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

(July 2013 – June 2014)

Department of Health Care Finance

February 2015
Washington DC

Presentation Outline

- ☑ **Overview Of Managed Care And Focus of Presentation**
- ☐ 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
- ☐ Mental Health Spending Trends
- ☐ Care Coordination: Goals and Outcomes
- ☐ MCO Report Card

Overview of The District's Managed Care Program

- Medicaid is the largest health insurance program in the District
  - 235,000 Medicaid beneficiaries (1 in 3 District residents)
  - 93,000 children in the District of Columbia Medicaid program
  - Nearly 70% of program beneficiaries are in one of four Managed Care Organizations (MCO)
    - AmeriHealth DC (AmeriHealth)
    - MedStar Family Choice (MedStar)
    - Trusted Health Plan (Trusted)
    - Health Services for Children With Special Needs (HSCSN)
- Three of these health plans offer comprehensive benefits and operate under full risk-based contracts with the District
- The District will spend more than $912.1 million on MCO services by the end of FY2015
- More than $763.6 million of this amount will be for the full risk-based contracts signed by AmeriHealth DC, MedStar Family Choice, and Trusted
  - These plans are the focus of this performance review

Overview of The District's Managed Care Program (continued)

- The District also funds managed heath care services for the Alliance program which offers health care to District residents who would be eligible for Medicaid but for their citizenship status

- Alliance has more than 14,000 members who are enrolled in the District's three full risk-based MCOs

- Benefits offered through the Alliance program are virtually identical to those provided in Medicaid but do not include non-emergency transportation or mental health services

- In FY2015, the District is projected to spend approximately $38 million on the Alliance program

Goals Of The District's Managed Care Program

- The District developed its MCO program in pursuit of three broad goals:

1. Increase access to a full range of primary, clinic-based, hospital, mental health, and specialty care services for managed care members

2. Ensure the proper management and coordination of care as a means of improving beneficiaries' health outcomes while promoting efficiency in the utilization of services

3. Establish greater control and predictability over the District's spending on health care

Medicaid Rate-Setting For Health Plans Governed By Federal Requirements

- For the full risk-based MCOs, the Department of Health Care Finance (DHCF) pays a capitated, per-member, per-month (PMPM) rate
  - The capitated rate is a set amount to cover projected costs for all benefits
- Medicaid federal regulations impose specific requirements to govern rate-setting
  - Rates must be actuarially sound, developed by an actuary certified by CMS
  - Rates must be appropriate for covered populations and benefit package
  - Uncertified rates are not eligible for federal match
- Alliance program does not need federal approval
  - Actuarial soundness rule for this program is a District contract requirement
- DHCF contracts with Mercer Consulting to establish the actuarially sound rates for the program and assist with data analytics on measuring MCO program performance

Key Program Requirements Faced By The District's Health Plans

Program Area	Requirement	Source
Network Adequacy	The District must ensure that each MCO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to all services covered under the contract. The network of providers must be sufficient in number, service mix (e.g. primary care, specialty care, dental etc.) and geographic distribution to meet the needs of the anticipated number of enrollees in the health plans.	Federal Requirement and District Contract
Member Choice of Plan	Beneficiaries who are required to enroll in managed care must be given a choice among at least two plans.	Federal Regulation
Navigation Support For Enrollees	The District must ensure that all services covered under the State plan are available and accessible to enrollees of the plans. Each MCO must maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.	Federal Regulation
Health Assessments	Health plans must assess each Medicaid enrollee identified by the District and the MCO as having special health care needs. The purpose of the assessment is to ascertain any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. In addition, the District's Enrollment Broker must complete a health assessment for every newly eligible enrollee. The information is submitted to the respective health plan to which the member is assigned for use in establishing an initial plan of care for the enrollee as needed.	Federal Requirement and District Contract

Key Program Requirements Faced By The District's Health Plans (continued)

Program Area	Requirement	Source
Out-of-Network Care	Health plans must afford enrollees the opportunity to seek a second medical opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain a second opinion from outside the network, at no cost to the enrollee. If the health plan's network is unable to provide necessary services covered under the contract, the MCO must adequately and, in a timely manner, cover these services out-of-network for the enrollee.	Federal Requirement
Medical Loss Ratio	The District requires its health plans to meet a medical loss ratio (MLR) which requires that they spend at least 85 cents of every premium dollar on medical care. The health plans must report their premium dollar expenditures to DHCF to facilitate an independent assessment of whether this requirement is met. Plans that do not reach this 85% threshold face a number of possible actions, including monetary penalties assessed by DHCF	District Contract
Risk-Based Capital	Risk-based Capital (RBC) is a widely used financial metric to measure the solvency of managed care plans. The District's insurance regulator requires plans to maintain assets equal to 200% of their RBC. Under District law, DISB has the authority to initiate preventive and corrective measures that vary depending on the capital deficiency indicated by the RBC review. DHCF revised the managed care contracts to indicate that the agency will freeze enrollments for any health plans with a RBC level of 150 or less	District Regulation

DHCF Implements A Performance Review Of Its Managed Care Program

- 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

- The goal of this project is three-fold:

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

End-of-Year Report Establishes Baseline For Evaluating Future Performance Of MCOs

- For the first time this report offers a full year's worth of health care utilization and spending data for the District's three Medicaid health plans

- This provides two important uses for future reporting:

  - Baseline development - the health care utilization data reported herein can now be used to establish baselines for each plan and thus provide a basis for assessing MCOs' progress in the remaining years of their contract with the District

    - This also offers the foundation to support a pay-for-performance system

  - Year over year comparisons - future reports will now offer meaningful analysis of utilization and expense trends for each plan based on previous performance by the health plans and not the predecessor MCOs

Changes To Report Format Will Be Implemented

- The quarterly MCO reports were established to provide complete transparency on the operations and performance of the managed care plans

- Two important changes will be instituted to the reporting process following this end-of-year document

  - Future reports will be conducted on a semi-annual basis – a six-month and end-of-year performance report

    - Will be comprehensive in nature focused on MCO finances, beneficiary utilization, and care coordination

  - Two quarterly snapshot newsletter reports will be issued to supplement the comprehensive reports – more issue specific based on stakeholder interests

2015 Timeframe For MCO Performance Report

Type of Report	Review Period	Report Date
1st Quarter Newsletter Report	October 2014 - December 2014	April 2015
Six-Month Report	October 2014 - March 2015	August 2015
3rd Quarter Newsletter Report	April 2015 - June 2015	October 2015
Annual End-of-Year Report	October 2014 - September 2015	December 2015

Focus Of The End-Of-Year Performance Review

- Previously focused on the quarterly performance of each health plan, this end-of-year report is based on MCO activity that encompasses the first 12-month period of the five-year contract, July 2013 through June 2014

- The following questions are addressed for each MCO:

  - After 12 months of operations are the MCOs financial healthy? Were plan annual 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 effective care management programs?

  - Did the MCOs successfully meet the 85% threshold requirement for medical spending while containing cost? What service levels were achieved for primary care visits as well as mental health penetration rates for children and adults?

Focus Of The Performance Review (continued)

- What was the rate at which Medicaid beneficiaries used the emergency room for low acuity or non-emergency health problems? What proportion of these visits should the health plans have been reasonably expected to prevent?

- What proportion of inpatient hospital admissions for Medicaid beneficiaries over the 12-month period were potentially avoidable? What proportion of these potentially avoidable admissions should the health plans have been reasonably expected to prevent.

- Were the level of hospital readmissions a problem for the health plans' members? If so, what proportion of those readmissions should the MCOs have been expected to prevent?

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Summary Of Key Findings

- This report summarizes the 12-month performance of the District's Medicaid managed care plans in five areas -- financial condition, administrative performance, beneficiaries service utilization, health plan medical spending, and the coordination of care for plan beneficiaries.

Financial Conditions

- Overall the health plans ended their first year of their contract in solid financial condition. Two of the three health plans completed the year in a positive cash position. And while MedStar reported a $1 million loss, all of the health plans enjoy sufficient liquidity to cover expenses for a significant number of days without having to use long-term assets. Moreover, the three health plans have ample monthly reserves to pay claims that have been incurred but were not submitted for payment during the 12-month period.

Summary Of Key Findings
(continued)

Financial Conditions (continued)

The estimated annual Risk-Based Capital (RBC) positions of the health plans are below the desired level of 200% but significantly above the threshold that would trigger any regulatory action by DHCF. Trusted still has the lowest RBC but has shown continued improvement since the 2013 annual filing – an indication that ownership is making additional investments in the health plan.

Administrative Performance

- For the most part, the three health plans ended the 12-month period with no problems in performing the administrative requirements of managed care plans. Provider networks were sufficiently adequate and claims were timely paid and properly documented. The encounter data systems -- so important for care coordination and rate setting -- were properly developed and maintained. In general however, Trusted needs to eliminate delays its claims payment process and develop a stronger in-house capacity to conduct beneficiary claims analysis.

Summary Of Key Findings
(continued)

Medical Expenses

- In managing beneficiaries' care, all three health plans met (and surpassed) the 85% Medical Loss Ratio -- the threshold requirement for spending on health care services. While two of the health plans were able to contain the cost of medical claims and administrative expenses within the revenue provided by the capitated payments, MedStar was not. Due to a late last quarter surge in claims cost, MedStar was forced to spend 92 percent of plan revenue to cover members' health care leaving insufficient capitated payments for administrative expenses.

- Since DHCF risk-adjusts the MCO capitated payments, close attention is being paid to the medical expenses incurred by the health plans and relative differences in beneficiaries' risk profiles. The data for the first year reveal that two of the three health plans -- MedStar and Trusted -- were not able to align the medical expenses they incurred with the risk scores calculated for their membership. This issue must be addressed by the health plans to avoid future and possibly unsustainable losses.

Summary Of Key Findings
(continued)

Medical Expenses (continued)

- This end-of-year report clearly indicates that progress is being made by the health plans with efforts to increase access to mental health services. While it is too early to draw definitive conclusions, it does appear that larger portions of both adults and children are receiving mental health treatment. For children, the mental health penetration rate for the 1st year of the contract exceeded prior levels by nearly 120 percent. DHCF will continue to monitor these trends and examine data to better understand the factors associated with the observed growth in mental health spending.

- We continue to track the physician visit rates for both adults and children as the desired gateway to appropriate and efficiently delivered health care and the results are mixed. The physician visit rate for children remained high through the last quarter of the 12-month period. However, with Trusted and MedStar, there was continued deterioration in the utilization rate for adults along with significant declines in the “well child” visit rate.

Summary Of Key Findings
(continued)

Case Management and Care Coordination

- The MCOs have much work to do with case management. While small progress was made during the first year of the program, each of the health plans struggled to enroll more than five percent of their membership into a program of case management.

- With respect to care coordination, the availability of 12 months of data offer important insights into the ability of the health plans to address three important issues: (1) limiting the use of the emergency room for routine care; (2) reducing potentially avoidable hospital admissions; and (3) slowing readmission rates for persons being treated for the same illness. After one year, there is considerable room for improvement in these areas.

- Notably, the rate at which beneficiaries continue to use the emergency room for routine care remains high -- from 64 to 72 percent of all visits to the emergency department. The health plans failure to prevent a reasonable portion of these visits created $8.4 million in additional cost for the MCOs and by extension the District.

Summary Of Key Findings
(continued)

Care Coordination (continued)

- Likewise, in the 12-month contract period, nearly seven percent of all hospital admissions for members of the three health plans were potentially avoidable at a cost of $7.6 million.

- Finally, analysis of claims data reveal that collectively our MCOs spent an additional $18.1 million on all-cause 30-day inpatient hospital readmissions – the rate was 1 hospital readmission for every 12 “index hospital admissions.” These readmissions occur within 30 days of a previous discharge and for the same basic health complaint which triggered the initial admission.

- Combined, these problems of emergency room use for low acuity illnesses and potentially avoidable hospital admissions and readmissions, cost the MCOs more than $34 million in the first year of the contract.

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DHCF's Oversight Of Managed Care Plans Includes A Close Look At Their Financial Health

- DHCF's assessments of MCOs' financial health is designed to determine whether the health plans meet financial net worth requirements or are trending towards financial deterioration

- Two key measures are used to evaluate the MCOs' financial conditions

1. The MCOs' net revenue gain or loss which is determined by subtracting claims expenses from health plan revenue, excluding investment income

2. A risk-based capital ratio is reported in the health plans' annual financial statements and used in our reporting. In addition, a proxy measure is calculated by the District's actuary and reported on a quarterly basis reflecting the health plans *total adjusted capital levels as a percent of the health plans' **authorized control levels. This provides DHCF with information to gauge changes in the health plans' financial condition between annual filings with DISB

*Adjusted Capital reflects total capital and surplus cash. **Authorized control level for this analysis reflects one half month of incurred claims.

