EXHIBIT 2

CHARTERED
HEALTH·PLAN

February 21, 2013

Ms. O'Linda Fuller
Contracting Officer
Office of Contracting and Procurement
Government of the District of Columbia
441 4th Street, NW
Washington, D.C. 20001

Re: Claim Under Contract DCHC-2008-D-5052

Dear Ms. Fuller:

I am the Special Deputy appointed by the District of Columbia Commissioner of the Department of Insurance, Securities and Banking ("DISB"), who was appointed by the District of Columbia Superior Court as Rehabilitator for D.C. Chartered Health Plan, Inc. ("Chartered"), pursuant to the Court's October 19, 2012 Order in *District of Columbia v. D.C. Chartered Health Plan*, 2012 CA 008227 2 (D.C. Super.). The Order is included as **Attachment A**. Part of our statutory and Court-ordered duty is to "take such action as deemed necessary or appropriate to reform and revitalize Chartered." **Attachment A** at 2. Pursuant to these obligations, I am charged to "pursue all appropriate claims and legal remedies on behalf of Chartered." *Id.* On behalf of Chartered, I respectfully submit the following claim for payment in the amount of $51,287,369 in connection with Contract DCHC-2008-D-5052 (hereinafter the "Contract"). The contract period at issue is August 1, 2010 through April 30, 2012.

This claim is related to and based on the same operative facts and request for an equitable adjustment set forth in the claim Chartered presented to former Contracting Officer Jacqueline Alpert by letter dated November 30, 2011. That claim, which is included as **Attachment B**, sought relief in the amount of $25,771,117 to compensate Chartered for the increased pharmacy benefit costs it incurred following the District of Columbia's (the "District's") transfer of certain members of the D.C. Health Care Alliance Program (the "Alliance Program") to the District of Columbia Healthy Families Program (the "Medicaid Program"). Chartered has now determined that it is entitled to compensation and recovery from the District for all of its increased costs under the Contract during the contract period at issue after the change in services mandated by the District, and not just the increased pharmacy costs as requested in the initial claim.

Accordingly, this claim letter represents the loss experience of Chartered during the period commencing with the District's transfer of the former Alliance members to the Medicaid Program on August 1, 2010 through April 30, 2012. Chartered incurred this loss due to the District's failure to properly review and/or adjust the capitation rates paid to Chartered for

services rendered subsequent to the transfer of the former Alliance population members to the Medicaid Program. This claim effectively amends and supersedes the claim submitted by Chartered on November 30, 2011. A different claim for retrospective premium is being filed with you today concerning premium due to Chartered because of unsound rates set by the District under the Alliance portion of the Contract, for Contract year 3. Both claim matters require the District's consideration as soon as possible.

I. Background

Starting in July 2010, pursuant to a new State Plan Amendment, the District unilaterally transferred certain members of the Alliance Program into the Medicaid Program. The transferred population included primarily childless adults living at or below 133% of the federal poverty level (the "774 population") and childless adults living between 133% and 200% of the federal poverty level (the "775 population").

After the transfer, Chartered's Medicaid Program costs increased precipitously. One of the most immediately apparent increases was in pharmacy costs associated with the transferred populations. Chartered proceeded to make a series of formal requests to the District for a review and increase in the capitation rates under the Contract because of the greatly increased costs of the pharmacy benefits primarily driven by the expanded coverage now required for the 774 and 775 populations. The District did not take appropriate action on these requests until it significantly raised capitation rates prospectively, starting on May 1, 2012. On November 30, 2011, Chartered filed a formal claim for payment for the additional pharmacy costs it incurred due to the District's contract change requiring Medicaid coverage and benefits for the 774 and 775 populations.

The District took no action in response to Chartered's November 30, 2011 claim. Accordingly, on April 9, 2012, Chartered filed a Notice of Appeal and Complaint with the District of Columbia Contract Appeals Board. That Appeal is currently pending.

In the course of its regulatory oversight of Chartered, DISB engaged an independent statutory accounting expert, Rector and Associates, Inc. ("Rector"), to review Chartered's outside statutory accounting consultant's interpretation of the Contract as a retrospectively rated contract and determine whether it was appropriate for Chartered to establish a premium receivable as an asset in its financial statements. Chartered's independent actuarial and auditing firms also reviewed this matter in the recently completed 2011 audit of the company. Specifically, OPTUM Insight (an actuary) and Brown Smith Wallace, LLC ("BSW") (an auditor) reviewed the Rector report and the report prepared by Millennium Consulting Services, LLC, Chartered's outside statutory accounting firm, regarding this retrospective premium. A significant conclusion by all of these parties is that the relevant contract language supports Chartered's position that the Contract is a retrospectively rated contract.

As noted by Rector, "[the Statement of Statutory Accounting Principles No. 66 ("SSAP66")] makes clear that a retrospectively rated contract's final policy premium is calculated based on the entire loss experience . . . during the term of the policy, not just the loss

experience resulting from a contract change or a particular set of benefits." **Attachment C**, "Report on Limited Scope Examination of DC Chartered Health Plan, Inc." submitted in November 2012 by Rector & Associates, Inc., at 4. Accordingly, Chartered is entitled to an equitable adjustment that takes into account its entire loss experience, not just the loss experience resulting from the transfer of the 774 and 775 populations. *See id.* at 9. Chartered and the independent actuarial and auditing firms have also reviewed the calculation of Chartered's loss experience under the Contract. Of course, these losses were primarily driven by HIV pharmacy costs of the 774 and 775 populations which the District did not consider in developing or basing its capitation rate. The District's unilateral change in the Contract required Chartered to provide Medicaid benefits to the 774 and 775 populations. Under the Contract, the District is required to review the effect of the change and equitably adjust the capitation rate, not only prospectively, but also retrospectively.

Therefore, Chartered is filing this revised claim, which seeks an equitable adjustment of $51,287,369 for the retrospective premium due to Chartered under the contract during the period from August 1, 2010 through April 30, 2012.

II. Facts

A. The District Must Make an Equitable Adjustment Under the Contract to Reflect Changes in Service

Chartered entered into the incentive, indefinite-delivery/indefinite-quantity Contract with the District to provide coverage for specified health care services to the Medicaid-eligible population enrolled in the Medicaid Program, and coverage for different services to the Alliance-eligible population enrolled in the Alliance Program. *See* Contract at B.1. The Contract provides for payments to Chartered based on fixed capitation rates, as well as a performance-based incentive system with a fee-for-service component. *See id.* at B.2.1.

The District was required to apply the following elements to set the rates under the Contract, including, but not limited to:

- base utilization and cost data from the Medicaid population;
- adjustments to smooth data and account for factors such as medical trend inflation and utilization;
- rate cells specific to the enrolled population based on eligibility, age, gender, locality; and
- risk adjustments based on diagnosis or health status.

See 42 C.F.R. § 438.6(c)(3).

The requirement for an equitable adjustment is also present in the Contract's incorporation of the clause at Section 15 of the District's 2007 Standard Contract Provisions. That "Changes" clause requires that when the Contracting Officer makes a change to the Contract or to the general scope of the Contract which "causes an increase or decrease in the cost of performance of [the] contract, or in the time required for performance, an equitable adjustment *shall* be made." 2007 Standard Contract Provisions § 15 (emphasis added).

The Contract provides a mechanism to facilitate the District's duty to make equitable adjustments when changes in services are mandated by the District. Specifically:

> [i]n the event that the District, pursuant to the Changes Clause of the Standard Contract Provisions, adds, deletes, or changes any services to be covered by the Contractor under [the Medicaid Program] or the Alliance Program, the District will review the effect of the change and equitably adjust the capitation rate (either upwards or downwards) if appropriate.

Contract at B.3.1. Thus, changes to the services covered under the Contract that increase or decrease performance costs *require* an equitable adjustment to the capitation rate. Such adjustments are not discretionary.

Under the Contract, if the contractor believes the rate adjustment (or lack thereof) is not equitable, the contractor may request that the District review the adjustment. *See id.* The Contract also provides that any review requested by the Contractor will not be unreasonably withheld by the District. *See id.*

In addition to providing for change-based equitable adjustments, the Contract requires the yearly review of the capitation rates. Section B.3.2 provides specific mandatory guidance for the reevaluation of capitation rates:

> No later than twelve (12) months after the date of Contract Award and annually thereafter, the District will conduct an actuarial review of the capitation rates in effect to determine the actuarial soundness of the rates paid to the Contractors. The actuarial review will be based upon the rates offered by Contractor and will take into account factors such as inflation, **significant changes in the demographic characteristics of the member population**, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts.

Id. at B.3.2 (emphasis added). The capitation rate letters generated by the District's actuary, Mercer Government Human Services Consulting ("Mercer"), state that the rates in 2010, 2011, and early 2012 do not account for the significant demographic changes resulting from the transfers of the 774 and 775 populations. In other words, base data on these groups was excluded from Mercer's calculations of capitation rates for those contract years.

Because the Contract is a retrospectively rated contract "the final policy premium [is] calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy or a formula required by law." SSAP66 ¶ 10; *see, e.g.*, **Attachment C** at 4-5. The Contract thus requires the District to pay an additional premium to Chartered based on the loss experienced due to the significant change in the Contract, and requires that that payment achieve a complete equitable adjustment.

B. The 774 and 775 Populations Were Transferred Without Any Adjustment to the Capitation Rates Under the Contract

The District has acknowledged that it unilaterally transferred the 774 and 775 populations, and before the transfer, these particular populations were not entitled to most pharmacy benefits which are provided under the Medicaid Program. After the transfer of the 774 population, Chartered was required to extend benefits under the Medicaid Program to certain individuals with incomes up to 133% of the federal poverty level, primarily childless adults. After the transfer of the 775 population, Chartered was required to extend benefits under the Medicaid Program to those with incomes between 134% and 200% of the federal poverty level. In short, as a result of the transfer, two new groups of individuals with unique demographic characteristics, needs, and circumstances became eligible for Medicaid benefits.

The transfer of the 774 and 775 populations resulted in increased work and costs to Chartered because the Contract, when originally executed, did not contemplate or require the coverage of the 774 or 775 populations under the Medicaid Program's benefits. As detailed in its November 30, 2011 claim letter, Chartered made several requests for capitation rate adjustments to alleviate the significant additional costs associated with the 774 and 775 populations, primarily driven by high and rapidly escalating HIV pharmacy costs. These requests were only belatedly addressed by the District through a capitation rate increase effective May 1, 2012, which had only a prospective effect. (And effective January 1, 2013, the District "carved out" HIV pharmacy costs from the Medicaid portion of the Contract.)

