Standing Mental Health Center	46
Physician Group Practice	54
Durable Medical Equipment	63
Nurse Practitioner	79
Hemodialysis, Freestanding	88

Note: Patient encounters with CY 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 February 2017.

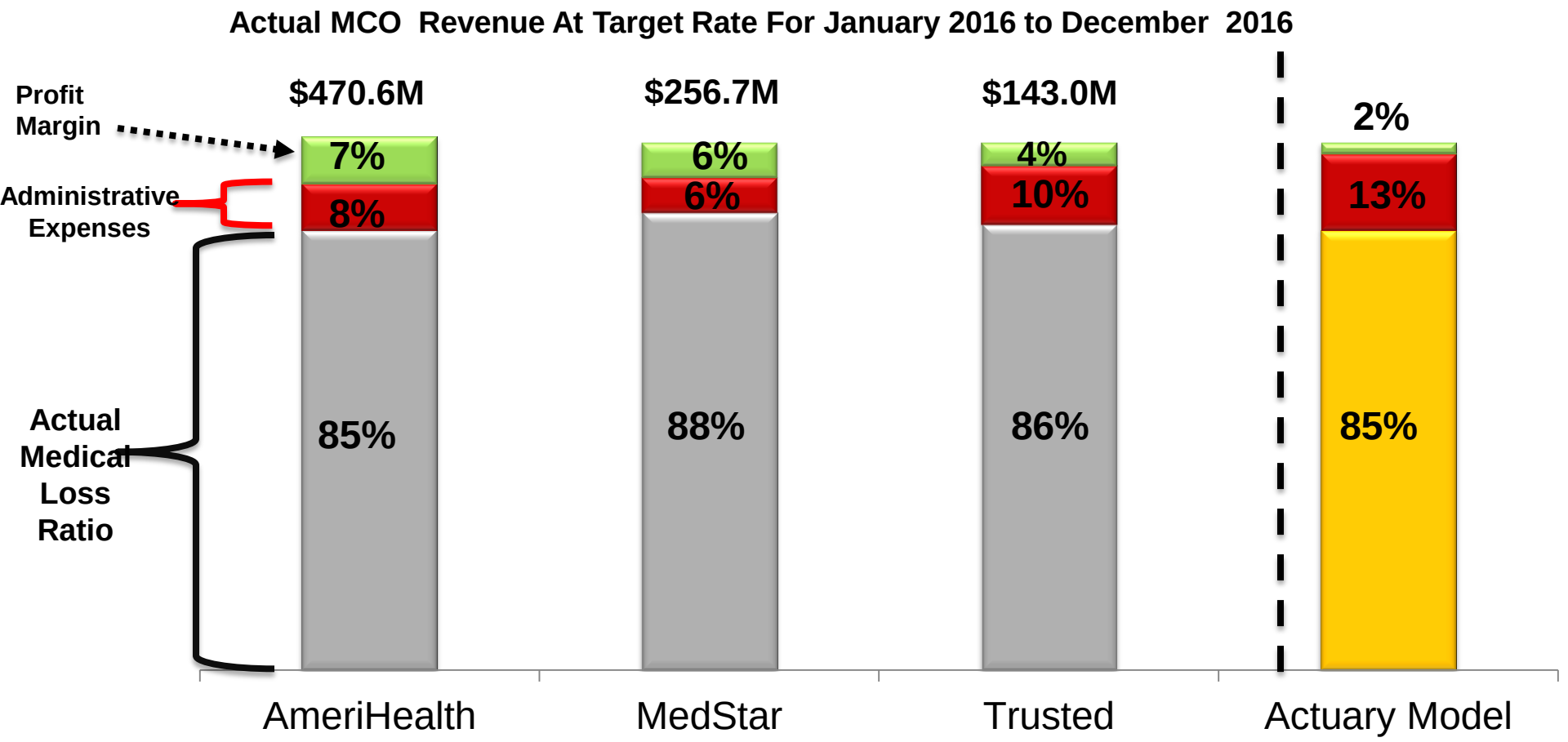
Denial Rates Have Remained Slightly Decreased Over Three Year Period

A Comparison of Outcomes From 2014, 2015 and 2016 (2014 paid claims exclude pharmacy)			
Outcome	**2014**	**2015**	**2016**
Total Claims Processed	2.26M	4.06M	4.23M
Claims Denied (%)	18%	14%	12%
Highest Denial Rate By Plan	31% (MedStar)	22% (Trusted)	19% (MedStar)
Denied Claims Later Approved	18%	6%	7%
Denied Claims Later Approved And Paid Within 30 Days	79%	43%	46%

Presentation Outline

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

Each Of The Full Risk Plans Spend A Least 85 Percent Of Revenue On Member Medical Expenses With All Three Plans Posted An End-of-Year Profit



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.

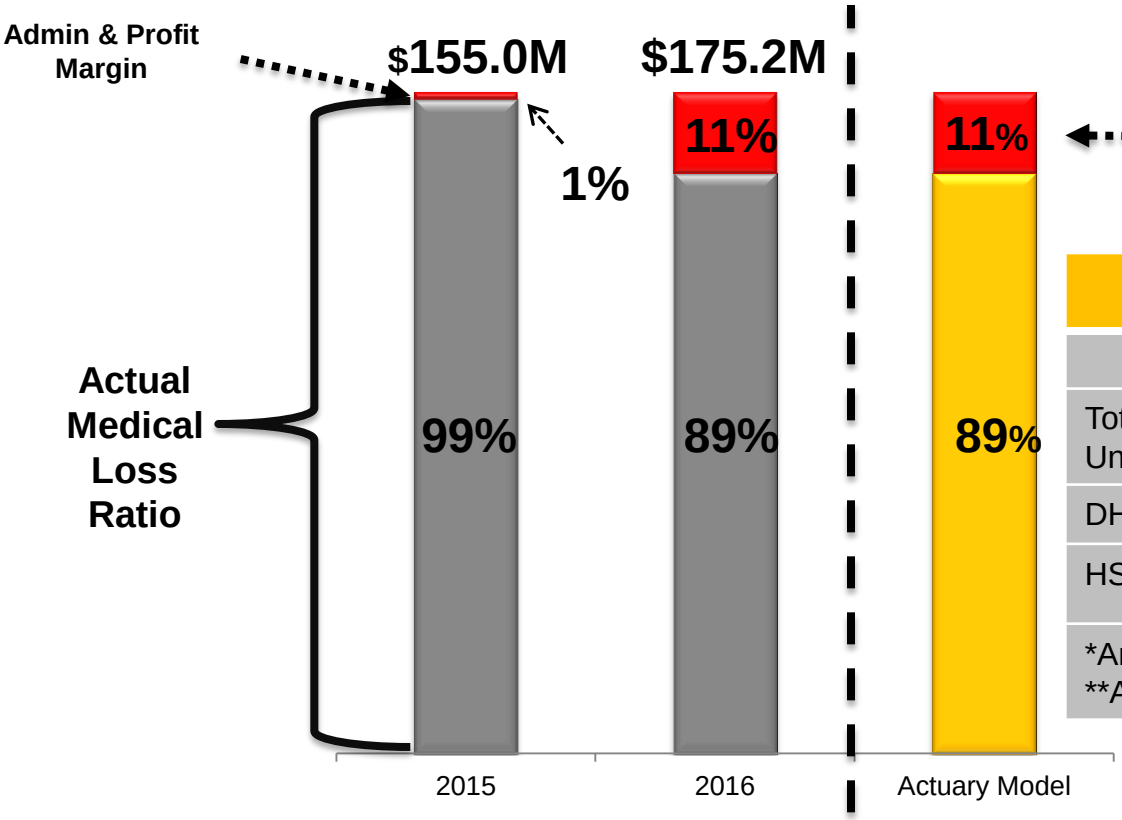
- The Table below shows the risk corridors for this contract and how financial gains or losses are shared between the HSCSN and the District

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

HSCSN Performance Did Not Trigger The Risk Sharing Provisions In Its Contract With DHCF