Most Membership Growth In First 12 Months Of The Contract Resided With MedStar With AmeriHealth And Trusted Following Closely Behind

MCO	July 2013 Enrollment	July 2014 Enrollment	Net Change
AmeriHealth	91,585	107,663	16,078 (+17.5)
MedStar	32,536	40,859	8,053 (+24.7%)
Trusted	26,204	30,096	3,892 (14.8%)

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

The Quarterly Revenue For Two Of The Three Health Plans Was Sufficient To Cover Both Claims And Administrative Cost During The Quarter

MCO Revenue and Expense Data for July 2013 to June 2014

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

MCO	Revenue	Claims	Administrative Cost	Net Gain (Loss)
AmeriHealth	$392.1M	$342.7M	$48.4M	$1.0M
MedStar	$145.5M	$134.0M	$12.5M	($1.0M)
Trusted	$102.6M	$92.5M	$9.0M	$1.0M

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 2014, 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 2013 financial statement filed with DISB to a more recent 12-month proxy measure calculated by Mercer Consulting

Insurance 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.

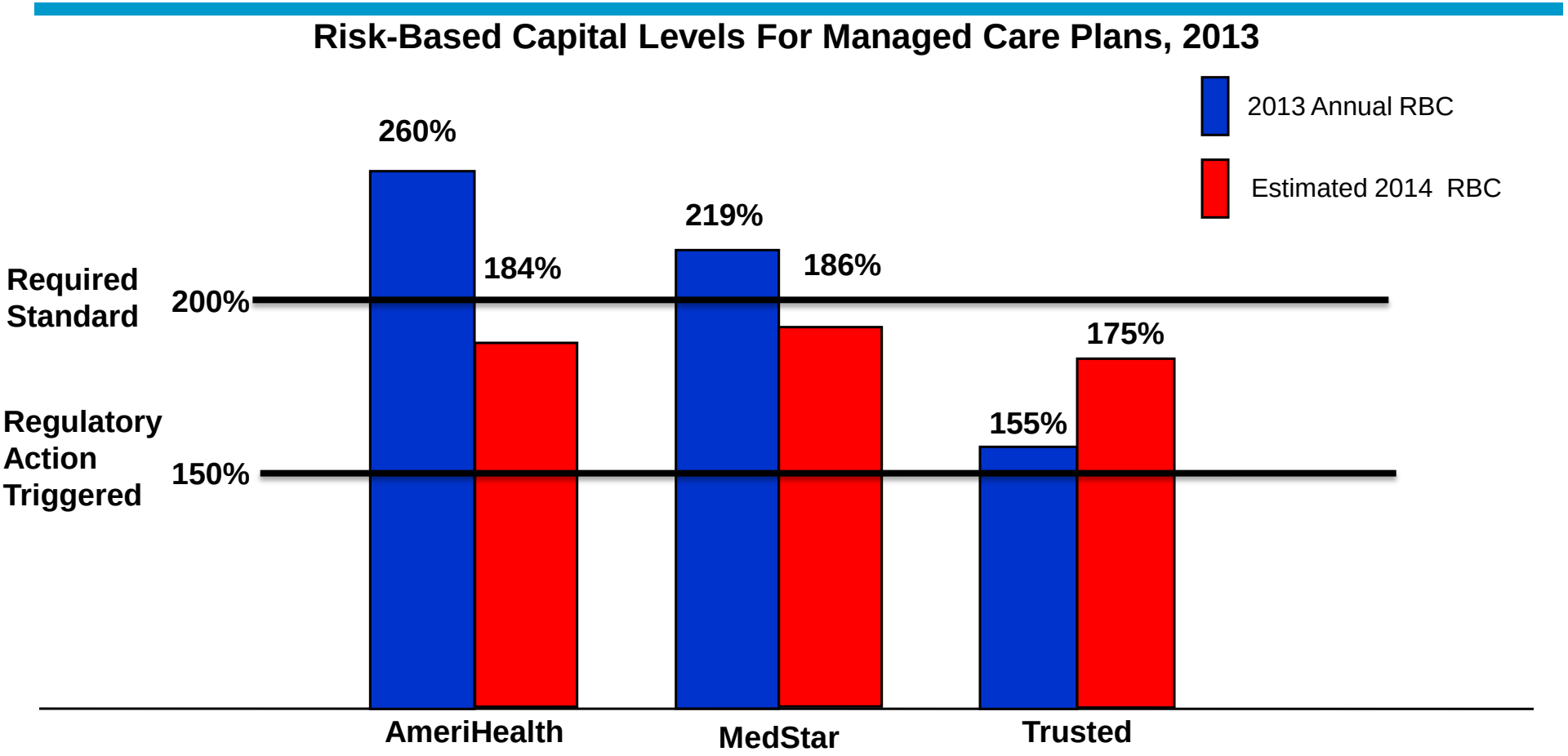
2. **Company Action Level** - Total Adjusted Capital of 150% to 200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.

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).

The 2014 Estimated Annual RBC For Each Plan Fell Short Of 200% But There Is No Cause For Concern



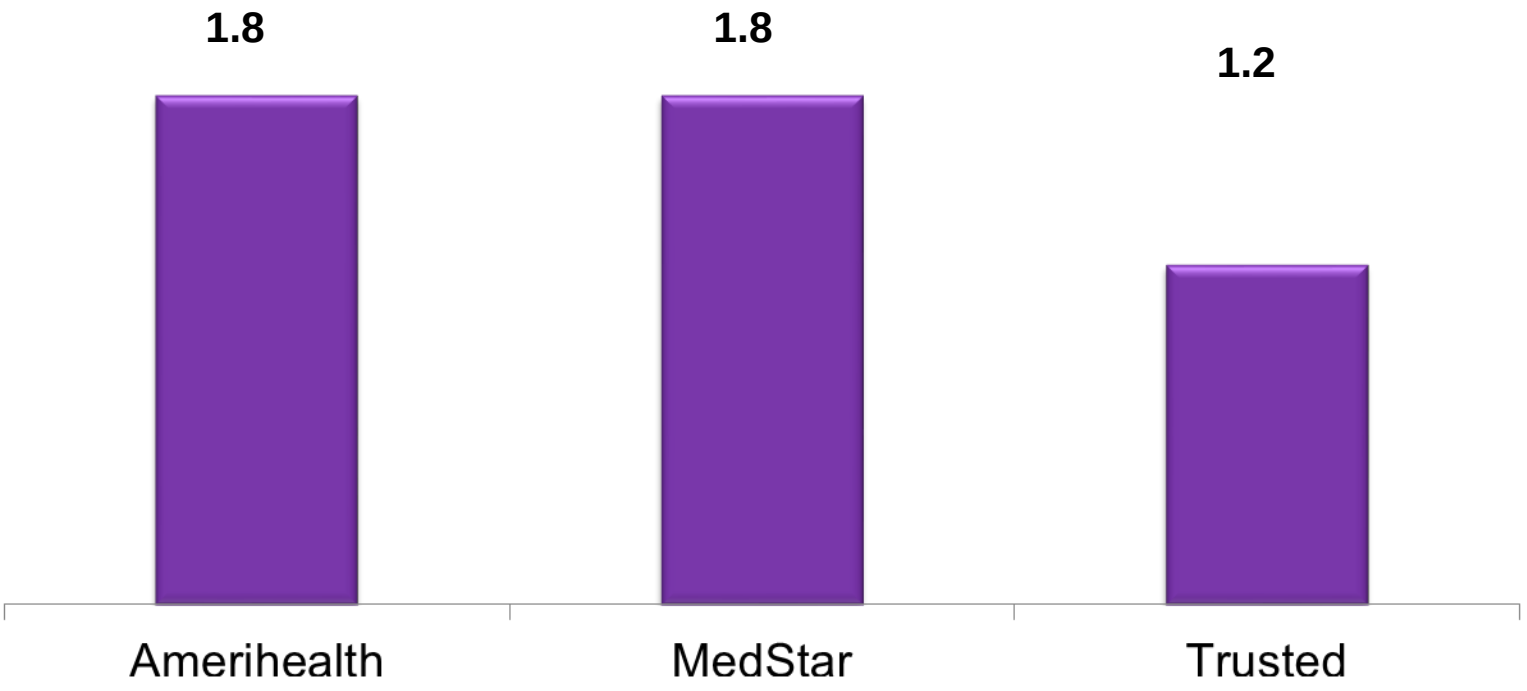
Note: Reported figures are from MCO's annual 2013 financial statement filed with DISB and Mercer's annual proxy measure for 2014. MedStar's data for Total Adjusted Capital and Authorized Control Level used in Mercer's calculation of the health plan's RBC level include information from Maryland and the District of Columbia.

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 A Little More Than One Month's Worth Of Cash Reserves On Hand To Pay Estimated Incurred But Not Reported Claims

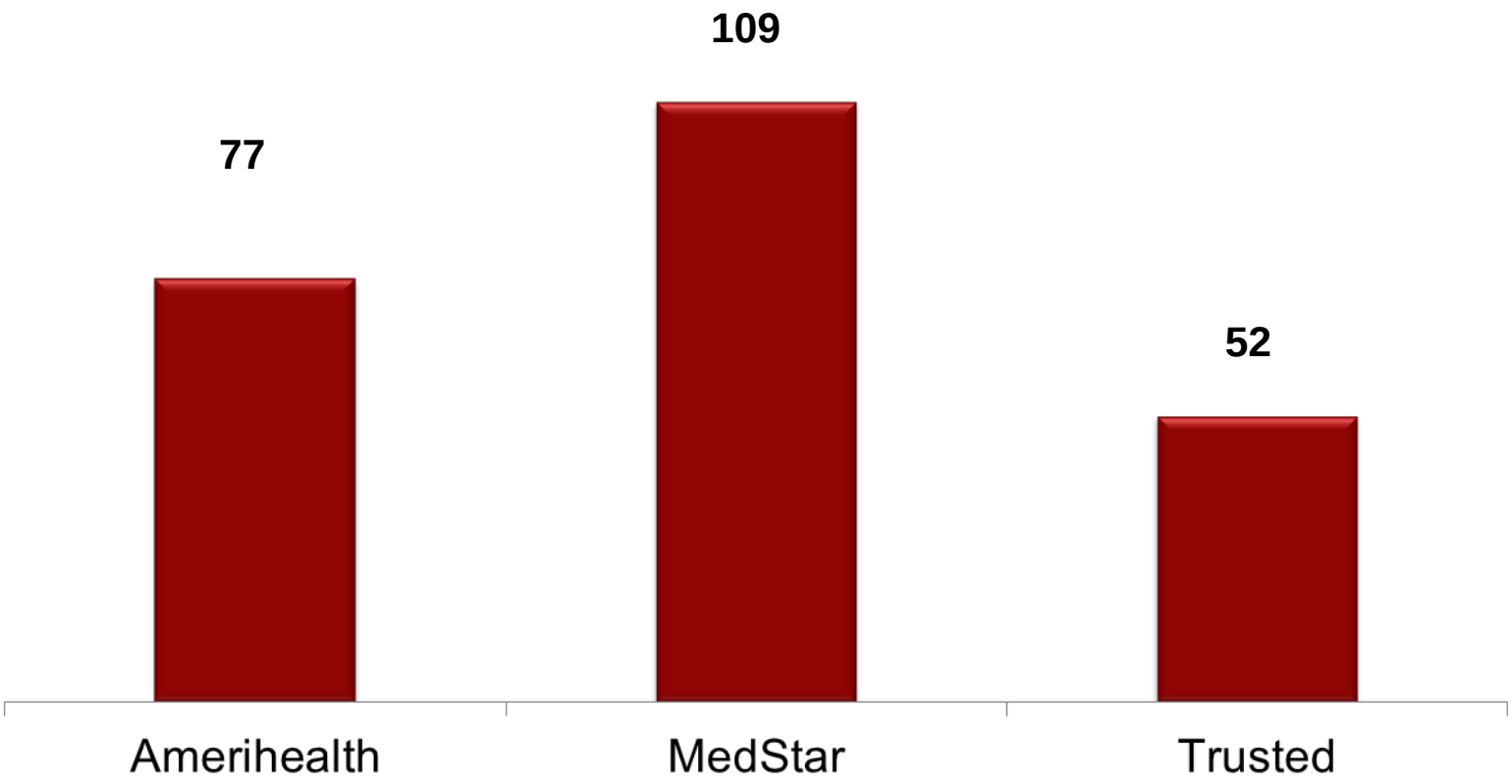
Estimated Number Of Months Reserves Compared To Average Monthly Incurred Claims For The Period Covering July 2013 to June 2014



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

The Defensive Interval Ratio – Which Compares MCO Assets To Company Liabilities – Was Favorable For All Three Health Plans

Days In A Year That MCOs Can Operate On Existing Cash Without Having To Access Long-Term Assets For The Period Covering July 2013 to June 2014



Note: Mercer calculated the Defensive Interval Ratio as cash and equivalents divided by daily operating expenses for the year defined as 365 days.