C. The Rates Under the Contract Did Not Account for the Costs Necessary to Pay Medicaid Benefits for the 774 and 775 Populations

The capitation rates in effect at the time the 774 and 775 populations were transferred did not properly account for the provision of Medicaid Program services to Alliance Program members. For example, these rates did not account for the provision of pharmacy services at the increased utilization rates, the increased number of prescriptions per utilizing member, or the increased costs of brand name drugs per member that are utilized by the 774 and 775 populations. In transferring the 774 and 775 populations, which have significant demographic and utilization differences from the "legacy" Medicaid population, the District was required to make an equitable adjustment to Chartered's capitation rates to account for the resulting change in services.

III. Discussion

The District contracts with Mercer to develop actuarially sound capitation rates covering specified periods of the Contract (usually annual periods). Mercer bases its rate development process primarily on managed care organization ("MCO") encounter and financial data, and characterizes the periodic rate development process as a "complete rebase of the capitation rates." *See, e.g.*, **Attachment D** at 1.

July 1, 2010 to April 30, 2011 Rates

In June 2010, the District set MCO contract rates within a range Mercer determined to be actuarially sound. Mercer's June 22, 2010 certification letter stated that the rates were for the 10-month period covering July 1, 2010 to April 30, 2011, the remaining time period of the third Contract year. *See id.* Mercer specifically noted that the rate projections were "based on the member months for the current DCHFP (Healthy Families Program) population and **do not consider the additional enrollment related to the coverage expansion up to 133% of the federal poverty level (FPL).**" *Id.* (emphasis added). In fact, not only was the coverage expansion of the 774 population not considered (nor the December 2010 coverage expansion of the 775 population), the base data Mercer utilized was encounter and financial data for only the legacy Medicaid population for the periods from August 1, 2007 through July 31, 2009. Mercer specifically noted that the "[Medicaid Program] covers individuals classified as temporary aid to needy families (TANF). Therefore, the base data is specific to the TANF population and excludes all other populations." *Id.* at 6. "All other populations" in this case included the transferred 774 and 775 populations. Thus, no consideration was given to encounter or financial data on the populations that would be covered following the District's State Plan Amendment.

There is no discussion or consideration by Mercer in its June 2010 certification letter of the expanded Medicaid coverage Chartered would be required to provide to the 774 or 775 populations during the Contract period, nor inclusion of any encounter or financial data on the Alliance populations in the base data used as a "key" consideration in developing the rate range. Mercer acknowledged that it "analyzed the rate cells to determine how to handle the population over age 50" due to the fact that "the District's 1115 waiver, covering the 50-64 year old expansion population, will end" and that "many individuals currently covered through the District's Alliance program will become Medicaid eligible." *Id.* at 7. Based on that analysis, Mercer merely created "separate rate cell for the 37-49 year old population and the 50+ population split by gender." *Id.* at 8.

In developing the rates for July 1, 2010 to April 30, 2011 Mercer did not consider the historic costs or utilization data of, or even trends related to the 774 and 775 populations, as base data on populations other than the TANF populations was specifically excluded.

Chartered's Notice to the District

In February 2011, Chartered provided the District with information comparing pharmacy utilization by the historic Medicaid population with that of the 774 and 775 populations transferred to the Medicaid Program, cost trends, and the extraordinary difference in HIV drug use by 774 and 775 transferees. *See generally* **Attachment B, Exhibit 2**. Chartered showed that in January 2011, 19,079 members of the 774 and 775 populations used $515,326 in HIV medications, while the 76,865 members of the legacy Medicaid population utilized only $419,107 in HIV medications. *See id.* at 2. The 774 and 775 populations were utilizing very expensive HIV medications at ***five times*** the rate of the legacy Medicaid population. *See id.* Chartered requested authorization to provide HIV medications for the 774 and 775 populations

"on an ASO (administrative services organization) basis only until sufficient experience is available to quantify and price the risk." *Id.*

At least internally, the District acknowledged this issue. A memorandum dated April 4, 2011 from Wayne Turnage, the Director of the District's Department of Health Care Finance ("DHCF"), to Mayor Vincent Gray states that "Medicaid expansion brought former Alliance members with ***higher health care costs*** into the Medicaid program and the expected margins on the Medicaid side have not materialized." **Attachment E** at 2 (emphasis added). Additionally, a June 24, 2011 presentation by DHCF to the District of Columbia Council noted that "[g]ains from higher Medicaid margins were predicted to offset expected losses from lower Alliance rates. The strategy failed because it coincided with a policy that moved many Alliance members to the Medicaid program. Medicaid margins did not materialize and Alliance losses were significant." **Attachment F** at 7.

DHCF Director Turnage has noted that he received Chartered's first letter on the 774 and 775 population costs one week after his tenure at DHCF began. In his April 4, 2011 memo to Mayor Gray, Director Turnage stated that he would "meet with Mercer to discuss the goals for FY 12 rate setting. Data on MCO losses will be examined. . . . In the Mayor's budget, significant savings were assumed on the premise that all MCO rates will be held flat . . . [but] this assumption may no longer be realistic thus creating a budget pressure for FY 12." **Attachment E** at 2.

Despite the assurance that MCO losses would be examined by Mercer and that it may not be realistic to hold rates flat, Mercer's July 8, 2011 certification letter set out the following:

- 0.9% overall rate increase;
- **Use of base data from MCOs for the period August 1, 2008 through July 31, 2010 (a two year period *prior to* 774/775 population enrollment in Medicaid);**
- **Base data specific to the TANF population and excluding all other populations;**
- Undefined analysis which showed "that the newly eligible Medicaid adults [up to 200% of FPL] have incurred lower costs than the current Medicaid adults in those rate cells."

See generally **Attachment G** (emphasis added). While Mercer indicated that it considered data related to issues raised by MCOs, among other sources, to develop trend assumptions, the essentially flat rate (less than 1% overall increase) did not reflect the dramatically increased pharmacy costs of the 774 and 775 populations that Chartered was actually experiencing, and had communicated to the District. Director Turnage has stated his position that the MCOs accepted the rates and signed the agency letter of agreement, apparently meaning that they accepted the risk of underpayment and have no recourse.

In fact, Mercer excluded the 774 and 775 populations from its base data, and the District failed to negotiate the new rate set by the District or explain how the new rate was appropriate to meet the additional increased costs resulting from the mandated transfer of the 774 and 775

populations to the Medicaid Program. Moreover, the rates were imposed by the District, ***not*** negotiated. As explained above, the key base data utilized by Mercer covered a period prior to the transfer of and therefore excluded the 774 and 775 populations. Indeed, the June 24, 2011 DHCF presentation to the Council explains the "timing problems" experienced because DHCF budgets were required to be established before Mercer provided the District with its range of contract rates. *See* **Attachment F** at 2, 6, 9.

Chartered's Appeal to DHCF

On September 30, 2011, Chartered again appealed to DHCF regarding the cost of providing Medicaid pharmacy benefits to the 774 and 775 populations. *See* **Attachment B, Exhibit 3**. Chartered's letter noted that when the rates were set in July 2011, "[DHCF] promised that if this trend proved to be a problem, [Chartered] could bring the matter back to [DHCF] for further consideration." *Id.* at 1.

The capitation rates certified by Mercer starting in August 1, 2011 anticipated a pharmacy expenditure of $23.16 per member per month ("PMPM"). *See id.* Chartered's pharmacy expense PMPM between March and August 2011 averaged $41.44 PMPM, primarily due to the increased and expensive HIV medications utilized by the 774 and 775 populations. *See id.* Chartered told DHCF that underfunding pharmacy costs by over $18 PMPM resulted in $1.8 million per month loss, an annualized loss of over $21 million. *See id.* at 1-2.

The trend was not abating, and it was not properly accounted for in the August 2011 rate adjustment by DHCF. Chartered requested a capitation increase of $18.00 PMPM effective October 1, 2011 and remediation for the losses already sustained from the 774 and 775 pharmacy utilization in the amount of $17,836,349. *See id.* at 2. No action was taken by DHCF regarding this request for retrospective and/or prospective equitable adjustment.

Formal Request for Review and CAB Appeal

On November 30, 2011, Chartered made a formal claim to DHCF for equitable adjustment to the capitated rate and payment for losses experienced by Chartered. *See* **Attachment B**. DHCF declined to make any determination on this claim within the statutory 120 day period, so Chartered filed an action with the Contract Appeals Board on April 9, 2012.

May 1, 2012 Mercer Certification Letter

On May 1, 2012 Mercer certified rates for May 1, 2012 through April 30, 2013, reflecting a 7.2% increase overall to current rates plus a new rate cell for adults in the 775 population which reflect a 48.8% increase overall to the current rates. *See* **Attachment H** at 1-2. The 775 population rate cells are now paid at the highest rate possible under federal rules, $657 PMPM. It should be noted that the 7.2% increase overall is at the bottom of the rate range Mercer found to be actuarially sound. *See id.* at 13. The increase could have been, and arguably should have been, 12-17%.

The May 2012 adjustment finally recognized costs and utilization history for the 774 and 775 populations, at least in encounter and financial reports through July 2011 and in trend considerations. The rate increases may not yet account for Chartered's actual costs of providing benefits under the Contract because they are at the lowest end of Mercer's range, as they have been historically, and because Chartered continues to experience losses.

The creation of separate cells for the 775 population in May 2012 with a 48.8% increase in rate clearly demonstrates that the past rates for this group did not account for its costs in the prior Contract years.

The District has never actually responded to Chartered's requests for an equitable adjustment for the periods between July 1, 2010 and May 1, 2012. But DHCF did raise rates significantly beginning May 1, 2012 and has now "carved out" the HIV pharmacy costs from the Contract, effective January 1, 2013, another acknowledgement that these costs present unique challenges and have not been adequately addressed in the prior Contract years.

Despite Chartered's numerous requests for appropriate rate adjustments, the District did not acknowledge or appropriately account for the 774 and 775 transfers except prospectively from May 1, 2012. (And now HIV/AIDS/Hepatitis pharmacy benefits/costs are carved out of the Medicaid contract effective January 1, 2013). Instead, the District unilaterally transferred the risk of Medicaid Program utilization by the 774 and 775 populations to Chartered without equitably adjusting the rates to account for that risk.

A. The Final Policy Premium Owed to Chartered Must Be Based on the Total Costs Chartered Experienced

The District's transfer of the 774 and 775 populations changed the circumstances under which Chartered performed the Contract: two new groups of individuals in populations with unique demographic characteristics, needs, and circumstances suddenly became eligible for Medicaid Program benefits. By requiring the transfer, the District caused Chartered to pay for additional benefits for which it was not being adequately compensated by the District.