HSCSN Revenue And Claims Cost For 2015 And 2016

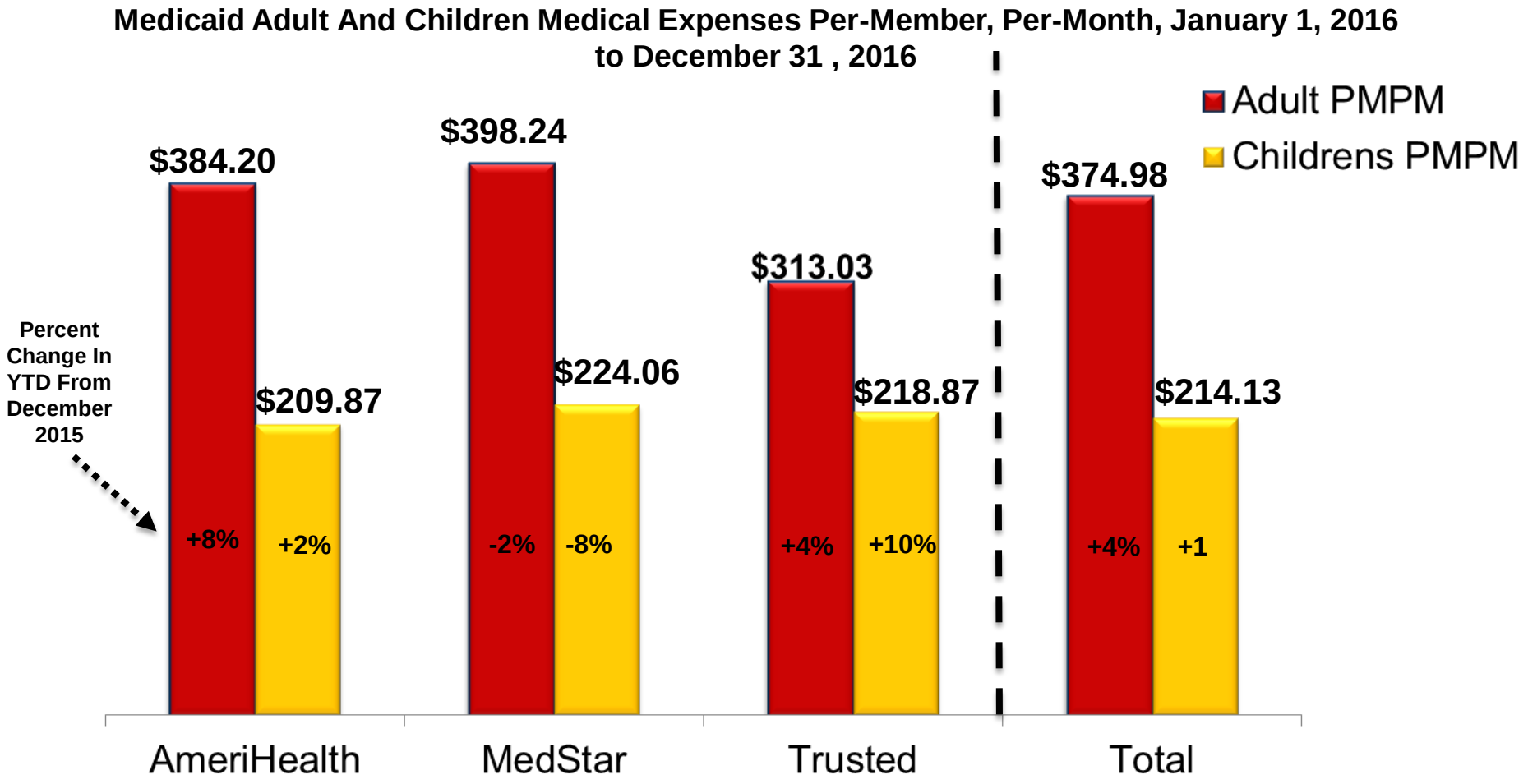


Risk Share Based on 89.6% MLR		
	2015	2016
Total (At Risk) or Underspend	*($14,864,405)	**$0
DHCF Share	($5,347,065)	-
HSCSN Share	($9,517,340)	-
*Amount of spent over level set by Medical Loss Ratio **Amount of surplus		

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: Self reported quarterly statements .

The Year-Over-Year Growth In Medical Expenses For Both Adults And Children in The Medicaid Program Has Moderated Due Mostly To Cost Control Measures Employed By MedStar

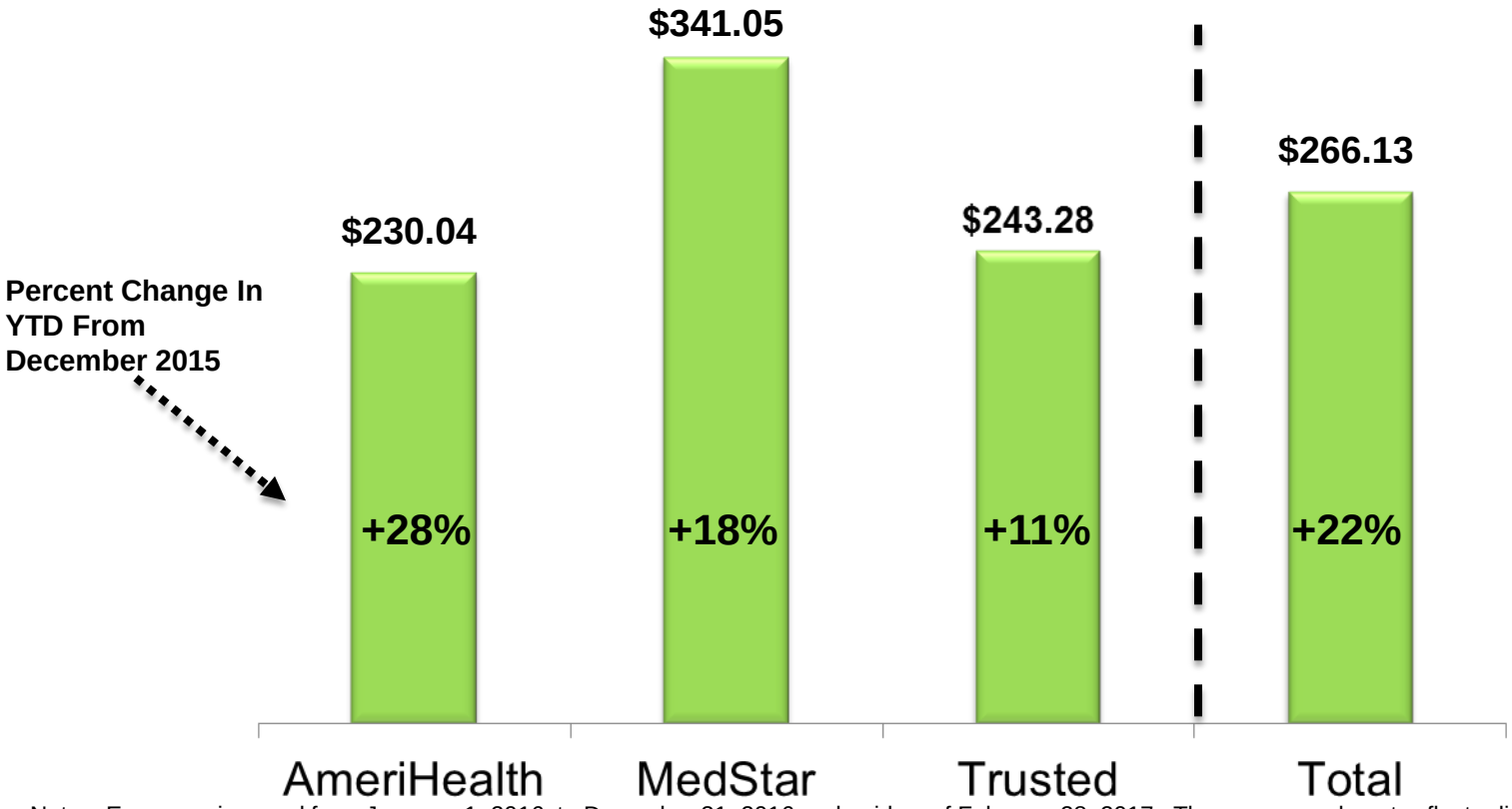


Notes: Expenses incurred from January 1, 2016 to December 31, 2016 and paid as of February 28, 2017. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOSs.

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

The Normal Double Digit Growth In Medical Expenses For Alliance Was Exacerbated By DHCF's Need To Move Most Of The Pharmacy Cost Of This Program Out Of The Department Of Defense Discount Program And Into The Managed Care Benefit

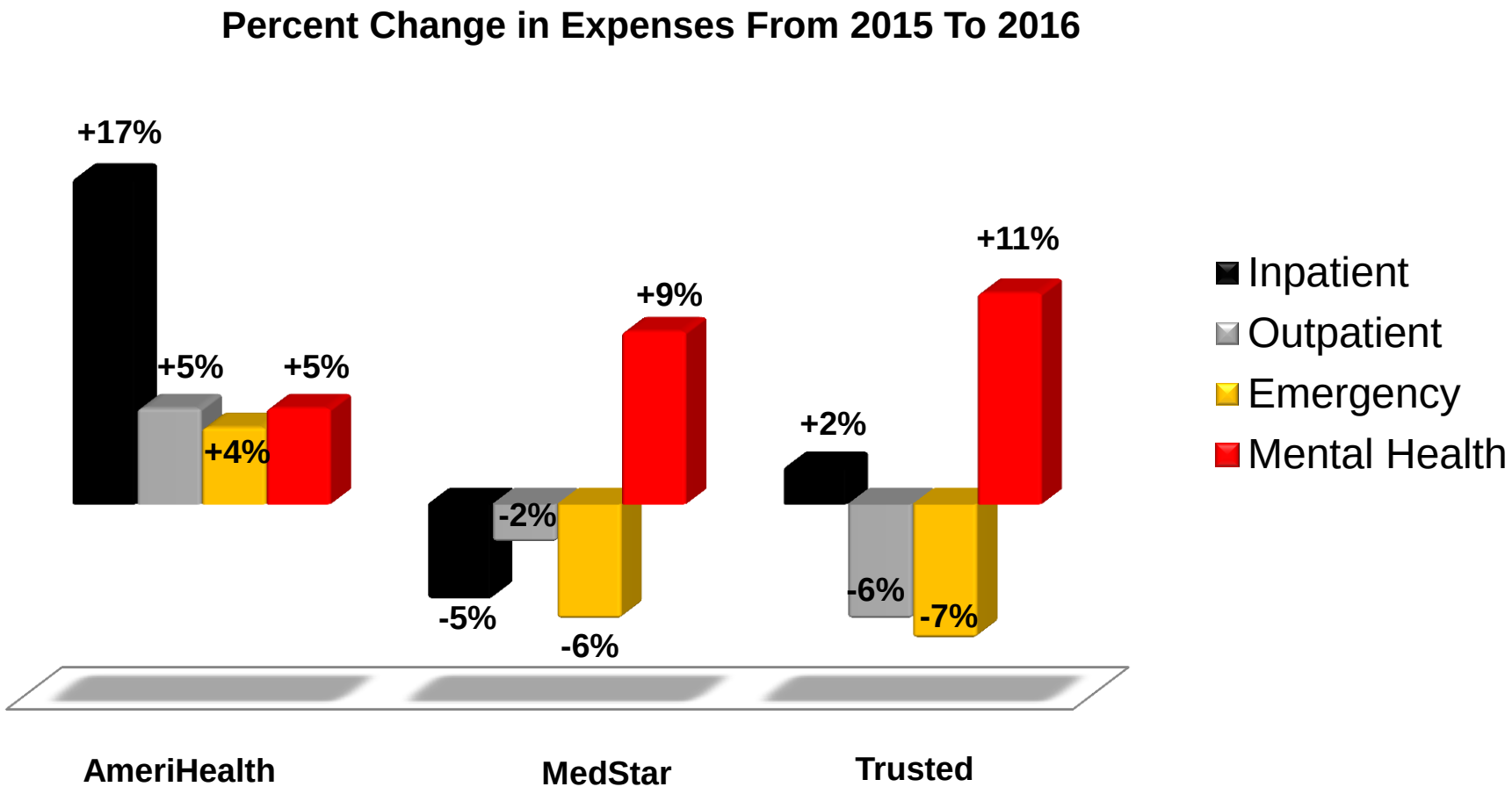
Alliance Adult Medical Expenses Per-Member, Per-Month, January 1, 2016 to December 31, 2016