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

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

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

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

3. Establish a system of care management and care coordination to identify health plan 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 Have Impaneled Substantially More Physicians Than Required By Contract Standards

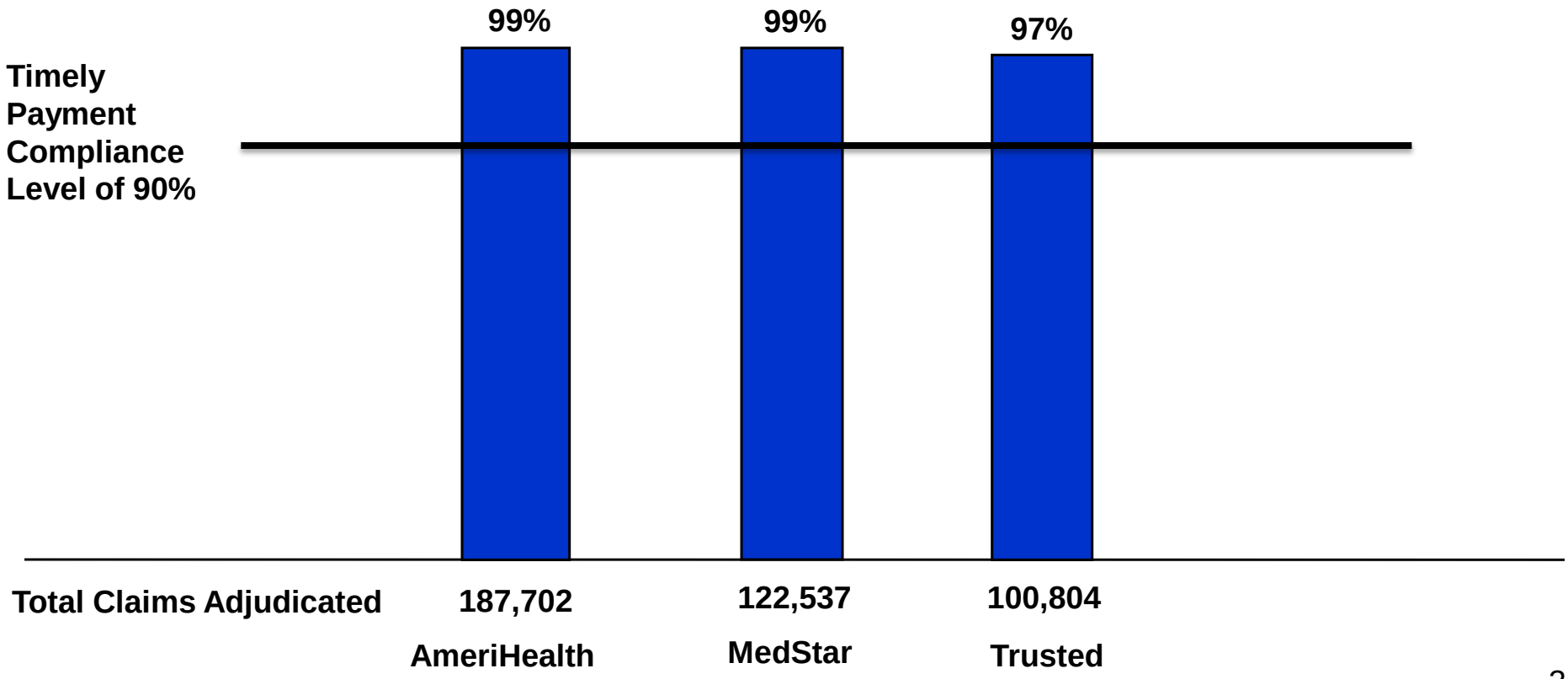
The Number of Providers In The MCO Networks Compared to Contract Requirements as of June 2014

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	36	**532**	53	**832**	71	**237**
MedStar FP	18	**513**	14	**368**	18	**500**
Trusted	13	**481**	10	**1545**	13	**236**

Source: This information is self-reported and attested by the MCOs as of June 30, 2014 and verified by Department of Health Care Finance and the Enrollment Broker through a sampling of providers.

The Three Health Plans Successfully Met The District's Timely Payment Requirement In The Last Quarter Of The Contract Year 2014

MCO Claims Paid Within 30 Days Based On The District's Timely Payment Requirement, April 2014 to June 2014



Source: Data reported by MCOs on the Department of Health Care Finance's Claims Payment Report, April-June 2014

The Health Plans Have Successfully Constructed Encounter Data Files With A High Degree Of Accuracy

Number of Recorded Encounters And Accuracy Transfer Rate, July 2013-July 2014

MCO	Average Monthly Enrollment	Total Encounters	Total Encounters Per Enrollee	Accuracy Rate For Encounter Transfers
AmeriHealth	102,549	1,239,885	12.1	89%
MedStar	35,608	416,106	11.7	93%
Trusted	27,446	254,445	9.3	82%

Source: Department of Health Care Finance Medicaid Management Information System as of June 2014

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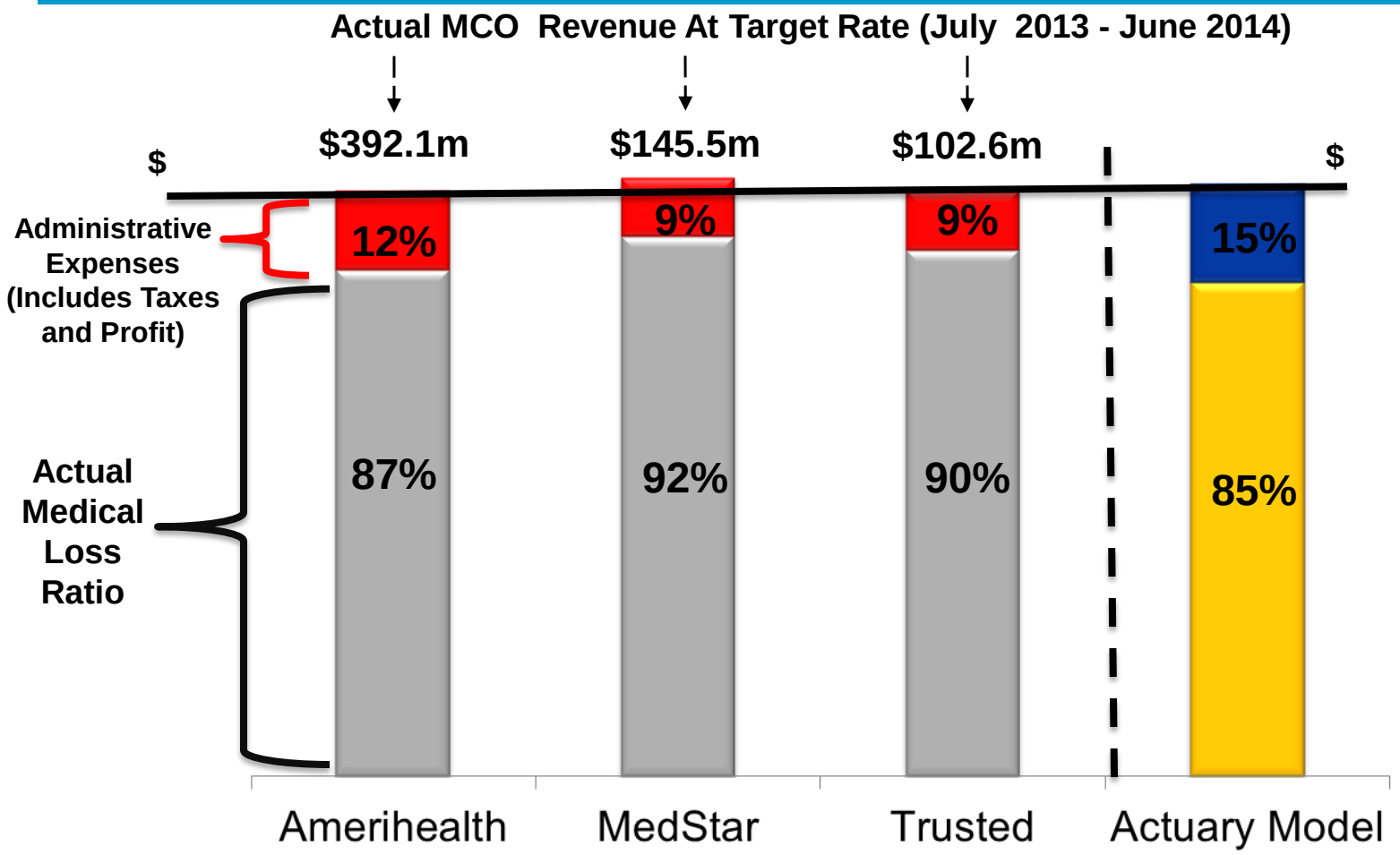
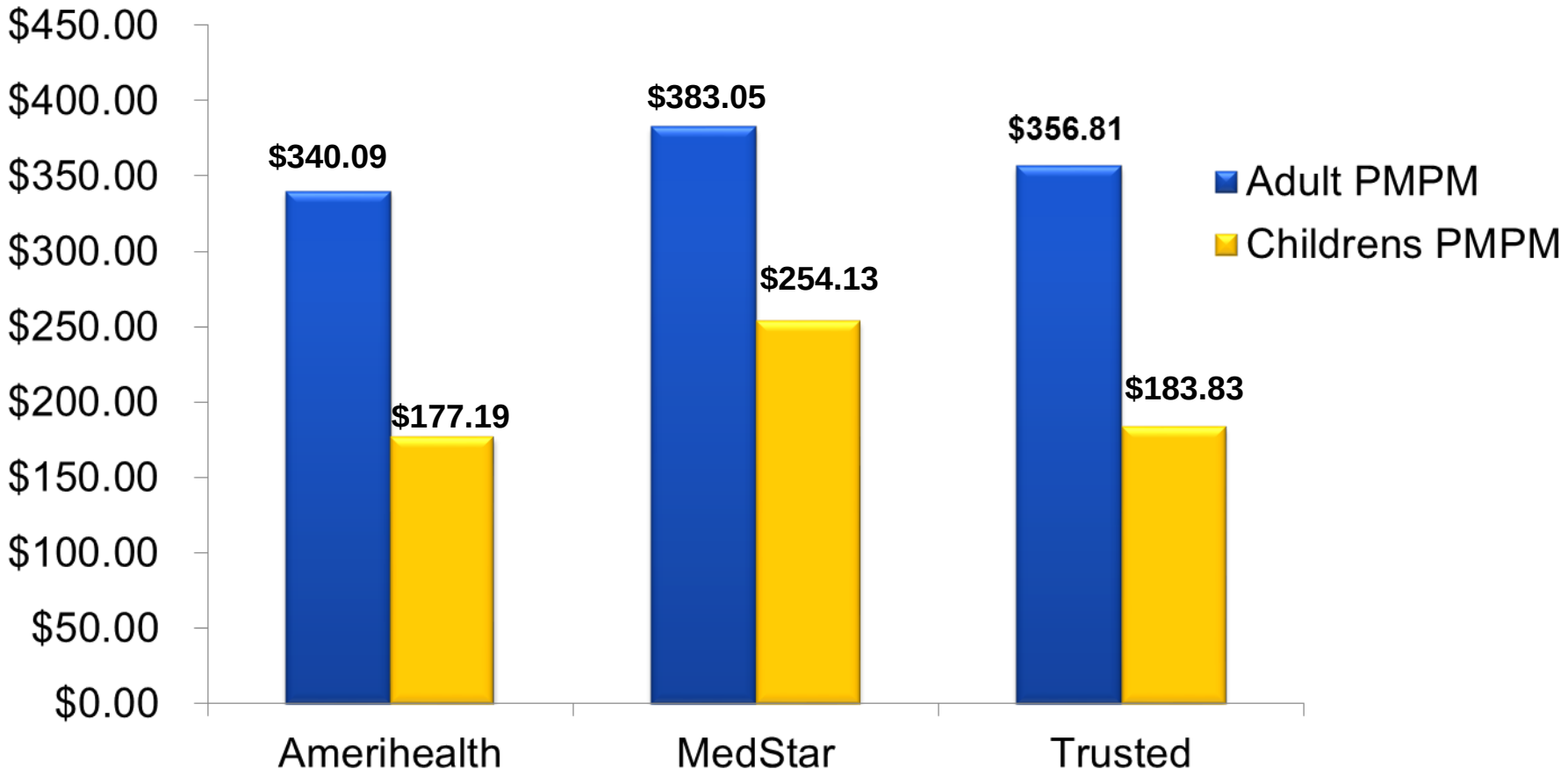
Even At The Target Rate In The Most Recently Completed Contract Year, MCO Medical Expenses Exceeded Actuarial Projections