As noted previously, the Contract is a retrospectively rated contract which obligates the District to provide an equitable adjustment when there is a change to the Contract. The term "equitable adjustment" is defined under District law. An equitable adjustment is a formula that accounts for the "difference between what it would have reasonably cost to perform the work as originally required and what it reasonably cost to perform the work as changed." *See District of Columbia v. Organization for Envt'l. Growth*, 700 A.2d 185, 203 (D.C. 1997) (citing *Modern Foods, Inc.*, ASBCA 2090, 57-1 BCA ¶ 1229, 1957 WL 4960; *Jack Picoult*, VABCA 1221, 78-1 BCA ¶ 13,024, 1978 WL 2469). There are two key factors in determining whether incurred costs may be included in an equitable adjustment: first, whether the costs represent additional work necessary to perform the changed work above the effort necessary to perform the contract as originally written; and second, whether the costs claimed for the additional effort are reasonable. *See, e.g., Prince Constr. Co., Inc.*, DCCAB No. D-1127, 2003 WL 2123568 (May 12, 2003).

The transfer of the 774 and 775 populations constituted a change in the Contract and resulted in a substantial increase in the total cost of Chartered's performance. Under the plain language of the Contract, because the District changed the terms of performance, the District is required to make an equitable adjustment. Chartered is therefore entitled to the reasonable additional costs of performing the Contract following the transfer of the 774 and 775 populations. These costs are not limited to those associated with pharmacy benefits, but include all costs associated with providing Medicaid Program benefits to the Medicaid population under the Contract.

B. The Total Additional Costs Chartered Experienced Exceed $50,000,000

After Chartered consented to be placed in rehabilitation and I was appointed as the Special Deputy to the Rehabilitator, a review of Chartered's records under SSAP66 guidelines was undertaken to determine the financial impact of the rates paid to Chartered between August 1, 2010 and April 30, 2012, the date of the Contract change up to the time the District implemented a new rate schedule prospectively. Using information from Chartered's claim data warehouse, the review contemplated revenues and costs from three time periods: between August 1, 2010 and July 31, 2011 ("Period 1"); between August 1, 2011 and December 31, 2011 ("Period 2"); and between January 1, 2012 and April 30, 2012 ("Period 3"). Period 1 represents the rate schedule before the District minimally revised it on August 1, 2011. Periods 2 and 3 represent that same rate schedule, but are divided because of Chartered's financial reporting calendar. The analysis ends with Period 3 on May 1, 2012, because the District implemented a new rate schedule going forward to April 30, 2013. Although the new rate schedule is higher, Chartered continues to doubt that the new rate adequately compensates it for the benefits required to be provided under the Contract.

Attachment I is a spreadsheet calculating Chartered's total increased costs resulting from the District's contract change during the period claimed. The spreadsheet uses data from a variety of sources, but primarily Chartered's claim data warehouse with cost data also set out in Chartered's reports to the District. The data is arrayed by age and sex cohorts. Each rate cohort is used to accumulate revenues and expenses for the three contract periods noted above.

The primary cost data utilized at the rate cohort level (rate schedule categories) in the spreadsheet are identified as being fee-for-service ("FFS") medical costs and pharmacy costs. This cost data is categorized by rate cohort and then further divided into subgroups 774, 775, and Legacy (i.e., all Medicaid program members other than 774 and 775 populations). Data from the rate cohort worksheets is aggregated. Certain subcontracted expenses (capitated PCP's, other capitated expenses, dental, and mental health) were added to this cost data after being reduced by reinsurance recovery amounts.[1] Capitation revenue has been calculated in the spreadsheet at the

[1] The subcapitated PCP costs, other subcapitated costs and reinsurance recoveries were added to the analysis at the cover worksheet level. Other subcapitated costs excluded the administrative fee paid on an ASO basis to the dental and mental health providers because the District has indicated to Chartered that such costs should be categorized as G&A expense. The dental and mental health claim costs for Periods 2 and 3 were derived by multiplying the member months for the respective periods by the respective average PMPM costs calculated as part of the above-described annual cost reports to the District for the period 8/1/11 to 7/31/12.

rate cohort level and summed on the cover worksheet. Birth payment ("kick") receipts were also added to the capitation revenue on the cover worksheet. The total revenue was then adjusted downward by 13.4% to reduce revenue amounts to account for the G&A (9.4%), premium tax (2.0%) and profit factor (2.0%) incorporated in the rates paid by the District. This figure is established by reference to the May 1, 2012 rate-setting document written by Mercer and distributed to participating health plans.

A review of Periods 1 through 3 determined that Chartered suffered a $44,414,862 loss in terms of its Medicaid population cost experience compared to healthcare costs found in the District's rates. When that shortfall is then grossed up to account for G&A, premium tax, and profit factors, Chartered's total loss increases to $51,287,369. The proper measure for an equitable adjustment is the difference between the cost of the work required by the original Contract terms and the reasonable cost of performing the work as changed. *Prince Constr. Co., Inc.*, DCCAB No. D-1127, 2003 WL 2123568 (May 12, 2003); *J.R. Pope, Inc.*, DOT CAB No. 78-55, 80-2 BCA ¶ 14,562 (1980). This total loss measures the difference in Chartered's costs to perform the Contract based on the District's Contract change resulting from the transfer of the 774 and 775 populations. Chartered's increased costs are reasonable because they are the increased costs that Chartered was actually required to incur to perform the Contract after the District's change. Moreover, this loss reflects just how inadequate the rates were after the District moved the 774 and 775 populations on August 1, 2010 until April 30, 2012 (the "Combined Period") when DHCF finally considered Chartered's increased costs after the transfer and adjusted the rates prospectively.

Thus, the District should follow the requirements of the Contract and make a retroactive equitable adjustment to the Medicaid Program capitation rate in the amount of $51,287,369 for the Combined Period.

IV. Summary and Conclusion

Director Turnage has claimed that actuarial soundness is not a retrospective determination (even though rates are determined in large part on historical costs and utilization). It is beyond dispute that the rates ranges developed by Mercer and set by DHCF between August 1, 2010 and April 30, 2012 ***excluded*** key base data on utilization and cost regarding the 774 and 775 populations. Accordingly, the actuarial opinion and certification of the rate ranges determined by Mercer during that period simply pertain to the legacy Medicaid population, not the whole population for which Chartered was required to provide Medicaid benefits. Whether the rates certified and set were actuarially sound for the Medicaid population, which included the 774 and 775 populations *after* the District made a change in the Contract regarding populations covered, is certainly doubtful and debatable. **But, that is not the issue in this claim.** The Contract requires that when a change is made which "causes an increase or decrease in the cost of performance of [the] contract . . . an equitable adjustment **shall** be made." The District's obligation to make an equitable adjustment is not discretionary. *See Stass v. Kaiser Found. Health Plan*, 744 A.2d 1000, 1013 (D.C. 2000) (distinguishing provisions covered by the mandatory term "shall" from those covered by the permissive "may.")

The need for an equitable adjustment is not a surprise to the District. Chartered has repeatedly put DHCF on notice through letters, meetings, and formal appeals that the change to Medicaid coverage for the 774 and 775 populations was not being adequately compensated under the rates set by DHCF. Until May 1, 2012, the District did not act to adjust the capitation rates to reflect Chartered's increased costs associated with the transfer of these populations. When DHCF did act, it only made a prospective adjustment. The prospective adjustment confirms that the past rates were not adequate to cover the benefits provided by Chartered. The "carve out" of the HIV pharmacy benefits effective January 1, 2013 further confirms Chartered's right to retrospective premium after the August 1, 2010 Contract change.

The District never adequately considered the costs or utilization of the 774 and 775 populations in setting rates until May 1, 2012 as confirmed in Mercer's 2010, 2011, and 2012 certification letters. Therefore, an equitable adjustment for the period between August 1, 2012 and May 1, 2012 is required under the Contract, regardless of the actuarial soundness or unsoundness of the rate ranges Mercer previously developed and the District set (not negotiated), which in any event utilized historic data of the legacy Medicaid populations only and excluded the 774 and 775 populations.

V. Relief Requested

As set out above, Chartered requests that the District make a retroactive equitable adjustment for $51,287,369, together with all available interest. Chartered further requests that you or a Contracting Officer's Representative meet with us within the next ten days to endeavor to resolve this matter. If we cannot reach an expeditious resolution, given Chartered's rehabilitation status, we request that you issue an expedited final decision on this claim within twenty days of receipt.

I believe a negotiated resolution of this claim for equitable adjustment would be in everyone's interest and look forward to discussing this claim with you soon.

Respectfully,

Daniel Watkins

Special Deputy to the Rehabilitator for D.C. Chartered Health Plan, Inc.

Enclosures

cc: Wayne Turnage, Director, District of Columbia Department of Health Care Finance
Maynard McAlpin, President and CEO, D.C. Chartered Health Plan, Inc.
A. Scott Bolden, Esq., Counsel to D.C. Chartered Health Plan, Inc.

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SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA,
Department of Insurance, Securities
and Banking,
810 First Street, NE, Suite 701
Washington, DC 20002

Petitioner,

v.

DC CHARTERED HEALTH PLAN, INC.,
1205 15th Street, NW
Washington, D. C. 20005,

Respondent.

Civil Action No.: 2012-8227
Judge:
Calendar No.:

COPY

Court Clerk
Judge-in-Chambers

Deputy Clerk

EMERGENCY CONSENT ORDER OF REHABILITATION

Upon consideration of the *Emergency Consent Petition for an Expedited Order of Rehabilitation pursuant to D.C. Official Code §§ 31-1303, 1310 - 1312 and 3420* and the entire record herein, it is, by the Court, this _____ day of October 2012,

ORDERED: That the *Emergency Consent Petition for an Expedited Order of Rehabilitation* be, and is hereby, **GRANTED**; and it is

FURTHER ORDERED: That the Commissioner, and his successors in office, are appointed Rehabilitator of Chartered pursuant to D.C. Official Code § 31-1311 (2001 ed.); and it is

FURTHER ORDERED: That the Commissioner, and his successors in office, shall be vested with all appropriate and necessary powers provided under chapter 13 of Title 31 of the D.C. Official Code, including:

(i) All powers of the directors, officers and managers of Chartered, whose authority is suspended except as may be re-delegated by the Rehabilitator.

(ii) Authority to take possession and control of Chartered's assets and administer them under the general supervision of the Court.