Notes: Expenses incurred from January 1, 2016 to December 31, 2016 and paid as of February 28, 2017. 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.

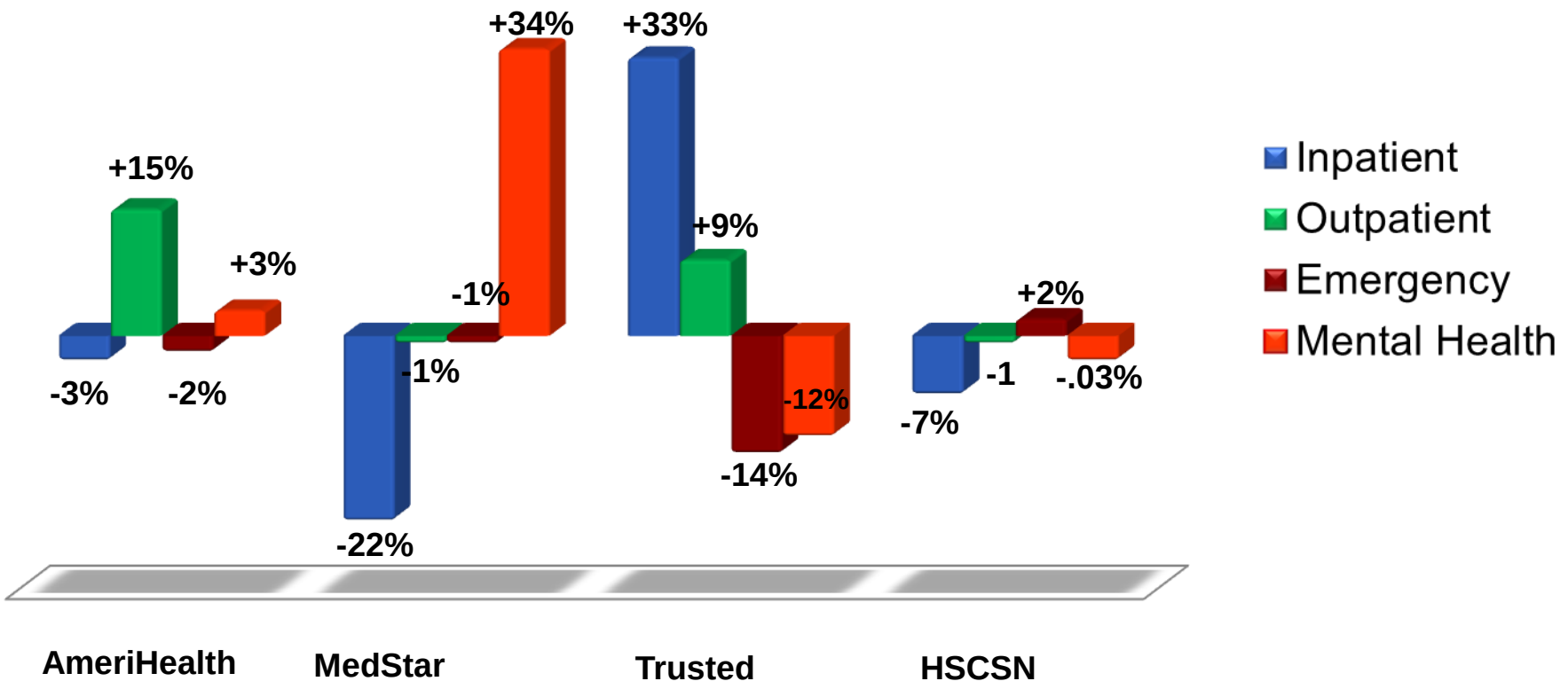
Across All Major Services For Adults, MedStar Has Significantly Reduced Its Cost From The Previous Year Which Was Substantially Higher Than Other Plans



Note: Expenses incurred from January 1, 2016 to December 30, 2016 and paid as of February 28, 2017. 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.

After Witnessing Double Digit Growth In Most Categories For Children's Medical Expenses, The Three Full Risk Health Plans And HSCSN Effectively Contained Cost In 2016 Relative To The Previous Year For Most Services

Percent Change in Expenses In 2016 Compared To 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.

While MedStar Has Significantly Reduced The Medical Expenses For Adults And Children In The Health Plan, Their Relative Ranking Does Not Match The Plan's Assigned Risk Scores

Ranking On Enrollee Risk Scores As Of October 2016

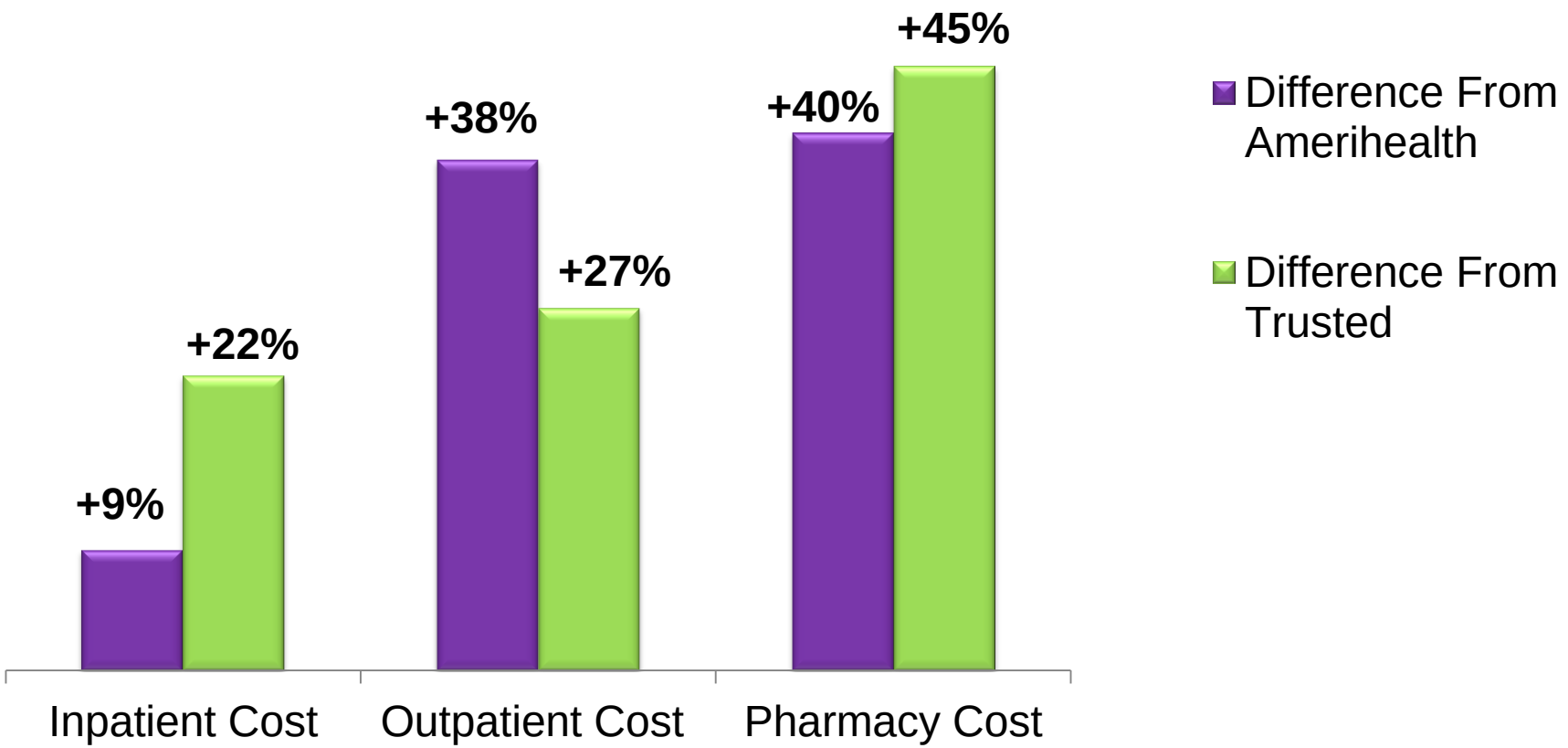
Ranking On Medical Cost	Low	Medium	High
Low	*Trusted - Adults		AmeriHealth - Children
Medium		Trusted - Children	AmeriHealth - Adults
High		MedStar - Adults MedStar - Children	

Notes: Expenses incurred from January 1 2016 to December 31 2016 and paid as of February 2017. 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.