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 Was Significant Across Plan Variation In The Per-Member, Per-Month Medical Expenses With MedStar Reporting The Highest Claims Cost For Children And Adults

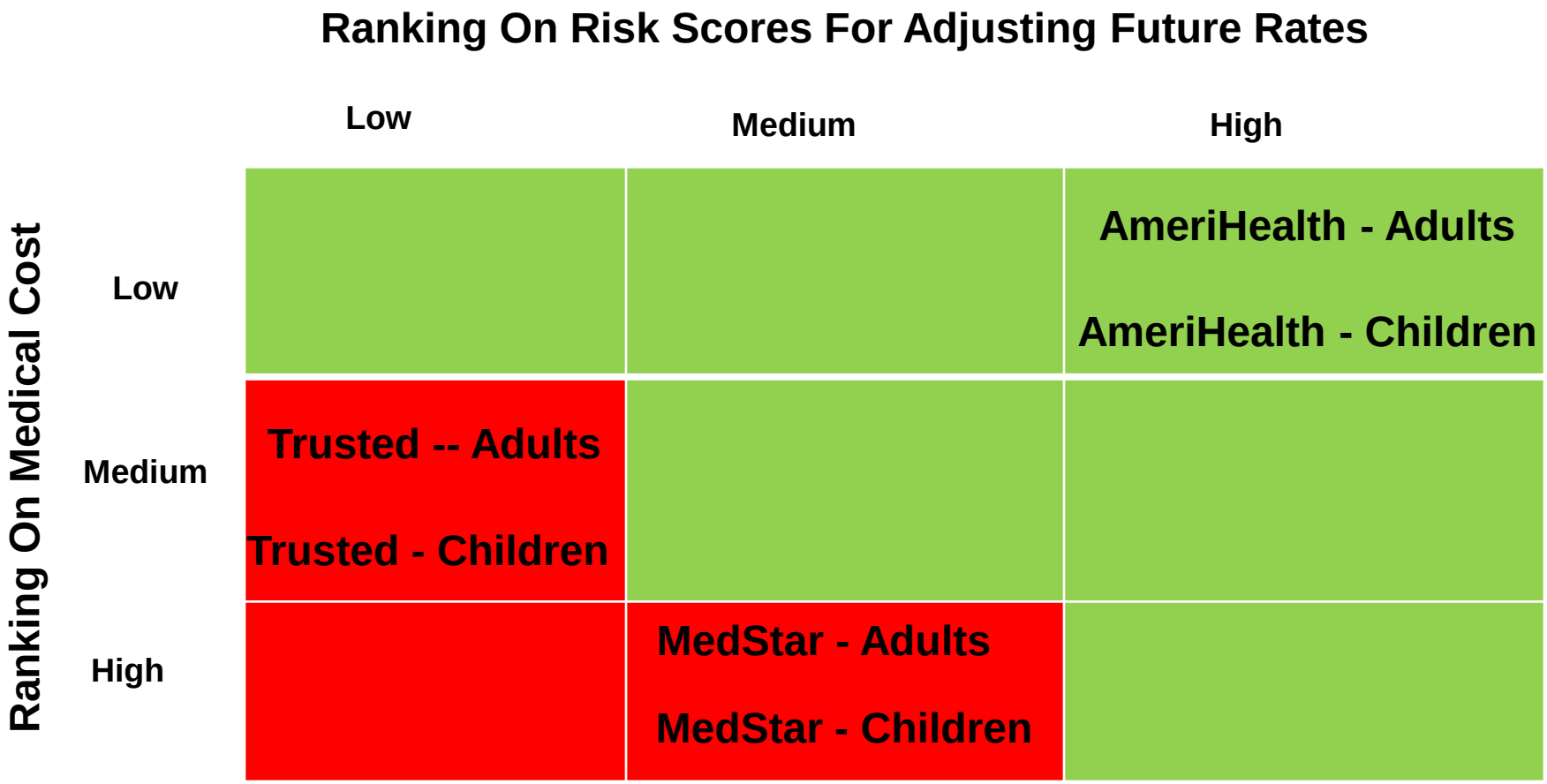
MCO Adult And Children Medical Expenses Per-Member, Per-Month, July 2013 through June, 2014



Notes: Expenses incurred from July 1, 2013 to June 30, 2014 and paid as of August 31, 2014. The expenses do not reflect adjustments to account for INBR claims.
Children defined as person up to age 21 in this analysis.

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

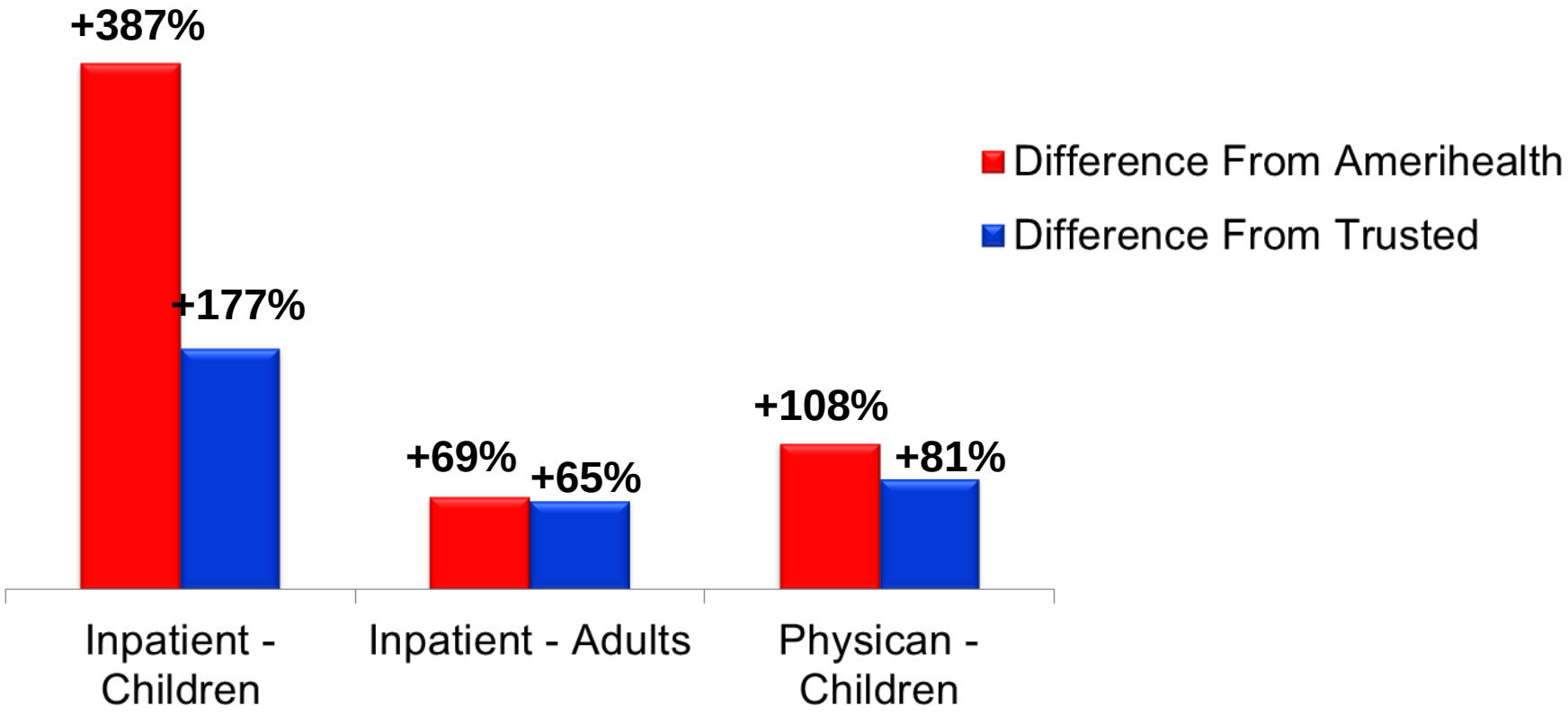
Neither MedStar Nor Trusted Were Able To Align Beneficiary Medical Costs With Their Assigned Risk Scores In The 1st Year Of The Contract



Notes: Expenses incurred from July 1, 2013 to June 30, 2014 and paid as of August 31, 2014. The expenses do not reflect adjustments to account for INBR claims.
Children defined as person up to age 21 in this analysis. Health plans' risk scores are derived from pharmacy data.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

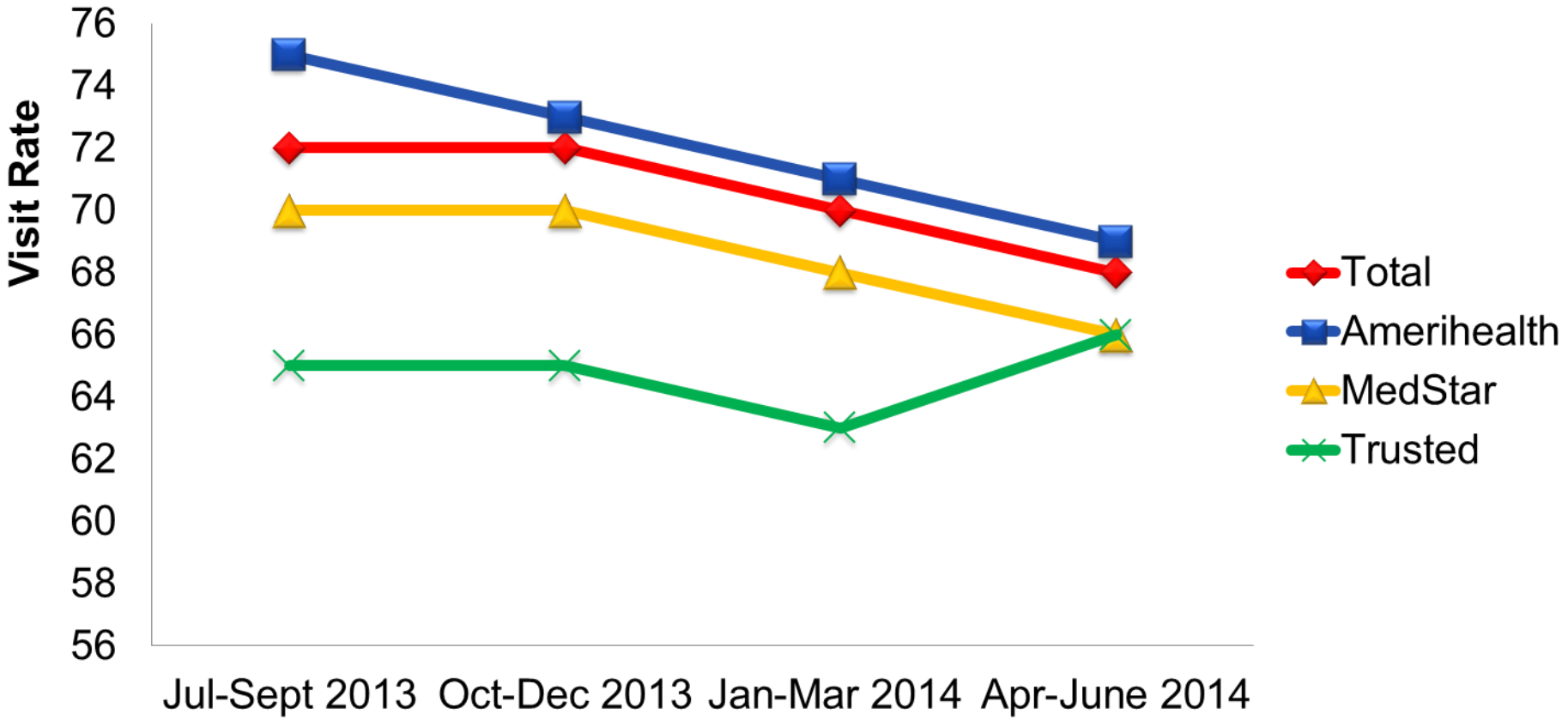
MedStar's Cost In The 4th Quarter Of The Contract For Several Areas Was Substantially Higher Than The Other MCOs