(iii) Authority to take such action as deemed necessary or appropriate to reform and revitalize Chartered.

(iv) Authority to pay claims.

(v) Authority to petition courts for stay of litigation pending against Chartered.

(vi) Authority to accept new or renewal business or extension of Chartered's contracts.

(vii) Authority to accept, direct, manage and pay employees and pay all other expenses necessary to the rehabilitation.

(viii) Authority to appoint and compensate from Chartered's assets one or more special deputies (who shall have all the powers and responsibilities of the Rehabilitator granted under the statute) and to engage and compensate counsel, consultants, financial advisors, clerks, and assistants deemed necessary to the rehabilitation.

(ix) Authority to pursue all appropriate claims and legal remedies on behalf of Chartered.

(x) Authority to avoid fraudulent transfers under D.C. Official Code §§ 31-1324 & 1325.

(xi) Authority to enjoin any person from interfering with the Rehabilitator in possession and control of the property, books, records and all other assets of Chartered.

FURTHER ORDERED: That title of all assets of Chartered is vested in the Rehabilitator by operation of law.

FURTHER ORDERED: That the Rehabilitator shall seek Court approval of any compromise or settlement of Chartered's claim pending before the District of Columbia's Contract Appeals Board and the contemplated claim regarding capitation rates for the Alliance Program.

FURTHER ORDERED: That officers, directors, employees, agents and others are directed to cooperate with the Rehabilitator as provided by D.C. Official Code § 31-1305.

FURTHER ORDERED: That the Rehabilitator may seek to enjoin the initiation of lawsuits, dissipation of bank accounts, obtaining of preferences, or any other interference with the Rehabilitator.

FURTHER ORDERED: That the Rehabilitator file periodic accountings with the Court, no less frequently than semi-annually.

FURTHER ORDERED: That the Rehabilitator submit a plan of rehabilitation of Chartered for Court approval, if one is feasible. If the Rehabilitator determines that a rehabilitation plan is not feasible, the Rehabilitator shall submit a report to the Court which states the basis for such determination.

FURTHER ORDERED: That entry of this Order of Rehabilitation shall not constitute an anticipatory breach of any contracts of Chartered nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of Chartered, unless the revocation or cancellation is done by the Rehabilitator pursuant to D.C. Official Code § 31-1312.

FURTHER ORDERED: That this Court retains jurisdiction in this matter during Chartered's rehabilitation, and for purposes of granting such other and further relief as this cause and the interest of the policyholders, creditors, or the public may require.

Judge, Superior Court

Copies to:

E. Louise R. Phillips
Assistant Attorney General
Office of the Attorney General
441 Fourth Street, N.W., Ste. 650N
Washington, D.C. 20001

Mr. Maynard G. McAlpin
President and CEO
DC Chartered Health Plan, Inc.
1025 15th Street, NW
Washington, DC 20005

William P. White, Commissioner
c/o Adam H. Levi
DISB, Office of the General Counsel
810 First St., NE, Suite 701
Washington, D. C. 20002

A. Scott Bolden, Esquire
Reed Smith, LLP
1301 K Street, NW
Suite 1100, East Tower
Washington, DC 20005


B

EPSTEIN BECKER & GREEN, P.C.

ATTORNEYS AT LAW

1227 25TH STREET, NW, SUITE 700
WASHINGTON, DC 20037-1175
202.861.0900
FAX: 202.296.2882
EBGLAW.COM

CLIFFORD E. BARNES
TEL: 202.861.1856
FAX: 202.296.2882
CBARNES@EBGLAW.COM

November 30, 2011

VIA E-MAIL

Ms. Jacquelyn Alpert, JD
Contracting Officer
Department of Health Care Finance
Government of the District of Columbia
899 North Capitol Street, N.W., Suite 6037
Washington, D.C. 20002

Re: DC Chartered Health Plan Contract No. DCHC – 2008 – D – 5052 (the "Contract")

Dear Ms. Alpert:

The undersigned is counsel to D.C. Chartered Health Plan, Inc., ("**Chartered**"). Pursuant to the D.C. procurement regulations, the Contract disputes clause, and other applicable clauses in the Contract, Chartered respectfully submits this claim seeking: (1) a review of the capitation rate decision along with the applicable assumptions as the rate chosen by the District is not equitable; (2) a review of the annual adjustment to the rates along with the applicable assumptions as the adjustment is not equitable; (3) an adjustment to capitated rate to make such rates actuarially sound; or, in the alternative, (4) an equitable adjustment to the capitated rate due to significant increases in actual pharmacy benefit costs; (5) payment in the amount of $13,665,419 dollars for the loses experienced by Chartered for the period of August 1, 2010 to October 31, 2011, for the District's failure to set actuarially sound rates; and (6) payments in the amount of $12,105,699, for the loses projected for the period between November 1, 2011 thru April 30, 2012.

I. Background

Chartered has requested on several occasions that the District review the rates regarding certain pharmacy benefits under the Contract. The First request for rate review occurred was on February 9, 2011, when Chartered sent a letter to the District as part of the contractual rate setting process. (See February 9, 2011 letter, attached as Exhibit 1 - The "**February Letter**"). In that letter, Chartered notified the Department of Health Care Finance ("**DHCF**") about the

adverse impact starting in July 2010, of the transfer of the former Alliance members to the Medicaid managed care program (the "774/775" populations) and sought a review of the capitated rates.[1] As explained in the February Letter, Chartered stated: 1) that the 774/775 populations were transferred to Chartered based upon the DHCF's erroneous assumption that such population will have the same actuarial experience as the existing Medicaid population (herein after reference to as the "**legacy Medicaid population**"); 2) that even though DHCF did not have access to data regarding the purchasing, dispensing and accounting of drugs for the 774/775 populations while in the Alliance Program, which precluded the ability to calculate an accurate pharmacy cost, DHCF should not transfer the entire unfunded risk of the pharmacy cost to Chartered; 3) that Chartered's pharmacy experience with the 774/775 populations pre and post transition reveals that:

- the rate of utilizing members per month is 50% greater than the legacy Medicaid population;
- the number of prescriptions per utilizing member is also 50% higher than the legacy Medicaid population;
- the cost of brand name drugs per member is 77% higher than the legacy Medicaid population; and
- together the three factors significantly increased the monthly pharmacy cost as compared to the existing legacy Medicaid population.

and 4) the increased costs for brand name drugs is driven in large part by an increase in the volume of HIV drugs provided to the 774/775 population. At the end of the February Letter Chartered requested a meeting to discuss the concerns raised in the February Letter. No such meeting was scheduled by DHCF.

Chartered's second request for a rate review occurred on June 2, 2011 when Chartered and officials from DHCF met to discuss the 774/775 population transfer issue. At that meeting Chartered summarized the history of the 774/775 population transfer issue including its February Letter. Chartered sought a follow up to develop a plan of action. No follow up was scheduled by DHCF.

The third request for a rate review occurred on September 12, 2011 when Chartered raised the 774/775 population transfer issue at its monthly meeting with DHCF. In that meeting, Chartered made a presentation explaining: 1) that the 774/775 population required an extraordinary number of HIV/AIDS drugs, among other medications; 2) that the 774/775 population more than doubled the past and present utilization of HIV/AIDS drugs by Chartered members; and 3) that during the

[1] The 774/775 population is the combination of the Group 774 individuals who are childless adults whose income is 133% of the Federal Poverty Level or less and the Group 775 individuals who are childless adults whose income is greater than 133% of the Federal Poverty Level, but less than 200%. Significantly The 774/775 populations would not qualify for Medicaid without a change in policy by the District of Columbia government.

period of January – July 2011 Chartered's cost for the top three drugs utilized for the 774/775 population was more than 600% higher per member per month than that of the legacy Medicaid population; and 4) based upon the extraordinary increasing utilization, with no end in sight, that the District carve-out the HIV drugs for the 774/775 from the managed care capitation. See Exhibit 2 for a copy of the presentation.

The fourth request for a rate review occurred when Chartered sent a second letter to DHCF on September 30, 2011. (See September 30, 2011 Letter attached as Exhibit 3 (the "**September Letter**"). In that letter, Chartered again brought to the attention of DHCF, the losses that resulted from the transfer of the 774/775 population to Chartered based upon inaccurate pharmacy cost assumptions. The September Letter, among other things, reported on a meeting held with DHCF, on September 12, 2011, where Chartered made a presentation regarding the adverse financial consequences of the pharmacy utilization of the 774/775 population. The September Letter also explained: 1) that the cost of providing the increasing utilization of the HIV drugs was not previously within Chartered's financial experience; 2) that the pharmacy cost anticipated by Mercer was $23.16 per member per month while Chartered's experience was $41.44 per member per month; and 3) Chartered's adverse experience occurred despite the substantial efforts of Chartered and Caremark (Chartered's pharmacy benefit manager) to control the pharmacy expenses.

II. Facts

A. The District Must Set Actuarially Sound Rates Pursuant To The Contract

Chartered entered into an incentive indefinite - delivery/indefinite - quantity ("IDIQ") Contract with the District to provide health care services to the Medicaid eligible population enrolled in the District of Columbia Healthy Families Programs and for Alliance eligible population enrolled in the DC Health Care Alliance Program. (See Contract at Section B.1.) The Contract provides for payments based on fixed capitated rates, as well as a performance-based incentive system with a fee-for-service component. (See Contract at B.2.1.) The Contract requires that the rate payments made to the contractor be "actuarially sound" in accordance with 42 C.F.R. § 438.6(c)(2)(i).

The Contract also provides a specific mechanism to facilitate the District's duty to set actuarially sound rates when changes in services are mandated. In the event that changes are made to any services covered by the Contractor under DCHFP, the District is obligated to conduct a review to determine whether the change requires a rate adjustment. (See Contract at Section B.3.1.) If the Contractor believes the rate adjustment, or lack thereof, is not equitable, it may request the District to review the adjustment. (See Contract at Section B.3.1.) The Contract also provides that the review requested by the Contractor will not be unreasonably withheld by the District. Id.

In addition, the Contract provides for a yearly review of the capitation rates in effect. This clause provides specific mandatory guidance for reevaluating the capitation rates:

> B.3.2. No later than twelve (12) months after the date of the Contract Award and annually thereafter, the District will conduct an actuarial review of the capitation rates in effect to determine the actuarial soundness of the rates paid to the Contractors. The actuarial review will be based upon the rates offered by the Contractor and will take into account factors such as inflation, significant changes in this demographic characteristics of the member population, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts.