In 2016 The Historically Sharp Differences In Adult Inpatient, Outpatient, and Pharmacy Cost Between MedStar And The Other Health Plans Were Somewhat Diminished

MedStar's Cost Differences Relative To AmeriHealth And Trusted, As Of December 31, 2016

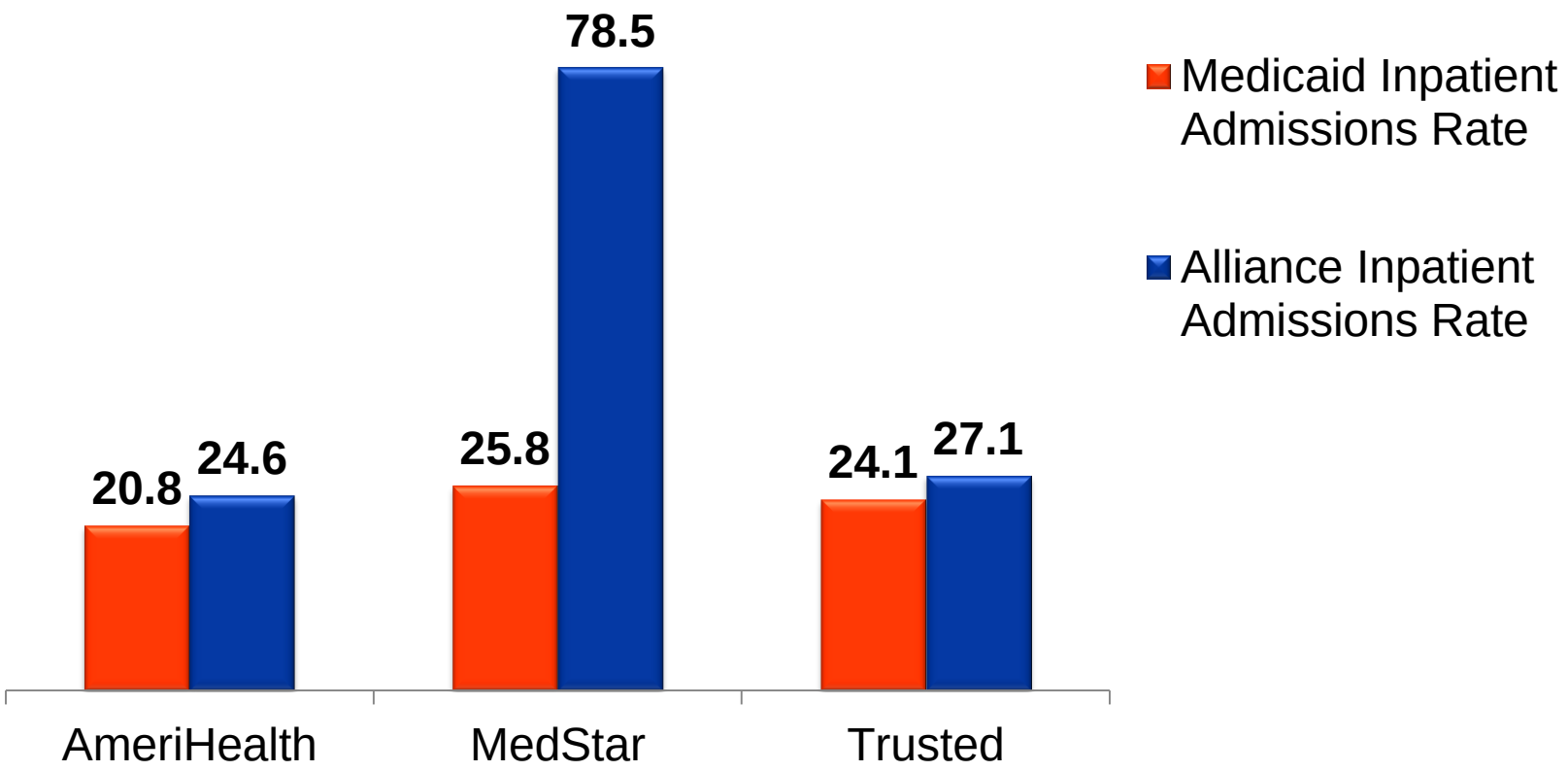


Notes: Expenses incurred from January 1 2016 to December 31, 2016 and paid as of February 2016. The large difference in pharmacy cost is partly attributed to the fact the MedStar serves a higher proportion of beneficiaries who use the expensive Hepatitis C medications.

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

MedStar Lowered Its Medicaid Inpatient Admissions Rate Relative To The Other Plans But The Rate For Alliance Hospital Admissions Are Considerably Higher

Total Number Of Inpatient Admissions In 2016 Per 1000 Members

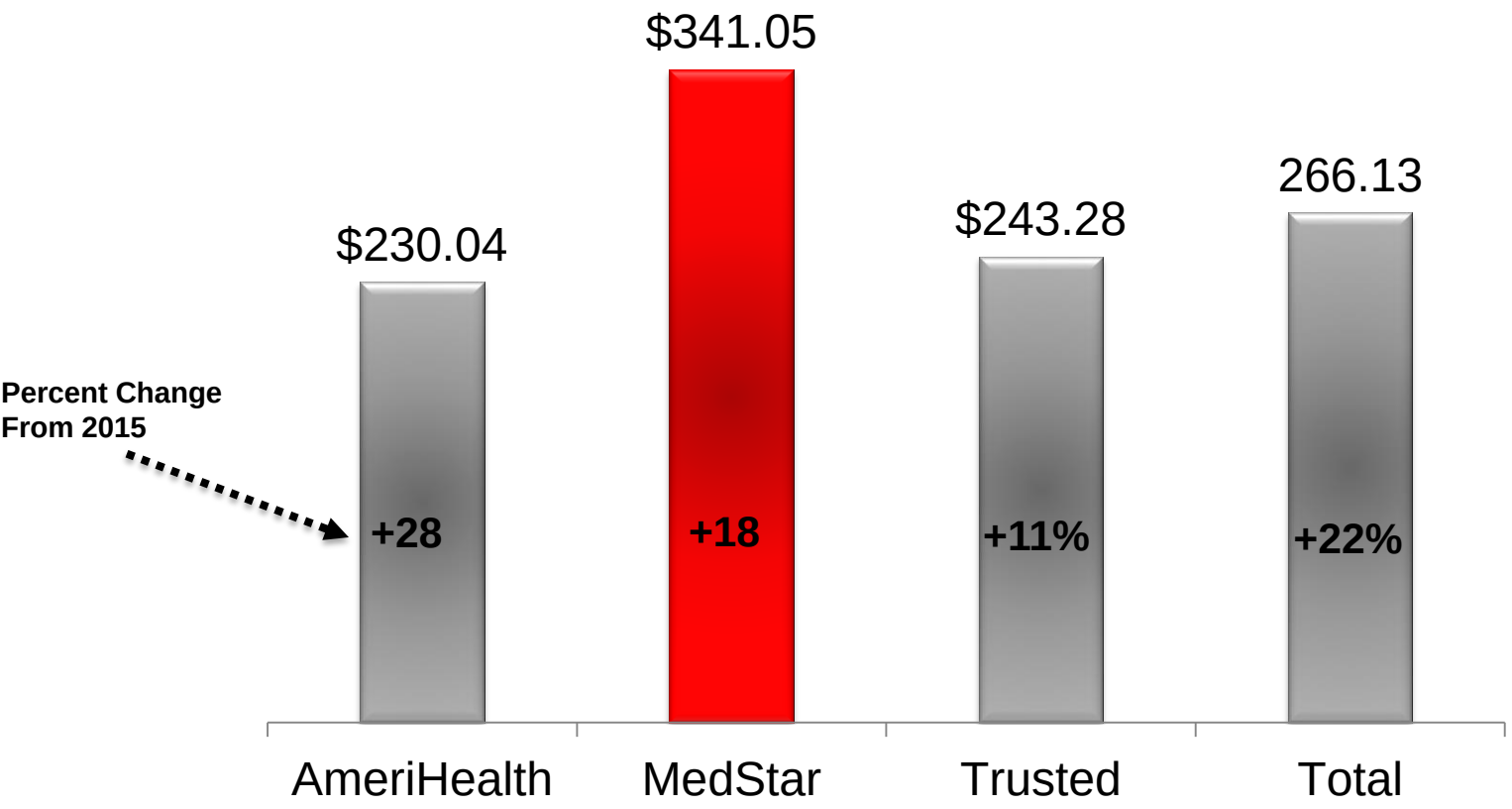


Notes: The current frequency of Index Admissions analysis for the period January 2016 to December 2016 includes encounters that are stamped by DHCF's MMIS both "Paid and Denied" encounters

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

This Partially Explains Why MedStar's Alliance Cost Are At Least 40 Percent Higher Than The Levels Observed For The Other Plans