MedStar's Cost Differences Relative To AmeriHealth And Trusted, April to June 2014



Overall, The Physician Visit Rate For Adults -- Once As High As 74 Percent -- Continues To Trend Downward

Quarterly Physician Care Visit Rates For Adults Who Were Enrolled In Managed Care

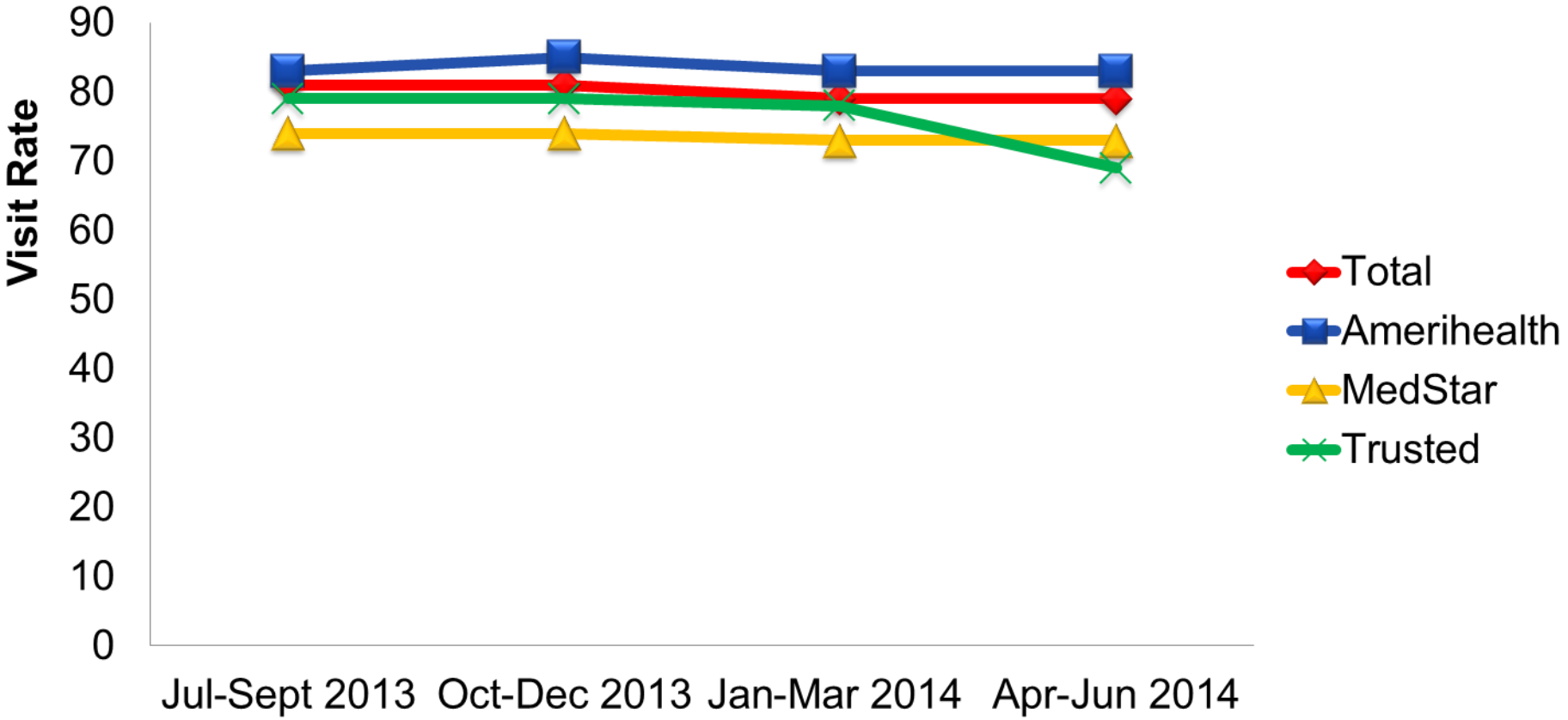


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

For Children, The Overall MCO Physician Visit Rates Are Consistently High Despite The Reductions Observed For Trusted

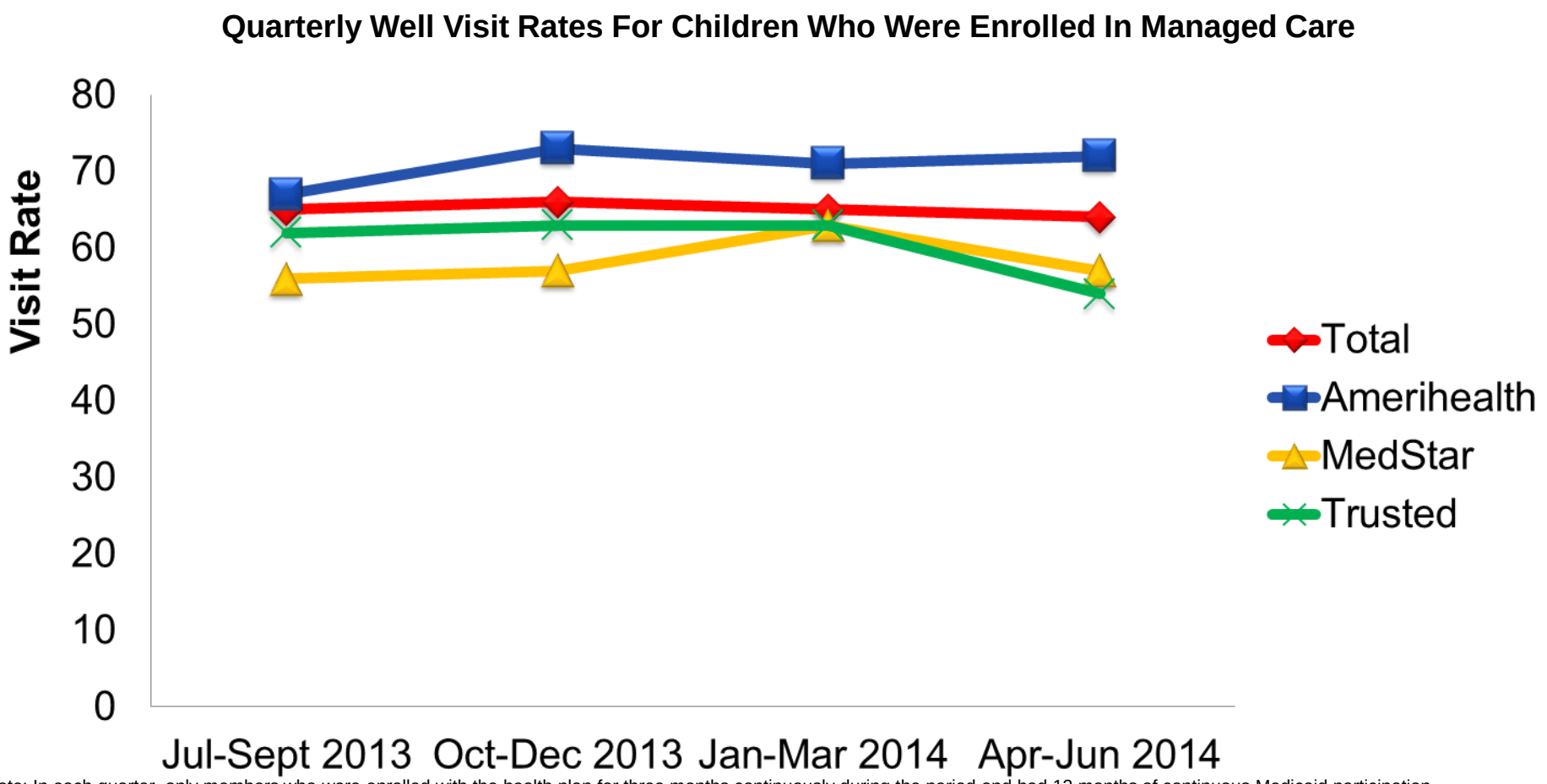
Quarterly Physician Visit Rates For Children Who Were Enrolled In Managed Care



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.

AmeriHealth's Persistently High Physician Visit Rates For Children With A Well Visit Component Obscure Significant Declines Observed For MedStar And Trusted On This Measure

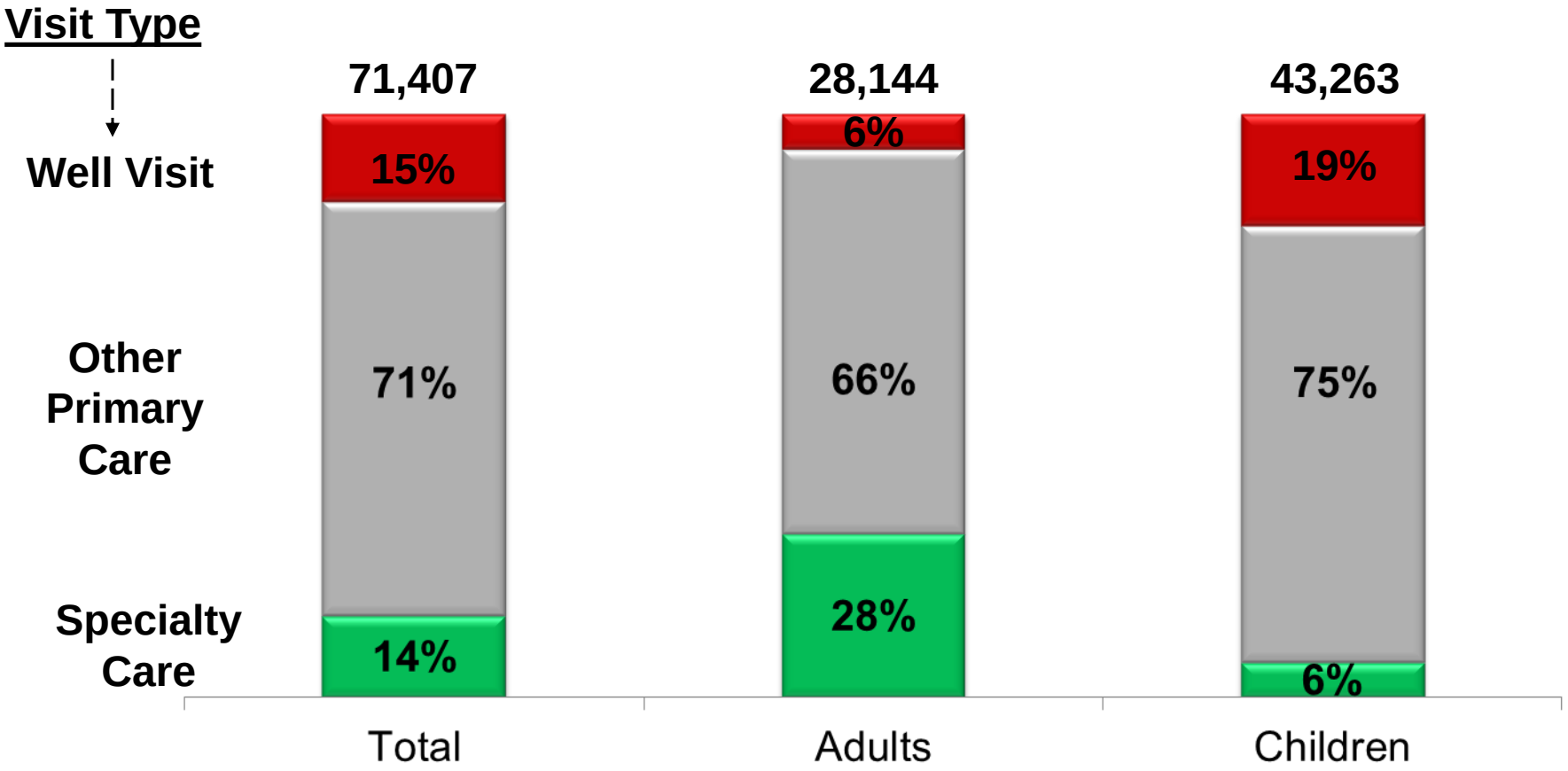


Note: In each quarter, only members who were enrolled with the health plan for three months continuously during the period and had 12 months of continuous Medicaid participation from that quarter are included in this analysis.. .