Section B.3.3. of the Contract also provides that:

> The District and the Contractor shall negotiate the actual amount of the adjustment; in determining the adjustment, the District shall apply the elements required under 42 C.F.R. § 438.6(c) for actuarially sound rates or explain why they are not applicable.

B. The Effects of the 774/775 Population Transfer

To determine the financial impact of the deficit in the pharmacy component of Chartered's capitation rates, Chartered reviewed its pharmacy experience from August 1, 2010 through July 31, 2011. During that initial time period ("**Initial Period**"), Chartered spent $38,353,291 or $33.60 per member per month ("**PMPM**") on pharmacy costs. Based upon the DHCF Databook issued in 2010 and the rates that Chartered ultimately received for the 2010-2011 Contract Year, Chartered estimates that DHCF included $22.45 PMPM for pharmacy for the Initial Period. Further, based on an enrollment of 1,141,467 member months, Chartered estimates that it received $25,625,938 for pharmacy over the Initial Period. The difference between the estimated amount received and the amount spent is the total underfunding for Chartered's pharmacy costs which amounts to $12,727,353 or $11.14 PMPM. See Exhibit 4. However, the total underfunding number does not isolate the underfunding in the 774/775 population as it also includes the underfunding for the legacy Medicaid population. To better focus and isolate the underfunding in the 774/775 populations, the legacy Medicaid population can be used as the baseline. As such, the pharmacy spend on the legacy Medicaid population averaged $25.66 PMPM for the period of August 1, 2010, through July 31, 2011 while the pharmacy spend for the 774/775 population for the same period averaged $69.06 PMPM. Under this more focused approach, $9,063,247.98 or $7.94 PMPM ($33.60 - 25.66 = 7.94 x 1,141,467 = $9,063,248) represents the cost differential between providing the pharmacy benefit to Chartered's legacy Medicaid population and to the 774/775 populations for the period August 1, 2010 through July 31, 2011. See Exhibit 4.

For the period after the Initial Period, that is, the three month period between August 1, 2011 and October 31, 2011, the losses become even more acute ("**Subsequent Period**"). Using the 2011 DHCF Databook and the new rates that Chartered received during the Subsequent Period as a guide, Chartered estimates that it is now receiving $25.62 for Pharmacy. Based upon the Chartered legacy Medicaid membership of 292,730 member months, Chartered received

$7,499,743 for the pharmacy component. Chartered's expense for pharmacy for the 774/775 population during the Subsequent Period was $12,101,914 or $41.04 PMPM. As a result, Chartered has spent $4,602,171 more for pharmacy for the 774/775 population than was paid to it since the new rates were effective on August 1, 2011, until the end of October 2011. Consequently, Chartered is currently underfunded in the pharmacy component by $15.52 PMPM. See Exhibit 4.

Similarly, for the period after the Subsequent Period, Chartered has projected losses for the period between November 1, 2011 and April 30, 2012 ("**Projection Period**"). Using the same metrics as described in the Subsequent Period, Chartered had projected the pharmacy cost for the 774/775 population at $27,198,285.95 and the projected per member per month pharmacy capitation at $15,092,587.02 which results in a projected loss of $12,105,698.93. See Exhibit 5.

To make matters worse, pharmacy cost are growing at an overall rate of 1.7% per month. Chartered repeatedly put DHCF on notice through meetings and letters that the pharmacy trend was significantly higher because of the 774/775 population and that the capitated rates needed to be reviewed and adjusted, but to Chartered's knowledge the increased expense was not considered by the District government in setting the new rates. As a result, Chartered should be made whole for this entire loss during this Initial Period, the Subsequent Period and the Projected Period in the total amount of $25,771,117. In addition, Chartered needs a rate increase to prevent both the growth of this underfunding and the continued reliance of inaccurate data to set rates.

Chartered can track the increase in pharmacy expense to the 774/775 population. An analysis of the pharmacy cost per member per month from August 2010 to October 2011, reveals that 774/775 populations' expense was greater on a per member per month basis starting after the first full month of the transfer in August of 2010. That analysis also reveals that the costs per month increased over the previous month nearly every month of the targeted period. The difference in PMPM capitated rates is dramatic. For example, in August 2010, after the first full month of the transfer, the 774/775 population experienced expenses on a per member per month basis of approximately 23% over the legacy Medicaid population (22.45 for legacy, 27.71 for 774/775), by the December, the fourth full month after the transfer, the 774/775 population experienced expenses approximately 50% over the legacy Medicaid population ($22.45 for legacy and $33.72 for 774/775 population); by July of 2011, the 12th full month after the transfer, the 774/775 population experienced expenses approximately 60% over the legacy Medicaid population ($22.45 for legacy, $35.98 for 774/775 population) and by October of 2011, the 15th month after the transfer, the 774/775 population experienced expenses on a per member per month basis of approximately 65% over the legacy Medicaid population ($25.62 for legacy, $42.34 for 774/775 population). The Chart in Exhibit 5 graphically illustrates the increasing nature of the 774/775 pharmacy expense.

Chartered can also track the specific drugs that account, in large part, for the increase in pharmacy expense in the 774/775 population. An analysis of the pharmacy cost for the period of January to July 2011 reveals that the top 3 HIV drugs account for a large amount of the total

increase in pharmacy cost. According to that analyses, the per member per month expense of the top 3 utilized drugs for the 774/775 population is $21.06, whereas the PMPM expense for the same drugs for the legacy Medicaid population is $3.44, amounting to a 612% increase. See Exhibit 6. Assessing the average expense per month for the top 3 drugs reveals that the 19,839 Chartered enrollees that are in the 774/775 population experienced an average expense of $417,783 and that the 77,131 Chartered enrollees that are legacy Medicaid population members experienced an average spend of $263,234. The increasing nature of the pharmacy expense of the 774/775 population shows that the additional expense is not an isolated event and is dramatically different from the legacy Medicaid population.

III. Discussion

Pursuant to the Contract, Chartered is entitled to request that the District review the underlying pharmacy rates applicable during both the Initial Period and the Subsequent Period. Moreover, Chartered is entitled to a rate adjustment pursuant to Section B.3 of the Contract for the Initial Period, Subsequent Period, as well as, for the Projection Period. Since the transfer of the 774/775 population has significantly changed the demographic characteristics of the member population and thereby altered the underlying assumptions that form the current rate, the current rate is not actuarially sound for the 774/775 population. Accordingly, Chartered is also entitled to receive payments for the Initial Period, the Subsequent Period and the Projection Period pursuant to an actuarially sound capitation rate. Alternatively, Chartered is entitled to an equitable adjustment pursuant to the Standard Contract Clause. In particular, implementation of the transfer of the 774/775 population has resulted in an unanticipated increase in the amount of prescription drug services needed by the 774/775 population. Chartered is entitled to an equitable adjustment for this unanticipated increase in costs.

A. The Districts' Rates Are Not Actuarially Sound and Must be Changed Pursuant to the Rates Clause of the Contract

Sections B.3.3 and G.1.6 of the Contract require that all rates and payments to Chartered be "actuarially sound" in accordance with 42 C.F.R.§438.6(c). Section B.3.2 requires the District to consider the following when setting actuarially sound rates:

> The actuarial review will be based upon the rates offered by the Contractor and will take into account factors such as inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts.

Similarly, 42 C.F.R. § 438.6(c) provides the following guidance regarding what is "actuarially sound":

In setting actuarially sound capitation rates, the State must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

(ii) Adjustments made to smooth data and adjustments to account for factors such as medical trend inflation, incomplete data, MCO, PIHP, or PAHP administration (subject to the limits in paragraph (c)(4)(ii) of this section), and utilization;

(iii) Rate cells specific to the enrolled population, by--

a. Eligibility category;

b. Age;

c. Gender;

d. Locality/region; and

e. Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

As explained by the American Academy of Actuaries ("AAA"), Medicaid Managed Care rates are actuarially sound if the following applies:

> Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes and the cost of capital.

(See Health Practice Council Practice Note, August 2005, attached as Exhibit 7.) Significantly, the AAA has stated that any certification of actuarial soundness must apply to each individual rate cell. Thus, if one individual rate cell (e.g., pharmacy benefit for adults) is not actuarially sound, the entire rate is not actuarially sound.

The District's capitation rate for the 774/775 population, which includes payment for pharmacy services, does not meet the above-referenced standards. In particular, the rates set by the District do not appropriately account for the actuarial experience of 774/775 population. The original Contract rates did not include pharmacy services at either the increased utilization rates, the increased number of prescriptions per utilizing member, or the increased costs of brand name drugs per member that are utilized by the 774/775 population.

As the attached data analysis indicates, the transfer of 774/775 population effected a significant change in the "[b]ase utilization and cost data" of the Medicaid managed care population See e.g., 42 C.F.R. §438.9(c). These higher utilization rates and increased cost have resulted in significantly higher costs to Chartered.

As the data indicates the District's capitation payment for pharmacy, when compared to the actual and projected pharmacy costs are not actuarially sound. The pharmacy capitation rates fail to account for the changes in population and utilization rates in the transfer of the 774/775 population. These actuarially unsound rates violate Section B.3 of the Contract and the applicable federal regulation. The District must reassess its rates and set rates that are actuarially sound.

B. Charted is Entitled to an Equitable Adjustment for the Unanticipated Changes Caused by the Transfer of the 774/775 Populations.

Chartered is requesting an equitable adjustment in the amount of $25,771,117 to cover the shortfall engendered by implementation of the transfer of the 774/775 populations. This request is appropriate and reasonable.

The proper measure for an equitable adjustment is the difference between the cost of the work required by the original Contract terms and the reasonable cost of performing the work as changed. In re Precision Dynamics, Inc., 05-2 BCA ¶ 33071 (Sep. 14, 2005) (citing Celesco Indus., Inc., 79-1 BCA ¶ 13604, at 66,683); Sauer, Inc. v. Danzig, 224 F.3d 1340, 1348 (Fed. Cir. 2000). There are two key factors in determining the inclusion of costs in an equitable adjustment. First, the additional effort necessary to perform the changed work above the effort necessary to perform the Contract as originally written and second, whether the costs claimed for the additional effort are reasonable. Prince Constr. Co., Inc. DCCAB No. D-1127, 2003 WL 21235618 (May 12, 2003).

Chartered's request meets both of those requirements. As detailed above, Chartered has been required, by the District of Columbia Department of Human Services notification dated August 26, 2010, ("**Policy Change**"), to perform work above that contemplated by the Contract as originally written. See Exhibit 8. The Contract, when executed, did not require the provision of pharmacy services for the 774/775 population at Medicaid rates as is now required by the Policy Change. Moreover, the Contract, when executed did not contemplate the increase in utilization rates of drugs otherwise seldom used by the legacy Medicaid population.