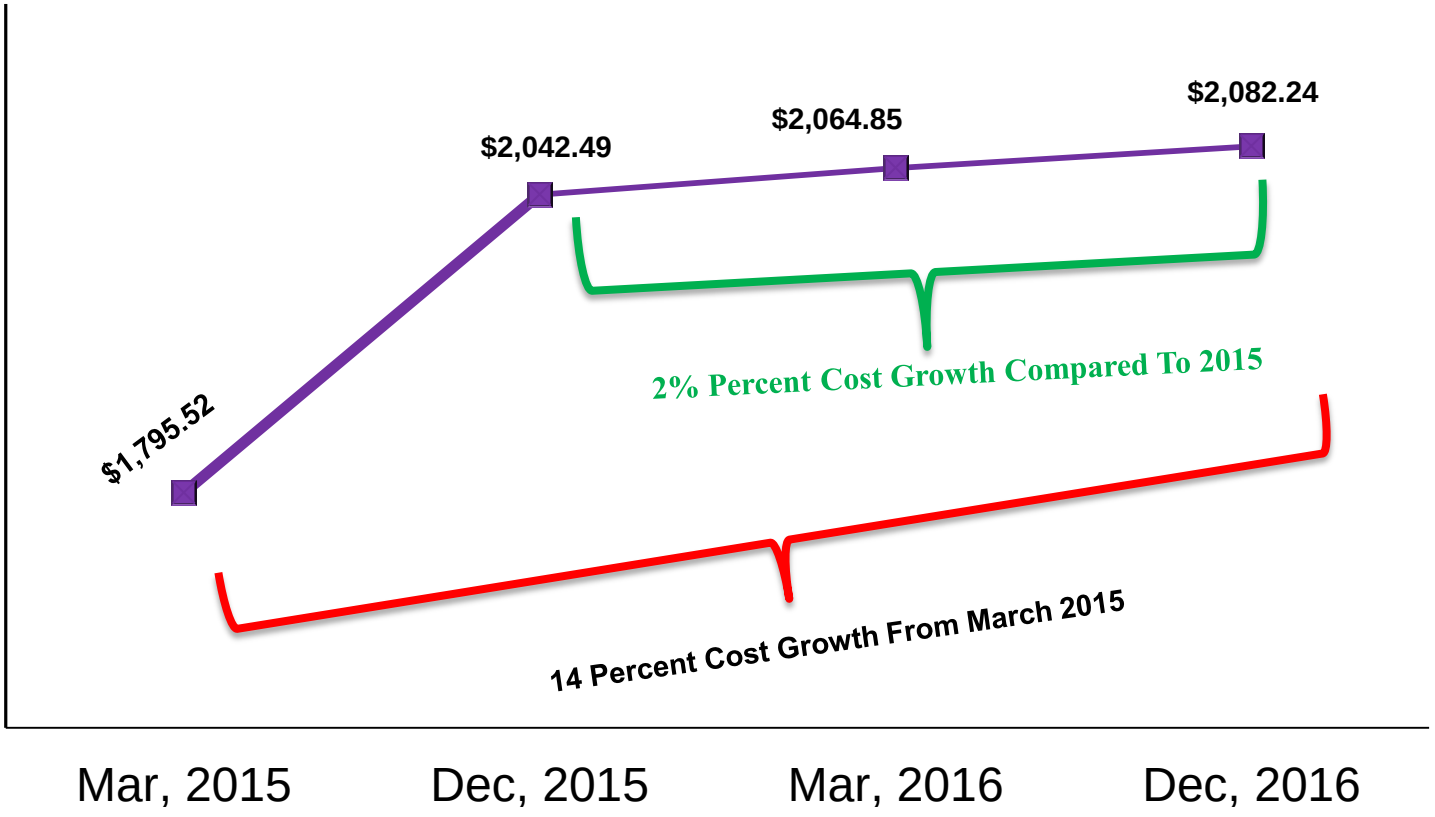
Alliance Adult Medical Expenses Per-Member, Per-Month, January 2016 to December 2016



Notes: Expenses incurred from January 1, 2016 to December 30, 2016 and paid as of January 2017 do not reflect IBNR claims .
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

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

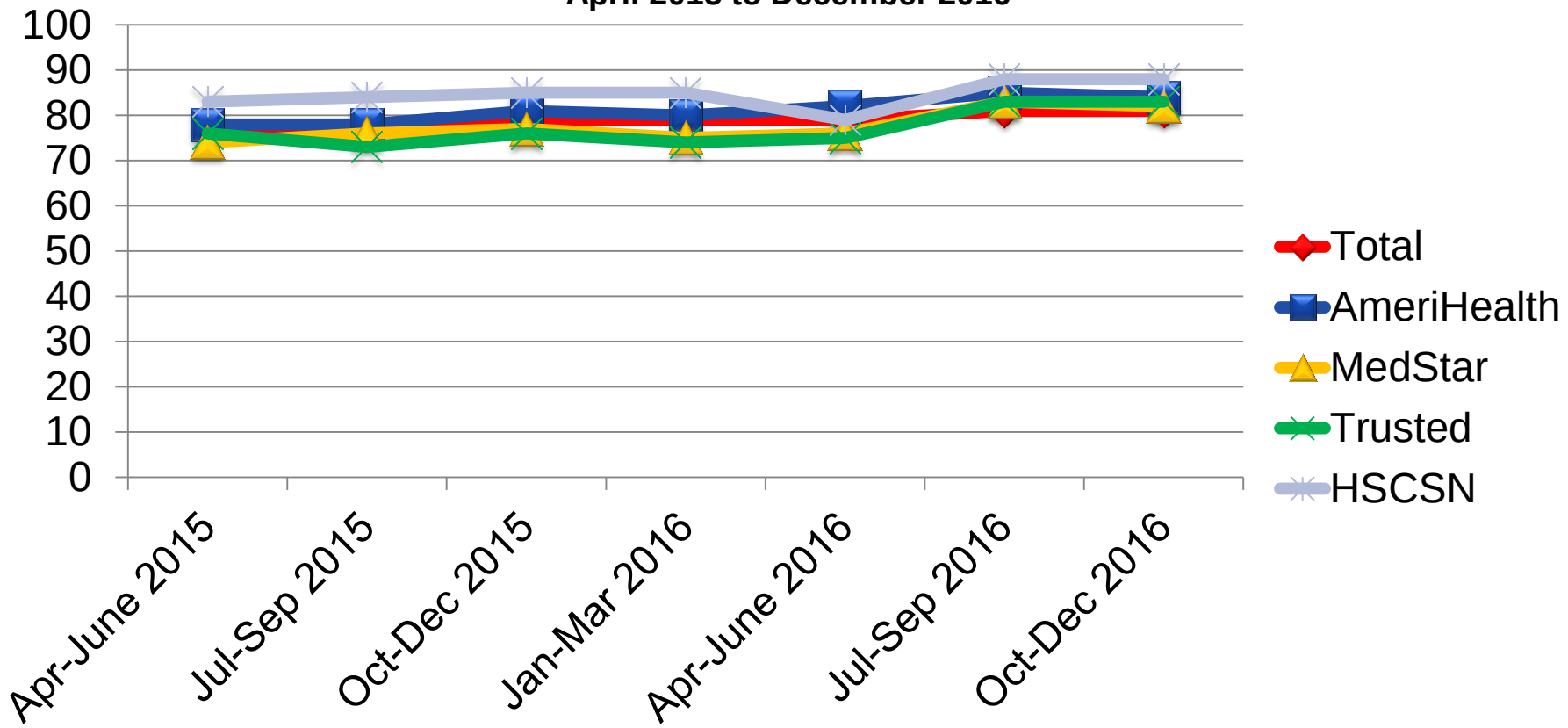
Medicaid Children Medical Expenses Per-Member, Per-Month, March 1, 2015 to December 31, 2016