Source Encounter data submitted by MCOs to DHCF.

Most MCO Members' Physician Visits Were For General Primary Care And Well Visits

Types Of Primary Care Utilization For Adults And Children



Note: Visit data are reported only for 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. Source: Encounter data submitted by MCOs to DHCF.

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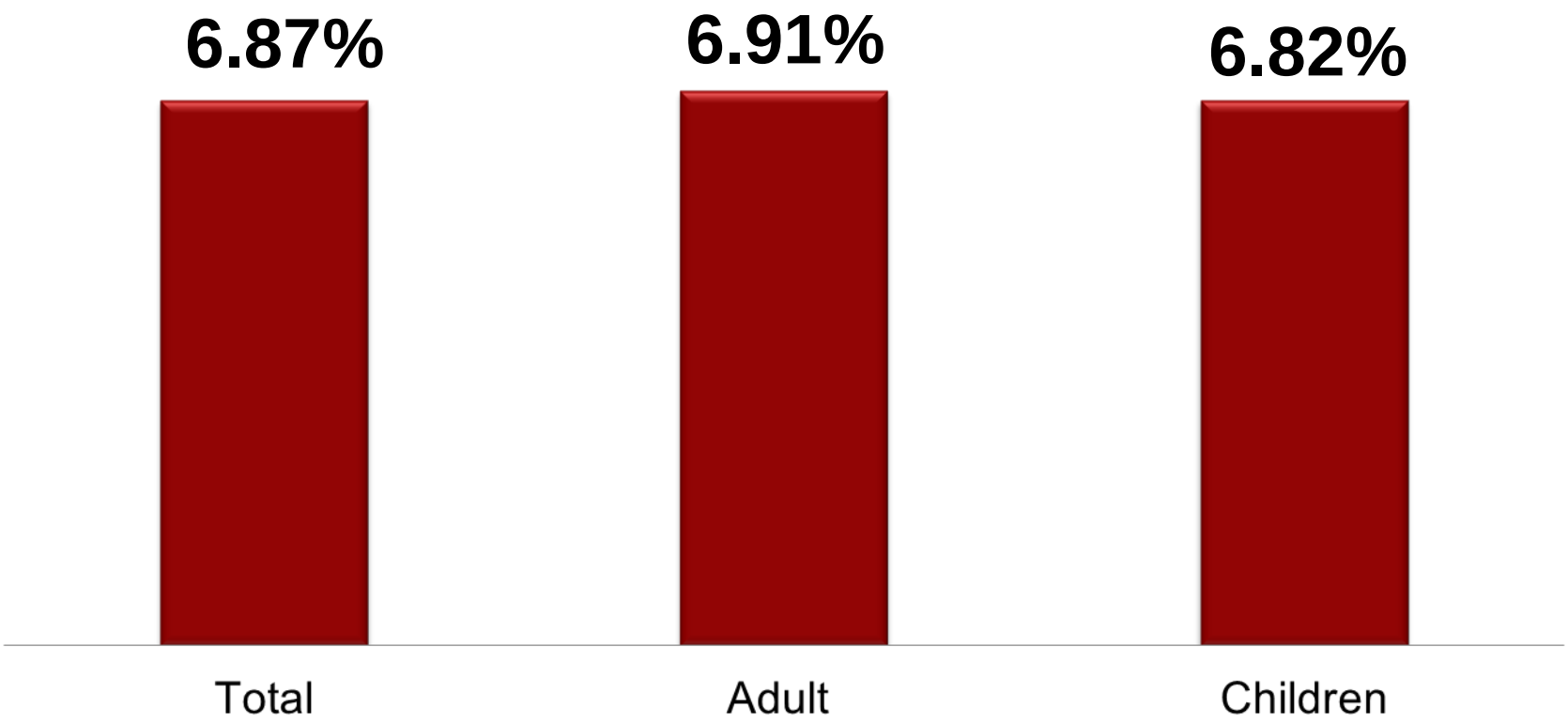
- ❑ MCO Report Card

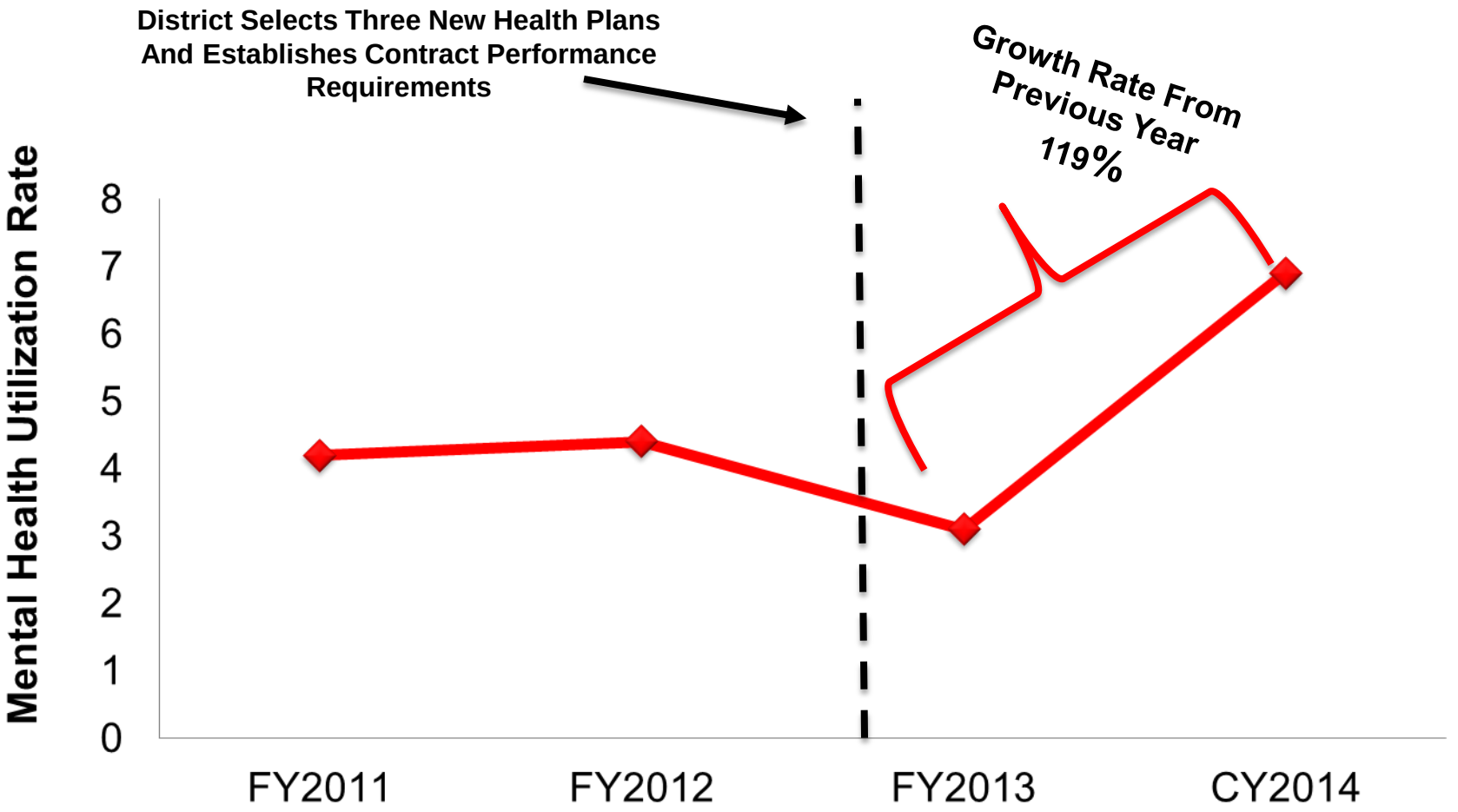
The MCO Penetration Rate For Mental Health Rehabilitation Services Now Approaches 7 Percent For Both Adults And Children

Percent of MCO Members Receiving Mental Health Rehabilitation Services Through The Health Plans, July 2013 Through March 2014



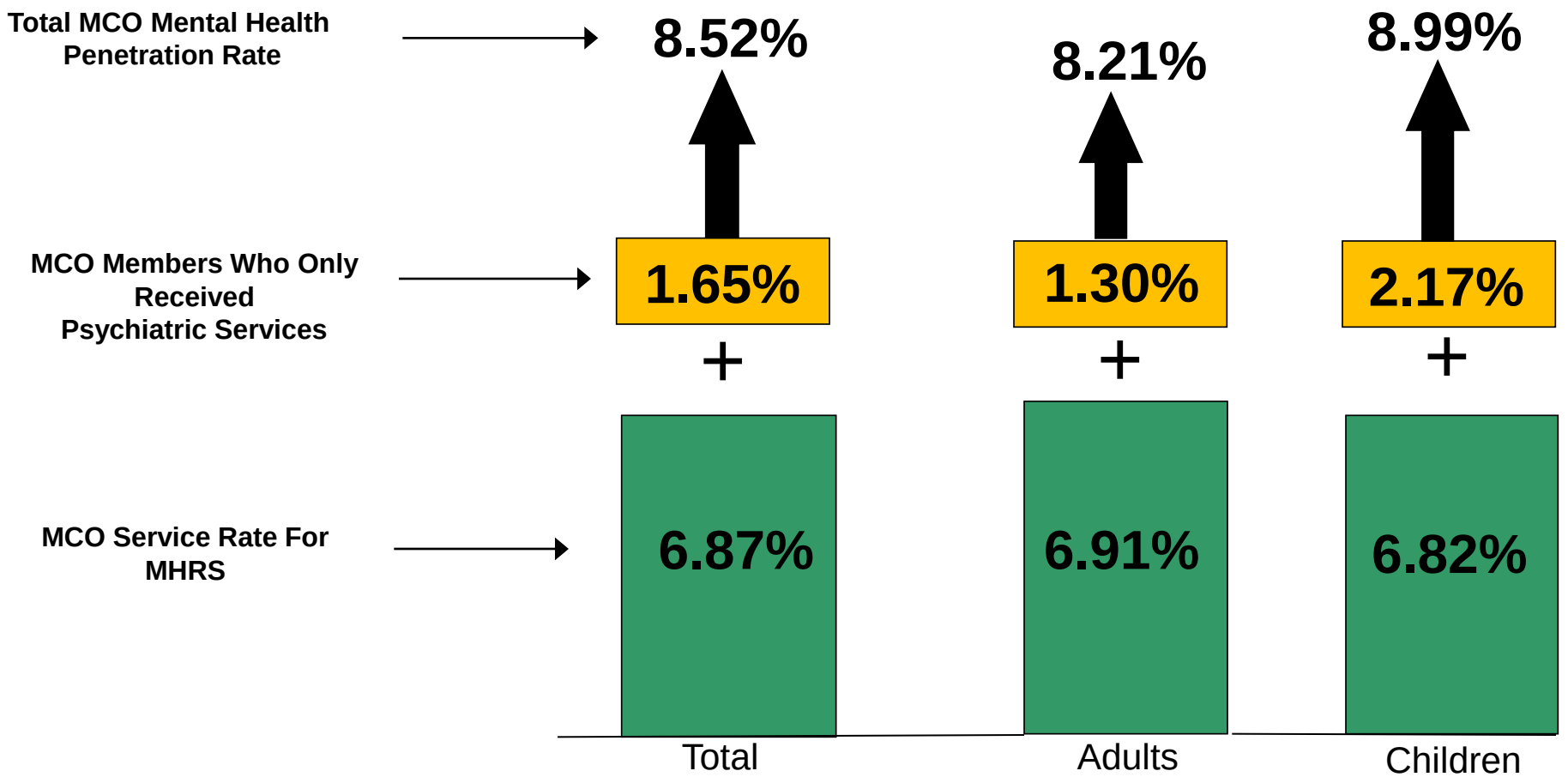
Note: The data presented above are based on MCO capitated payments from the period of July 2013 through March through 2014 and in.
Source: Encounter data submitted by MCOs to DHCF.

The Level For Children In The First Year Of The New MCO Contract – A Special Focus Of Recent Reports – Is Sharply Higher Than Those Observed In Previous Years



Note: There is some overlap between the last few months of FY2013 and the first two quarters of the MCO contract year.
Source: Encounter data submitted by MCOs to DHCF.