In short, the transfer of 774/775 populations required an increase in benefits unaccounted for in the original Contract or its subsequent renewals. As such, such costs are above the efforts required to perform the Contract as originally written or renewed.

In addition, Chartered's costs are eminately reasonable given the requirements of the 774/775 population transfer. Chartered is now required to meet the Policy Change which includes significantly higher utilization of HIV/AIDS drugs. Nevertheless, and despite the District's unwillingness to establish an actuarially sound rate, Chartered has provided services while it contained costs to the best of its ability. An example of the one cost containment initiative is Chartered's work with Caremark, its pharmacy benefits manager, to increase the use of generic substitutes for the 774/775 population. However, in spite of such actions, as well as other efforts, additional cost efficiencies will not compensate for the ever increasing prescription drug requirements of the 774/775 population.

In summary, Chartered has suffered additional costs that were not covered by the original Contract or any renewals. Moreover, these costs are reasonable. As such, Chartered is entitled to an equitable adjustment for the 2010-2011 Contract year in the amount of $25,771,117 for the loss incurred through October 31, 2011 and projected loss through April 30, 2012.

IV. REQUESTED RELIEF

As indicated above, Chartered requests that the District (1) set actuarially sound rates that account for the 774/775 population with respect to pharmacy benefits; (2) pay to Chartered $25,771,117 for the District's failure to set an actuarially sound rate for the period of January 2011 through April, 2012; and (3) as an alternative to #2 above, Chartered requests an equitable adjustment in the amount of $25,771,117 for the changed circumstances occasioned by the implementation of the 774/775 population transfer.

V. CONCLUSION

For the foregoing reasons, Chartered requests that the Contracting Officer meet with Chartered to resolve this matter and if not resolved to issue a final decision on this claim within ninety (90) days of receipt of this claim granting all relief requested in this claim. To the extent that it will not delay the issuance of, or waive Chartered's right to, a Contracting Officer's final decision, Chartered remains willing to discuss this claim and reach a negotiated resolution if possible. Please do not hesitate to contact the undersigned if you have any questions or would like to discuss the claim.

Sincerely,

Clifford E. Barnes

Enclosures

cc: Ganayswaran Nathan
Lisa Truitt
Maynard G. McAlpin

Exhibit List

Exhibit 1	February 9, 2011 Letter from Chartered to Lisa Truitt
Exhibit 2	Copy of OMC/DC Chartered Monthly Meeting Presentation dated September 15, 2011
Exhibit 3	September 30, 2011 Letter from Chartered to Wayne Turnage
Exhibit 4	Pharmacy Deficit Calculations
Exhibit 5	Chart of Projected Loses
Exhibit 6	Top 3 HIV Drug Spend
Exhibit 7	Health Practice Council Practice Note, August 2005
Exhibit 8	Memo dated August 26, 2011 regarding correction for Childless Adult Medicaid

EXHIBIT 1

CHARTERED HEALTH·PLAN

February 9, 2011

Ms Lisa Truitt
Interim Associate Director/Project Manager
Department of Health Care Finance
Office of Managed Care
899 North Capitol St., NE Suite 6037
Washington, DC 20002

Dear Lisa,

The Department of Health Care Financing (DHCF) has announced that it intends to transfer the administration of the DC Health Care Alliance program pharmacy benefit from the current Unity clinic based dispensaries to the MCOs' pharmacy Benefit Management (PBM) programs as of May 1, 2011. Recent experience with former Alliance members transferred to the Medicaid program (the "774" and "775" populations) raises serious questions about how such a transition must be handled in order to avoid adverse impact to the MCOs.

The Alliance pharmacy has historically been "carved-out" of the MCO contracts, with the exception of "formulary overrides" where needed prescriptions were outside the list of drugs available through the District's purchasing arrangement with Department of Defense, or for prescriptions requiring filling after hours and on weekends when the Unity sites were not open (resulting in the MCO PBMs providing up to a 72 hour supply). This resulted in an Alliance pharmacy category of care cost to Chartered of $1- 2 per member per month (PMPM).

DHCF has consistently maintained that the process of direct purchasing, inventorying, distributing to clinics and, ultimately, dispensing these medications, coupled with the use of the functionally limited former D.C. General pharmacy accounting system, precludes the ability to calculate an accurate pharmacy PMPM cost for the Alliance transfer population. Chartered's experience since July, 2010, gained from providing full pharmacy coverage to the Alliance population that transferred to Medicaid rolls, however, has allowed Chartered to monitor and accurately classify and quantify these pharmaceutical costs. The results of this analysis demonstrate a demand that is at considerable variance with the utilization pattern of Chartered's "legacy" Medicaid population.

As can be readily seen in the attached charts depicting Chartered's pharmacy experience pre-and-post transition of Alliance members, the rate of *utilizing members per month* is elevated by more than 50% in the 774/5 population (33% vs. 21% in December 2010). The *average scripts per utilizing member* is similarly elevated by more than 50% in this 774/5 population (3.8 vs. 2.5). These factors compound to create a utilization rate more than 140% above the legacy Medicaid volume of scripts (125 scripts per 100 members vs. only 52 scripts per 100 historic Medicaid beneficiaries.

D.C. CHARTERED HEALTH PLAN, INC.
1025 15th Street, NW • Washington, DC 20005-2601 • Tel: 202.408.4720 • Fax: 202.408.4730

This substantial increase in *volume* of scripts is further aggravated by an escalation in the *average cost of ingredients* for brand name prescriptions used by the 774/5 populations. As documented in the attachments, Chartered's average Medicaid branded prescription ingredient cost has had a stable (even decreasing) trend, in the range of $170.00. The 774/5 branded prescription cost started in that range but has steadily increased to a level in excess of $220.00. All of these factors ultimately create a monthly pharmacy cost for this population of $65.93 in comparison to $27.10 for the legacy Medicaid population.

The escalation in total cost and branded ingredient cost is driven in part by an extraordinary increase in the volume of HIV spectrum drugs. A comparison of the populations reveals that in January 2011, the 19,079 members of the 774/5 group used $515,326 in HIV medications, while the 76,865 members of the legacy Medicaid group utilized only $419,107 of these drugs, for a *$21.56 PMPM cost difference* for this category of drugs. The $27.01 expense for these medications for the 774/5 groups is almost equal to the *entire* pharmacy cost of $27.10 for the legacy population, which includes HIV drugs. The population of unique utilizers of this spectrum of medications within the 774/5 groups is 257, compared to 215 in the far larger historic population; a penetration rate of 1.3% compared to an historic rate of only 0.3%, with an average cost for *these drugs alone*, of $2,000.00 per month for such utilizers.

Chartered is willing to work with DHCF to transfer the Alliance pharmacy benefit from the current Unity-based arrangement to a distribution model using our PBM and pharmacy network, but in light of the above cited experience Chartered must require that any such arrangement be done on an administrative services organization (ASO) only basis until sufficient experience is available to quantify and price this risk. Please let me know when we can get together to plan how to move forward with this transition.