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

The Physician Visit Rates For Children In Health Plans Are High Across All MCOs

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

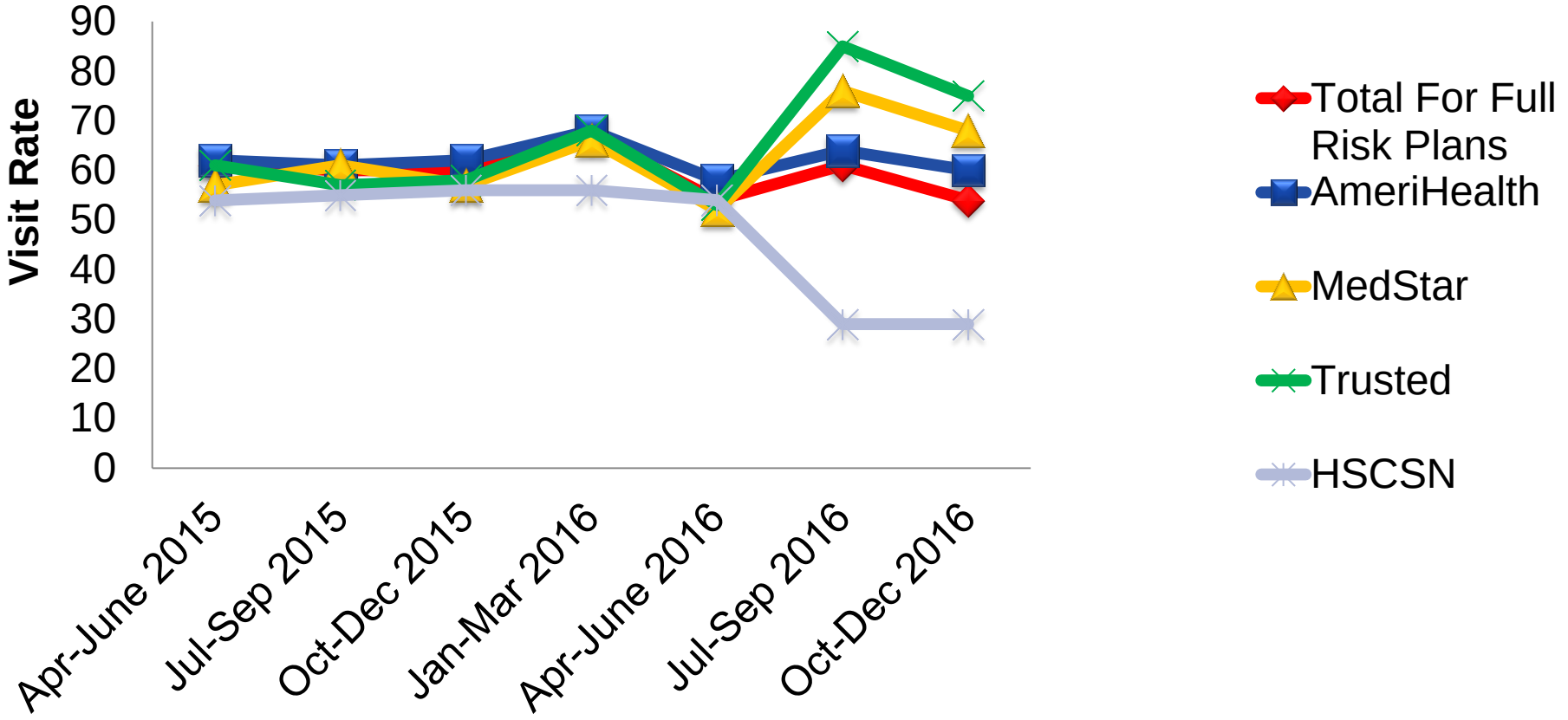


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The Three Full Risk Health Plans Measurably Increased The Physician Visit Rate For Children With An Added Well-Child Component But HSCSN Witnessed A Sharp Decline In The Last Two Quarters Of 2016

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

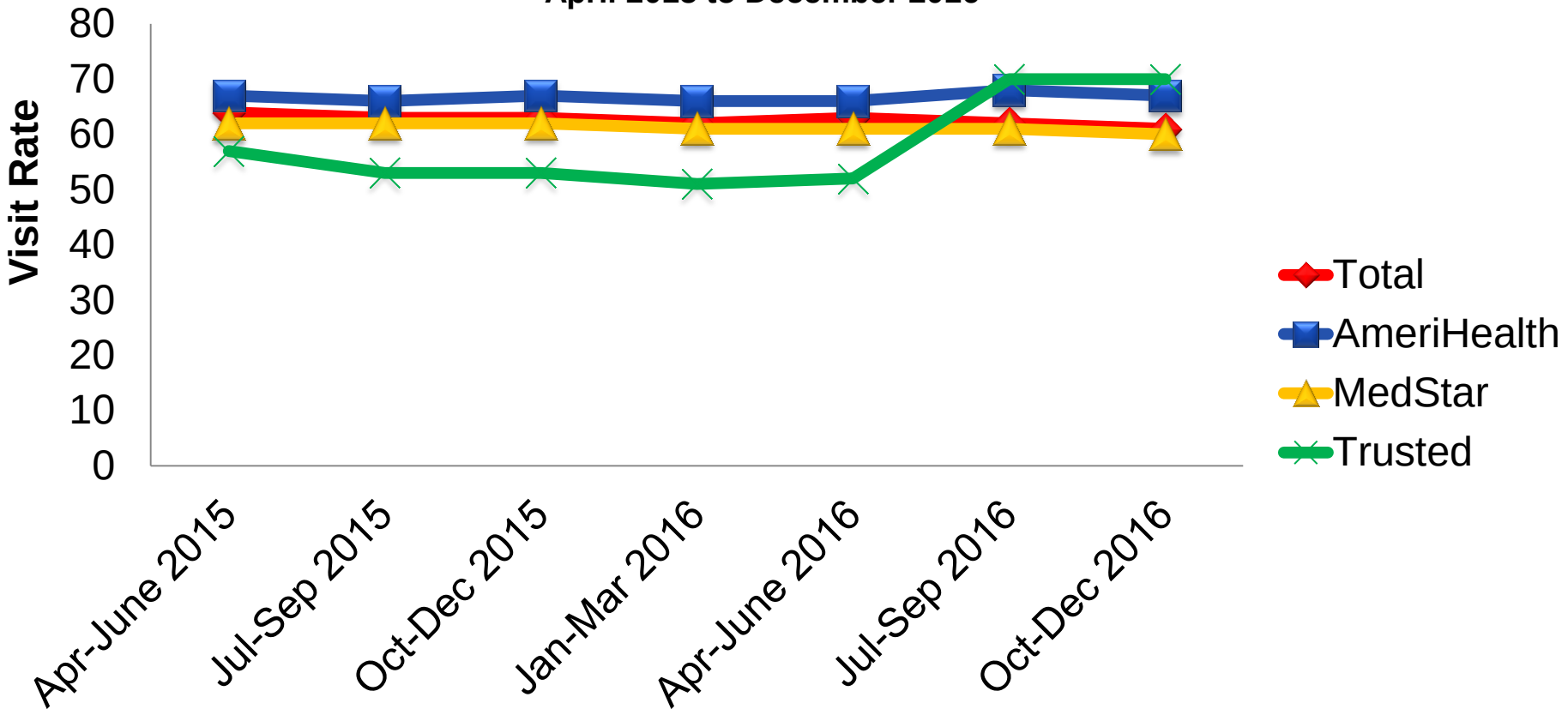


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The Physician Visit Rate For Adults Is Mostly Unchanged From The First Half Of The Year With Trusted Showing A Marked Increase In Its Rates

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

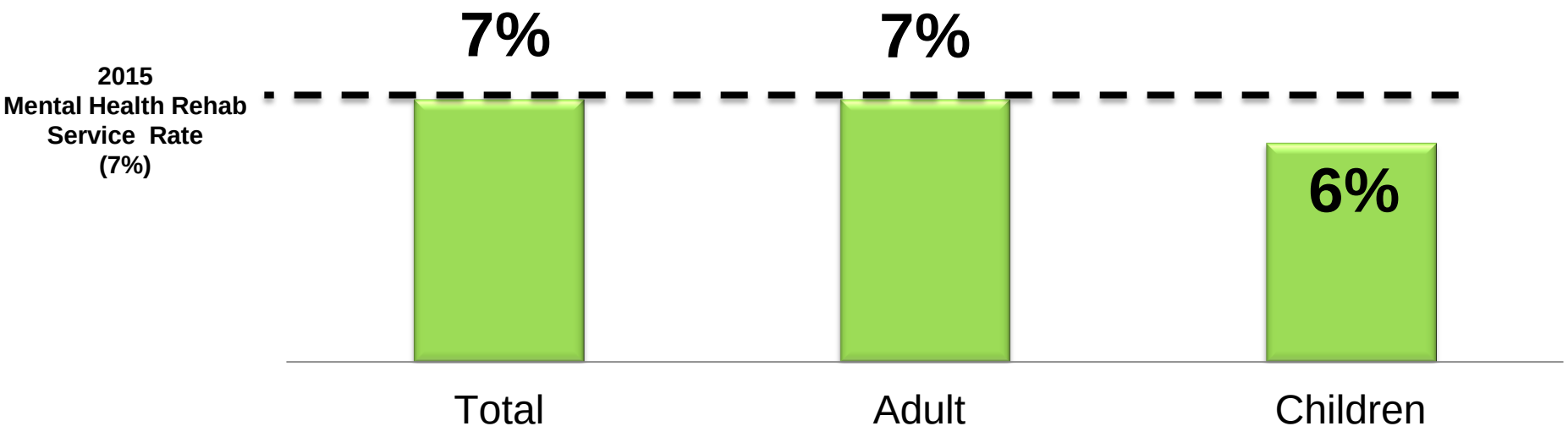


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

The 2016 Utilization Rate For Medicaid-Funded Mental Health Rehabilitation Services Equals Last Year's Rate