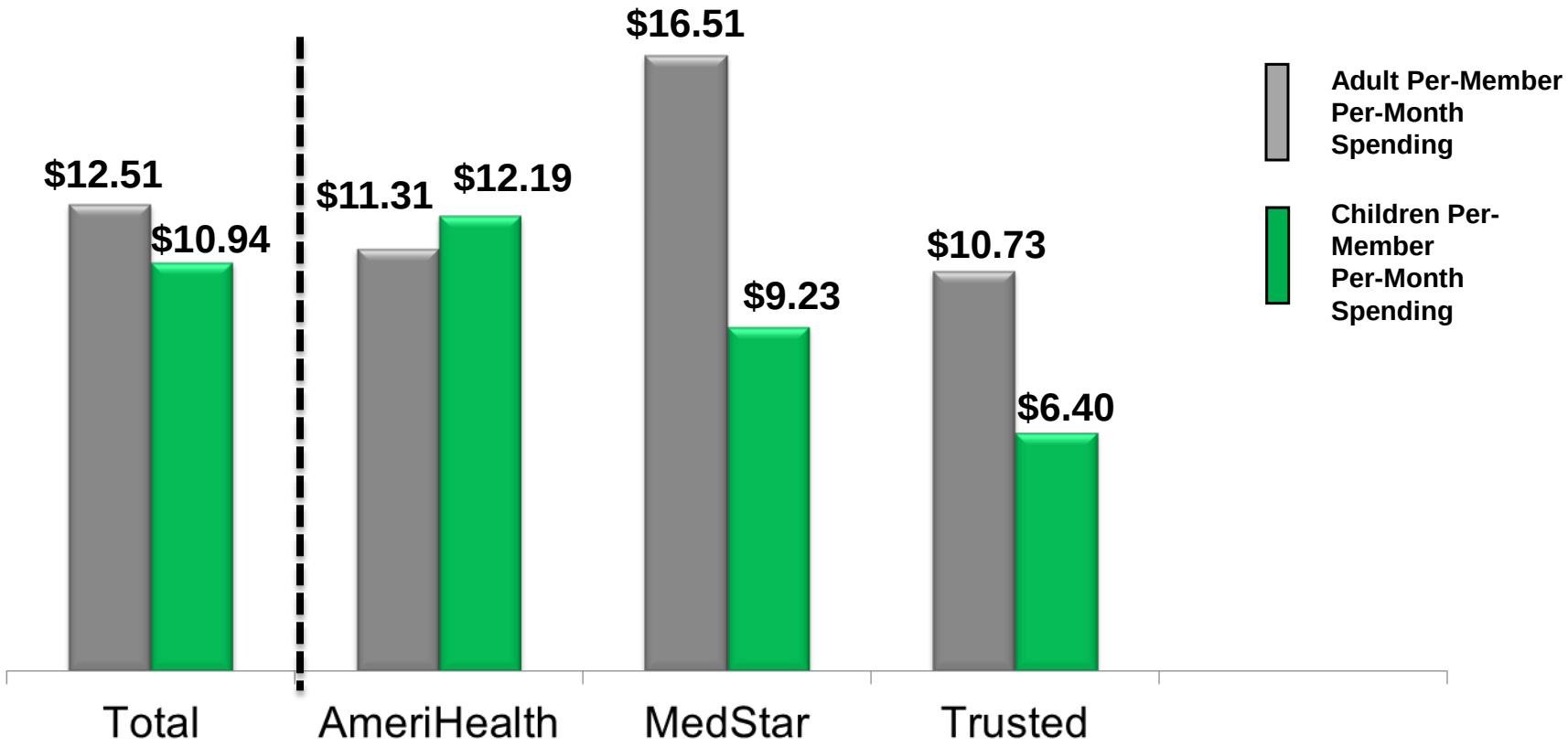
….When MCO Members Who Received Only Psychiatric Services Are Included, The Total Penetration Rate For All Mental Health Services Exceeds 8 Percent



Note: The data presented above are based on MCO capitated payments from the period of July 2013 through June through 2014.
Source: Encounter data submitted by MCOs to DHCF.

The Increased Overall Utilization Is Reflected In Higher MCO Mental Health Spending On Children And Adults Which Was Once As Low as $6.00 Per-Member, Per-Month

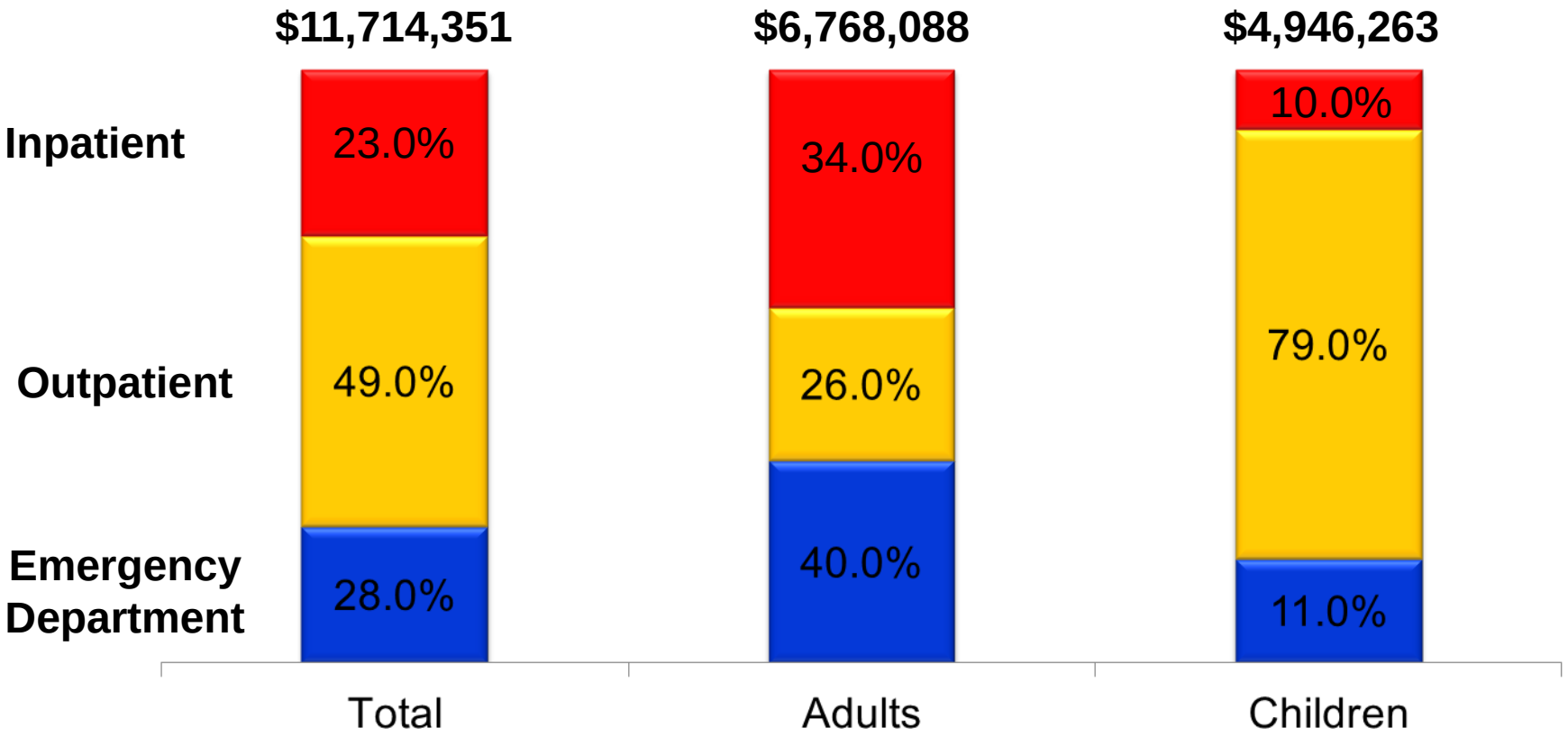
The Per-Member Per-Month MCO Expenses For Behavioral Health Services, July 1, 2013 to March 31, 2014



Notes: Expenses incurred from July 1, 2013 to March 31, 2014 and paid as of May 31, 2014. 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.

MCO Mental Health Spending For The 12-Month Contract Period Exceeded $11.7 Million With Almost Half Of These Expenditures Occurring For Outpatient Services

MCO Mental Spending By Type Of Service, July 2013 Through June 2014



Note: The data presented above are based on MCO capitated payments from the period of July 2013 through March through 2014.
Source: Encounter data submitted by MCOs to DHCF.

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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 one year's worth of data on each plan, DHCF can now more closely examine the following performance indicators for each of the District's three health plans:

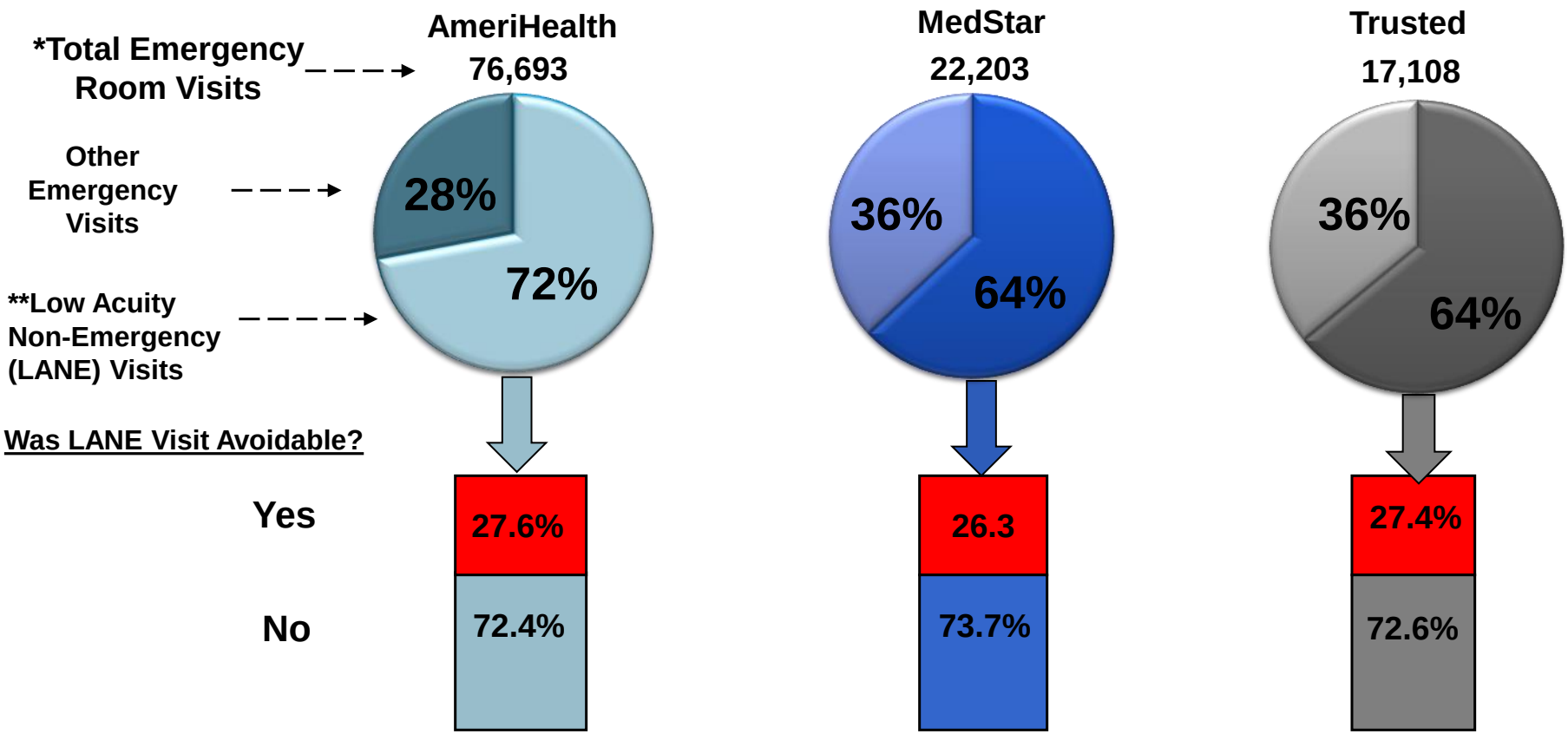
  - Emergency room utilization for non-emergency conditions

  - 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

Across MCOs At Least Six Of 10 Emergency Room Visits Made By Plan Members Are For Low Acuity Diagnoses And Nearly Three In Ten Of These Visits Were Avoidable

Emergency Room Utilization For Members By Level Of Acuity, July 1 2013 to June 30, 2014