Sincerely,

Francis Smith
Interim President and CEO

Attachments: Pharmacy Utilization graphs/tables

DC Chartered Health Plan

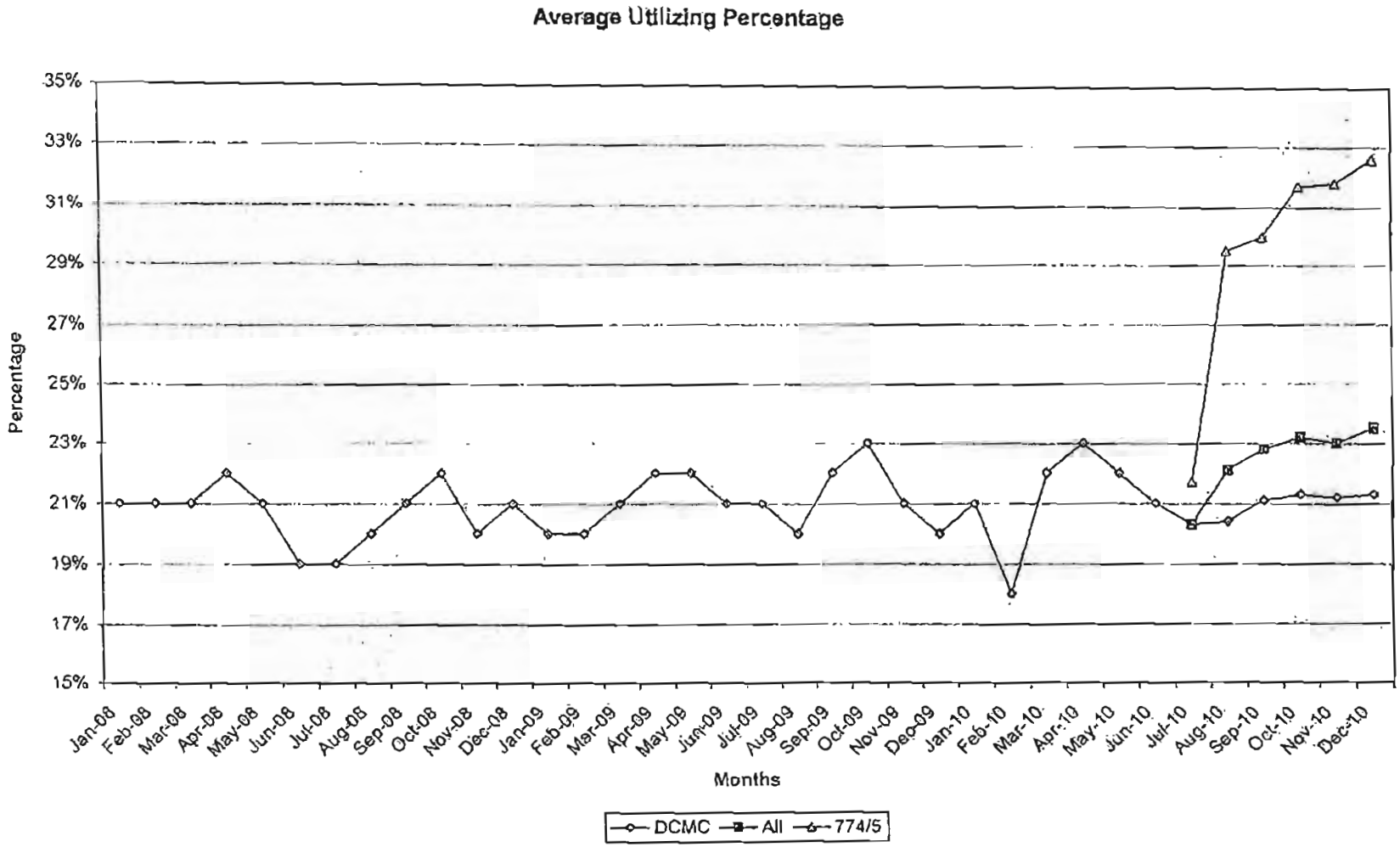
Pharmacy Utilization Analysis

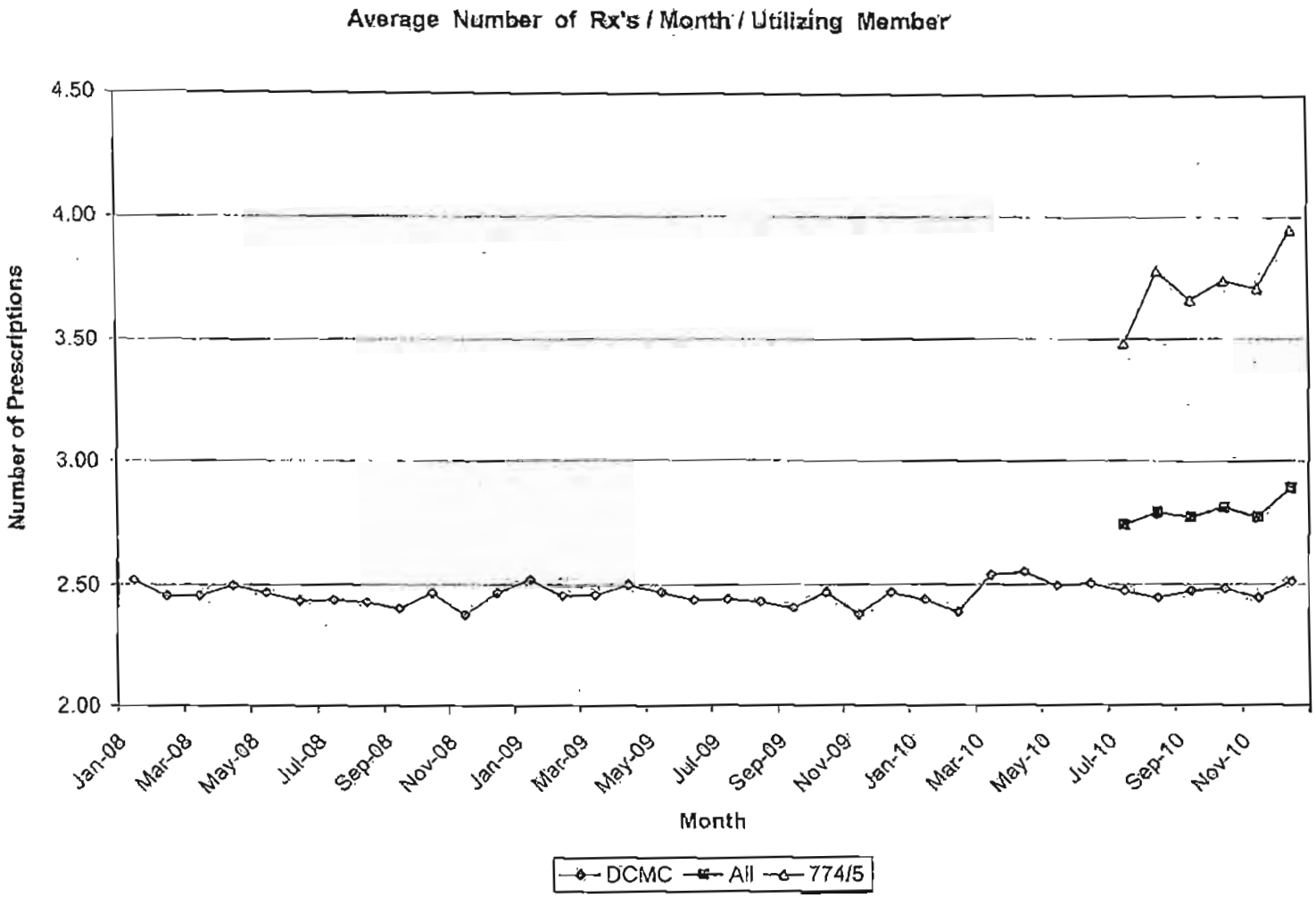
Comparison of

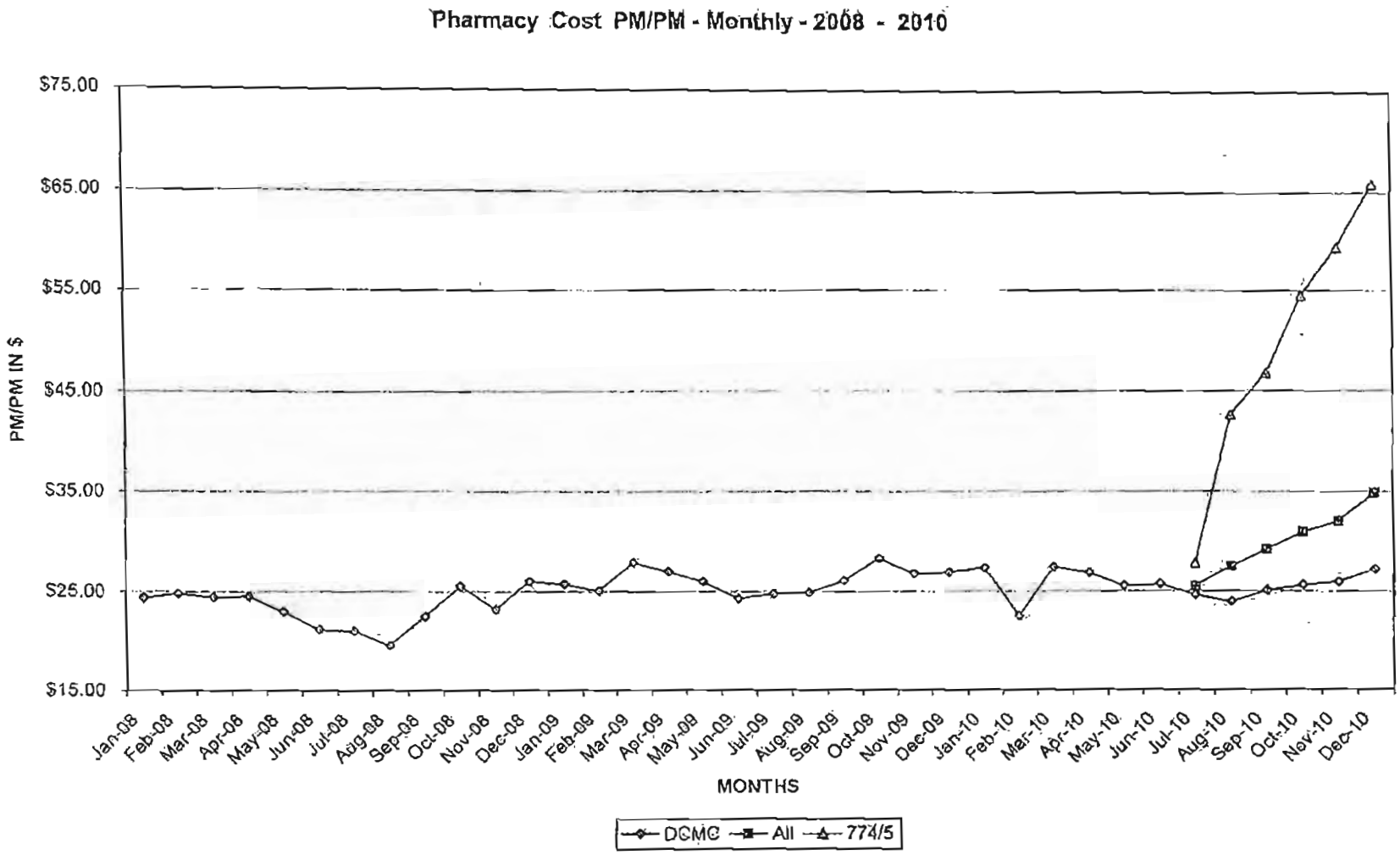
Historic Medicaid Population
and
Alliance Members Transferred to Medicaid (774/5)

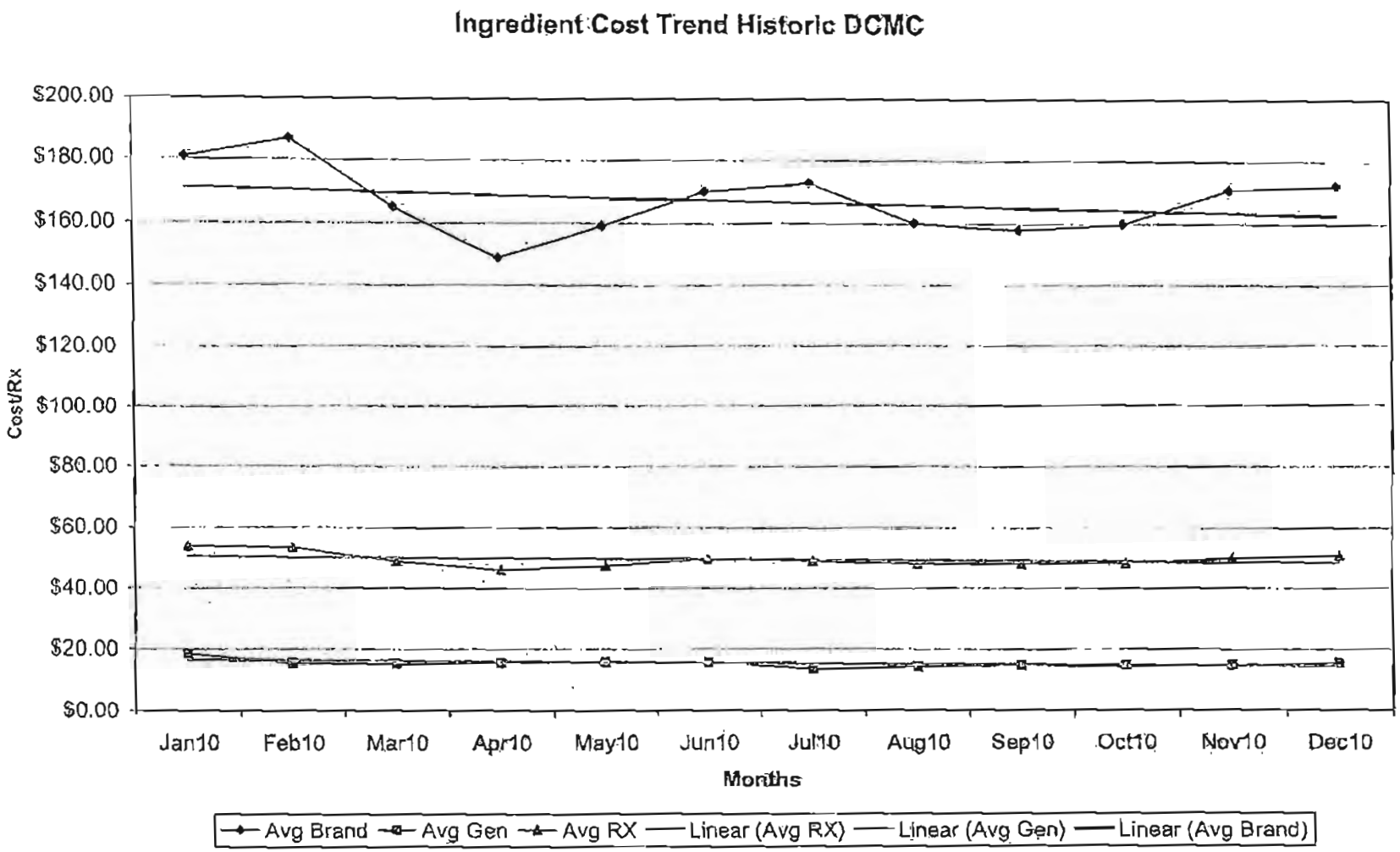
(July - December, 2010)