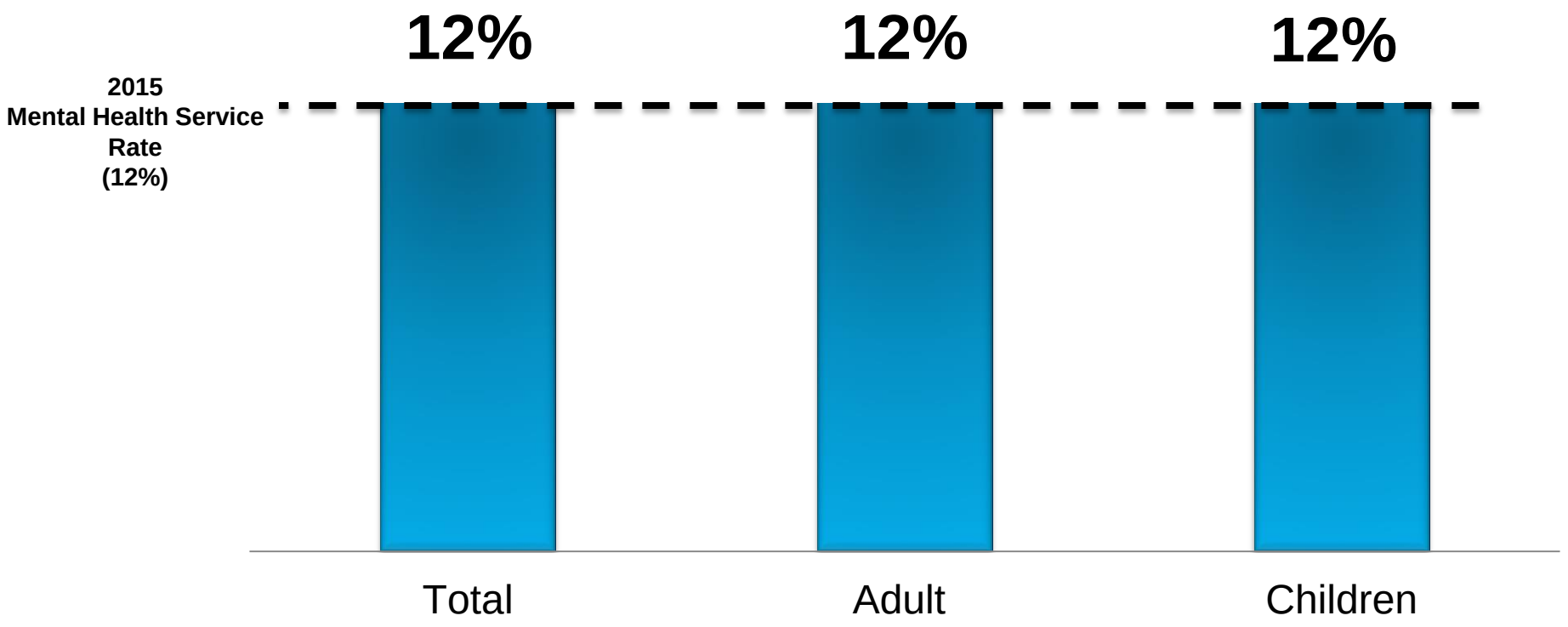
Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans, January 2016 to December 2016



Note: The data presented above are based on MCO paid encounters for the 2016, with a claims run out period through February 2017.
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

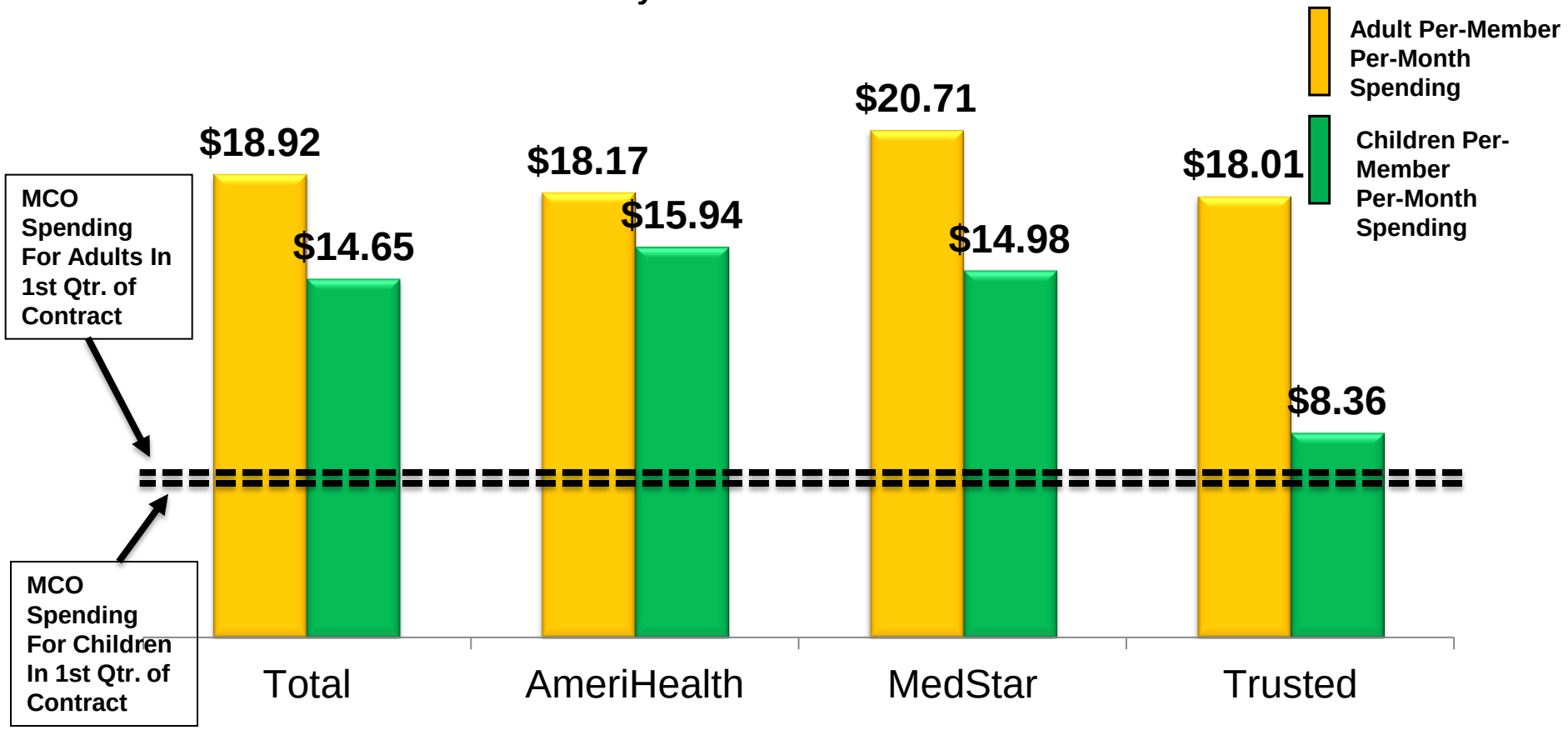
Percent of MCO Members Receiving Any Mental Health Services Through The Health Plans, January 2016 to December 2016



Note: The data presented above are based on MCO paid encounters for the 2016, with a claims run out period through February 2017.
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 December 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.

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

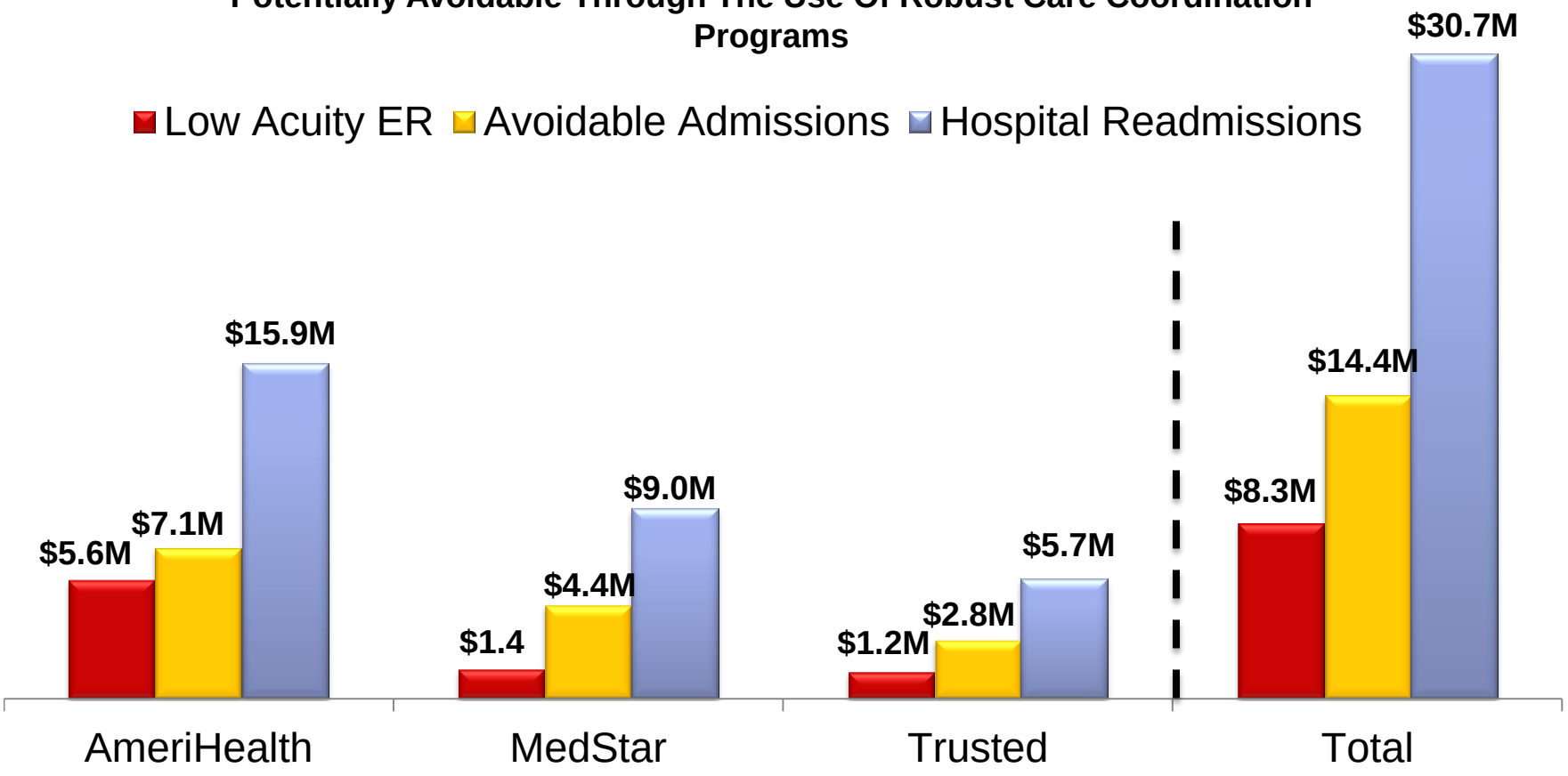
  - Emergency room utilization for non-emergency conditions