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

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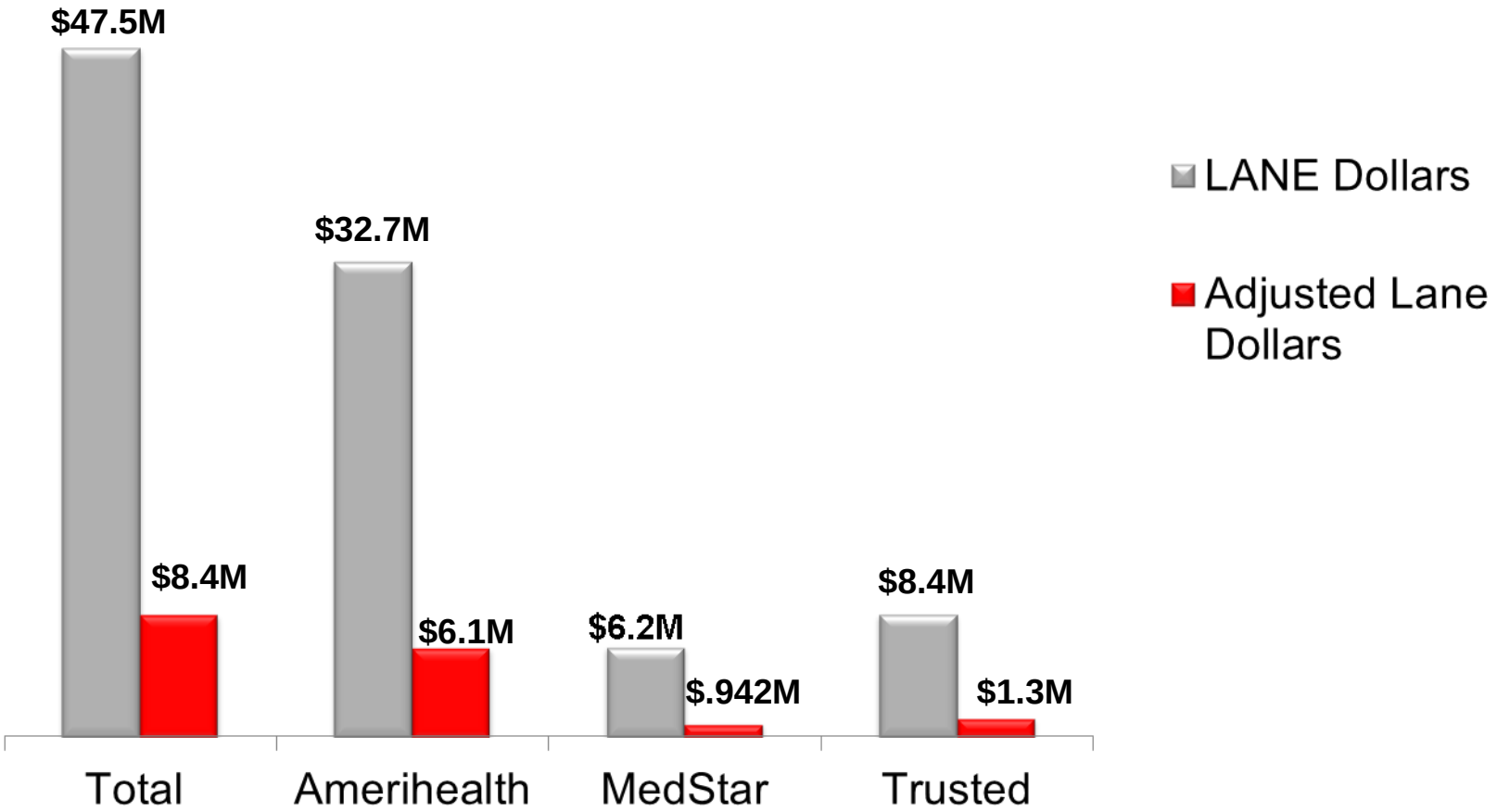
Source: Encounter data submitted by MCOs to DHCF.

The Low Acuity Avoidable Emergency Room Visits Cost The MCO's More Than $8.4 Million In The First Year Of The Contract

Cost Of Low-Acuity Visits During The Period From July 2013 through June, 2014



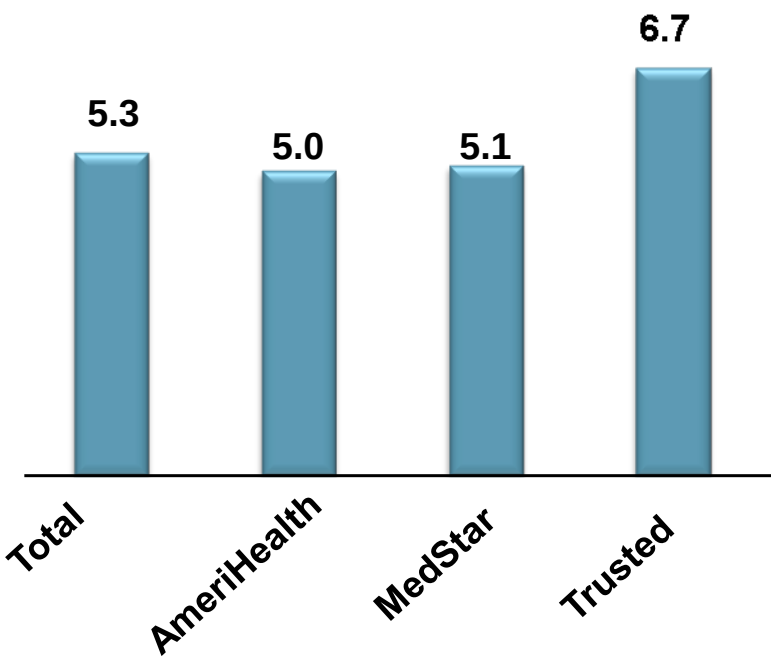
Notes: The LANE dollars are adjusted for the duration of enrollment and percent credibility factors are applied to each diagnosis based on professional judgment.

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

Nearly Seven Percent Of Inpatient Hospital Admissions Were Potentially Avoidable, Costing MCOs An Additional $7.6 Million

Potentially Avoidable Inpatient Admissions (PPA) And The Associated Cost For The Period From July 2013 Through March, 2014

Adjusted Potentially Avoidable Admissions As A Percent Of Inpatients Admits



Managed Care Plan	Cost Of PPA	Adjusted PPA Cost	Adjusted Avoidable Admits Per 1000
AmeriHealth	$5,785,732	$4,045,384	4.9
MedStar	$3,449,776	$2,260,803	7.2
Trusted	$2,182,494	$1,353.030	5.2
Total	$11,418,003	$7,659,217	5.5

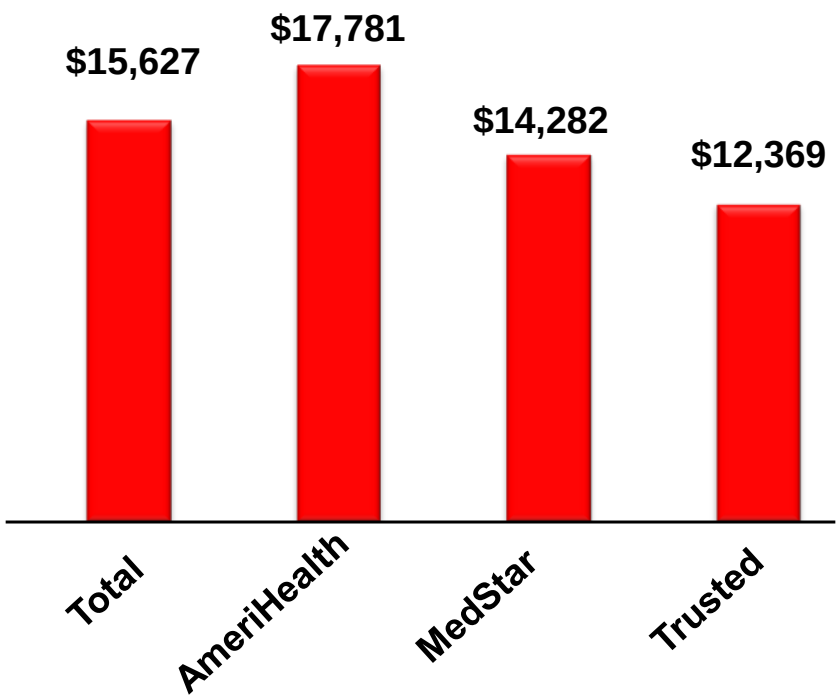
Note: Results are based on prevention quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) that can be used with hospital discharge data to identify potentially preventable admissions for adults.
Source: MCO Encounter data provided by MCOs to DHCF.

The Problem of Hospital Readmissions Add More Than $18 Million To The MCOs' Beneficiary Medical Cost

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

Managed Care Plan	Ratio Of Hospital Readmissions To Index Hospital Admissions	Total Cost Of Readmissions
AmeriHealth	1 to 14.0	$9,543,434
MedStar	1 to 10.8	$6,255,786
Trusted	1 to 9.6	$2,313,035
Total	1 to 12.3	**$18,112,256**

The Average Cost Per Readmissions For Each Health Plan



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

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Year One Grades For Managed Care Organizations

Program Area	AmeriHealth	MedStar	Trusted
Financial Condition			
Risk-Based Capital Level	A-	A-	C-
Reserve Capacity	A-	A	B-
Administrative Performance			
Provider Network	A	A	A
Claims Payment	A-	A	C+
Utilization of Physician Care			
Adults	B+	C+	C
Children	A	B	A-
“Well-Child” Visits	A-	C-	C+
Care Coordination			
Managing ER	D	D	D
Avoidable Hospital Admissions	B-	C-	C+
Reducing Hospital Readmissions	C	C-	D+
Overall Grade Year One	**B+**	**B-**	**C+**

AmeriHealth's Quarterly Report Card

Program Area	Q1	Q2	Q3	Q4	Comments
Financial Condition Risk-Based Capital Level Reserve Capacity	 A --	 A --	 B+ A-	 B+ A-	AmeriHealth is a financially strong plan with adequate liquidity and reserves.
Administrative Performance Provider Network Claims Payment	 A A-	 A A	 A A	 A A	AmeriHealth's administrative operations are first rate.
Utilization of Physician Care Adults Children "Well-Child" Visits	 A A A-	 A A A	 B+ A A	 B A A	AmeriHealth had high utilization rates for physician services for both it's children and adult members but there is some concern about the recent decline in the adult physician visit rate.
Care Coordination Managing ER Avoidable Hospital Admissions Reducing Hospital Readmissions	 D- -- --	 D- -- --	 D- B- C+	 D- B- D+	Although the plan's medical expenses are well in check for a high risk membership, care coordination activities must be

MedStar's Quarterly Report Card

Program Area	Q1	Q2	Q3	Q4	Comments
Financial Condition Risk-Based Capital Level Reserve Capacity	 A --	 A --	 A A	 B+ A	MedStar is a financially strong plan with adequate liquidity and reserves.
Administrative Performance Provider Network Claims Payment	 A A	 A A	 A A	 A A	MedStar's administrative operations are first rate.
Utilization of Physician Care Adults Children "Well-Child" Visits	 B+ B+ C+	 C+ B+ C	 C B C-	 C- B- C-	MedStar needs to take steps to ensure higher physician utilization and well child visit rates for its membership.
Care Coordination Managing ER Avoidable Hospital Admissions Reducing Hospital Readmissions	 D- -- --	 D- -- --	 D- C- C-	 D- C- C-	MedStar's memberships' medical cost does not align with their risk scores and improvements are needed in care coordination activities to address this problem.

Trusted's Quarterly Report Card

Program Area	Q1	Q2	Q3	Q4	Comments
Financial Condition Risk-Based Capital Level Reserve Capacity	 D --	 D --	 C B-	 B B	Trusted has emerged from a financially perilous position but more improvement is needed
Administrative Performance Provider Network Claims Payment	 A D-	 A C+	 A A	 A A	Trusted has an adequate provider network and has significantly improved its claims payment practices since the first half of the contract year
Access To Physician Care Adults Children "Well-Child" Visits	 C- A B	 C- A B	 D+ A- C-	 D+ B+ C-	Trusted needs to take steps to ensure higher physician utilization and well child visit rates for its membership.
Care Coordination Managing ER Avoidable Hospital Admissions Reducing Hospital Readmissions	 D -- --	 D -- --	 D C+ C-	 D- C+ D+	Trusted's memberships' medical cost does not align with their risk scores and improvements are needed in care coordination activities to address this problem