  - 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

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

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

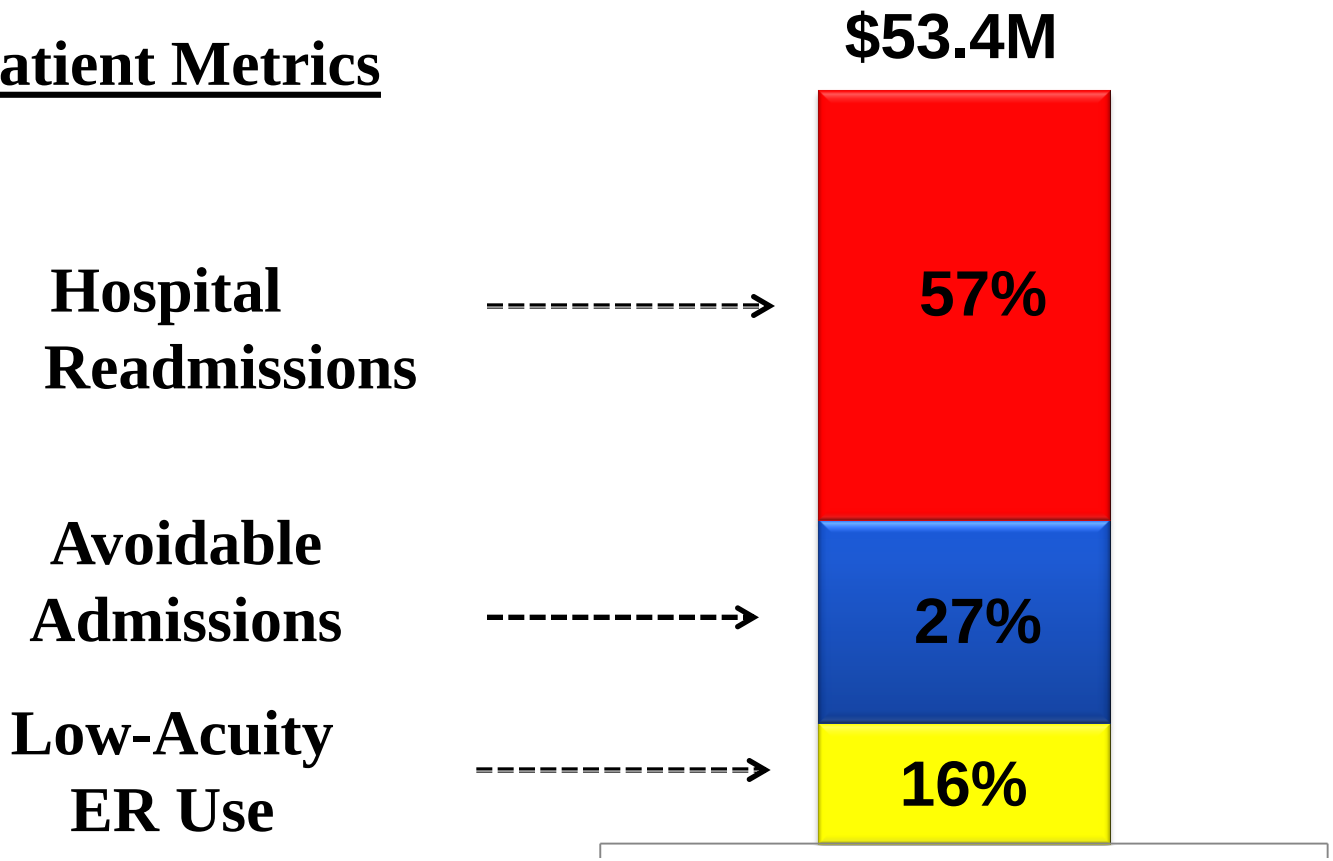


Notes: Expenses incurred from January 1, 2016 to December 31, 2016 and paid as of February 28, 2017. The expenses do not reflect adjustments to account for IBNR claims. Children defined as person up to age 21 in this analysis for the three full risk MCOSs.

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

In Total More Than $53 Million In Managed Care Expenses in 2016 Were Potentially Avoidable

Patient Metrics



Notes: Low acuity non-emergent visits are emergency room visits that could have been potentially avoided , identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that within 30 days of a qualifying initial inpatient admissions.

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

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

- Beginning in October 2017, DHCF's three full-risk MCOs were required to meet performance goals in order to receive their full capitated payment rate.

- These performance goals require the MCOs to reduce the incidence of the following three patient outcomes:

  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 is 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 begin October 1, 2017 and is in effect through September 30, 2018.

- The baseline period used to set the target is April 1, 2015 through March 31, 2016 and the MCOs are 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)

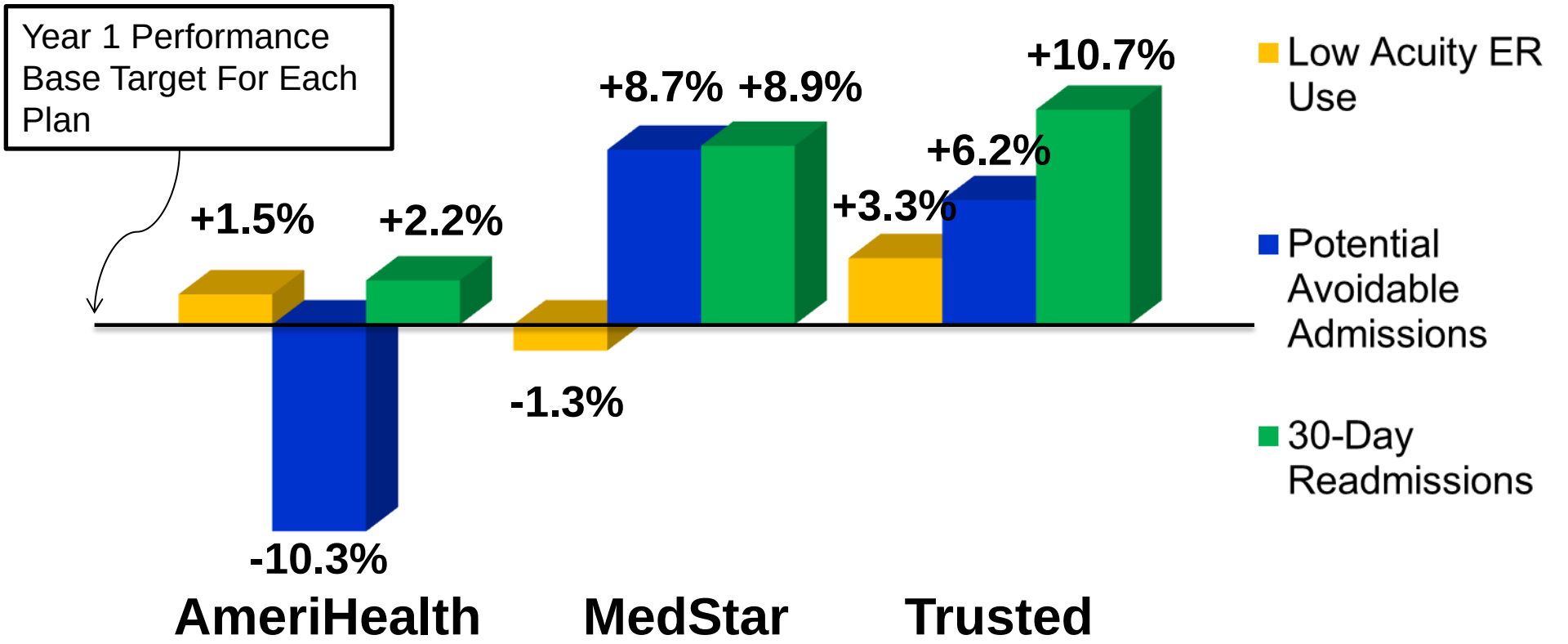
- The scoring system is the same for the third measure -- All-Cause Hospital Readmissions -- but this outcome is weighted at 34% of the capitation withhold.

- 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 relies upon claims data to measure the MCOs performance in this system. Since a run-out period must be allowed to ensure a more complete picture of claims activity, payments will likely occur 4 to 6 months after the measurement period closes.

Had The Pay-For-Performance Program Been In Place In FY2016, Only Trusted Would Have Shown Improvement From Its Baseline Targets On All Three Measures

Comparison of FY2016 Results To Year One Baseline Performance Metrics



Notes: Low acuity non-emergent visits are emergency room visits that could have been potentially avoided , identified using a list of diagnosis applied to outpatient data. Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data. Readmissions represent inpatient visits that within 30 days of a qualifying initial inpatient admissions. Year 1 Baseline reflects data incurred April 2015-March 2016. The Year 1 Pay-For-Performance target for each plan is set based on a 5% expected improvement to the baseline for each metric.

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