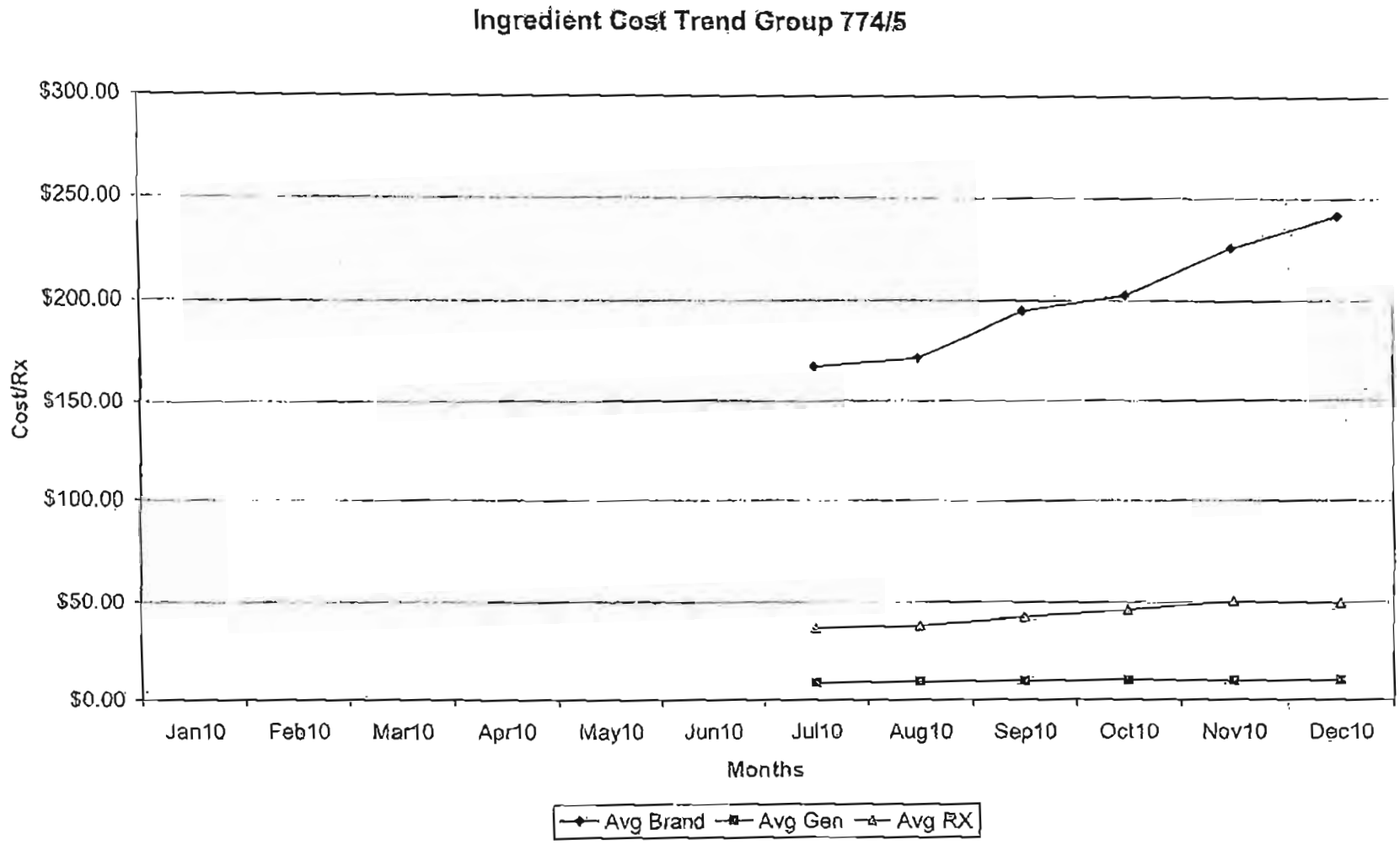
- Average Utilizing Percentage – showing historic Medicaid population at consistent 21% average utilization over three year period 2008 – 2010, with Alliance transferees utilizing at 30+% rates
- Average Scripts per Month for Utilizing Members – showing historic rate of 2.5 or fewer scripts, in comparison to Alliance transferees accessing approximately 3.8 scripts per utilizing member per month
- Ingredient Cost Trend – two graphs showing cost trend for prescriptions, with essentially consistent and flat ingredient costs for generic scripts, but diverging (and increasing) costs for branded scripts
- Pharmacy Cost PM/PM – demonstrating long term (3 yr) pharmacy cost stability for historic Medicaid population in comparison to Alliance transferees
- HIV Drug Utilization Comparison – two tables demonstrating extraordinary difference in HIV drug use by Alliance transferees


Average Utilizing Percentage
35%
33%
31%
29%
27%
25%
23%
21%
19%
17%
15%
Percentage
Jan-08
Feb-08
Mar-08
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Months
DCMC
All
774/5


Average Number of Rx's / Month / Utilizing Member
Number of Prescriptions
4.50
4.00
3.50
3.00
2.50
2.00
Jan-08
Mar-08
May-08
Jul-08
Sep-08
Nov-08
Jan-09
Mar-09
May-09
Jul-09
Sep-09
Nov-09
Jan-10
Mar-10
May-10
Jul-10
Sep-10
Nov-10
Month
DCMC
All
774/5


Pharmacy Cost PM/PM - Monthly - 2008 - 2010
$75.00
$65.00
$55.00
$45.00
$35.00
$25.00
$15.00
PM/PM IN $
Jan-08
Feb-08
Mar-08
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
MONTHS
DCMC
All
774/5


Ingredient Cost Trend Historic DCMC
$200.00
$180.00
$160.00
$140.00
$120.00
$100.00
$80.00
$60.00
$40.00
$20.00
$0.00
Cost/Rx
Jan10
Feb10
Mar10
Apr10
May10
Jun10
Jul10
Aug10
Sep10
Oct10
Nov10
Dec10
Months
Avg Brand
Avg Gen
Avg RX
Linear (Avg RX)
Linear (Avg Gen)
Linear (Avg Brand)


Ingredient Cost Trend Group 774/5
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$0.00
Cost/Rx
Jan10
Feb10
Mar10
Apr10
May10
Jun10
Jul10
Aug10
Sep10
Oct10
Nov10
Dec10
Months
Avg Brand
Avg Gen
Avg RX

Brand Name	AVG Amount Paid	Total Rxs	Utilizers	Total cost/Drug	Total Cost/Utilizing Member
ATRIPLA	$2,586.53	120	114	$290,383.62	$1,670.03
TRUVADA	$1,001.80	100	94	$102,180.00	$1,087.02
REYATAZ	$956.60	71	62	$67,918.82	$1,061.23
NORVIR	$277.38	106	97	$29,401.95	$303.11
PREZISTA	$948.70	28	27	$26,563.66	$983.84
EPZICOM	$917.82	24	22	$22,027.68	$1,001.26
ISENTRESS	$959.29	24	23	$23,022.96	$1,001.00
COMBIVIR	$849.21	13	13	$11,039.73	$849.21
KALETRA	$720.23	14	14	$10,083.22	$720.23
LEXIVA	$821.22	11	9	$8,923.37	$991.49
VIREAD	$712.20	10	10	$7,122.00	$712.20
VIRAMUNE	$522.17	8	8	$4,177.36	$522.17
INTELENCE	$777.55	4	4	$3,110.20	$777.55
TRIZIVIR	$1,374.56	2	2	$2,749.12	$1,374.56
SUSTIVA	$567.50	5	5	$2,837.50	$567.50
EMTRIVA	$400.56	3	3	$1,201.68	$400.56
ZIAGEN	$526.85	2	2	$1,053.70	$526.85
DIDANOSINE	$247.65	4	4	$990.60	$247.65
EPIVIR	$392.47	1	1	$392.47	$392.47
STAVUDINE	$111.25	2	2	$111.25	$111.25
ZIDOVUDINE	$35.50	1	1	$35.50	$35.50
		552	518	$525,326.28	

HIV DRUG PM/PM COST FOR All 774/5 $17.01

PM/PM Utilizing members $2,005.16

JANUARY 2011 HIV DRUG UTILIZATION 774/5 GROUPS

774	237	Unique Members
775	20	Unique Members
	257	Total

Brand Name	Avg. Amount Paid	Total Rxs	Utilizers	Total Drug Cost	Carrier	Group	Total Cost/Utilizing Member
ATRIPLA	$ 1,586.87	70	64	$ 111,080.69	2740	5000	$1,735.64
COMBIVIR	$ 849.21	23	23	$ 19,531.83	2740	5000	$849.21
DIDANOSINE	$ 221.94	4	4	$ 887.74	2740	5000	$221.94
EMTRIVA	$ 234.29	2	2	$ 468.57	2740	5000	$234.29
EPIVIR	$ 397.70	5	5	$ 1,988.48	2740	5000	$397.70
EPZICOM	$ 917.82	17	17	$ 15,602.94	2740	5000	$917.82
INTELENCE	$ 786.72	4	4	$ 3,146.88	2740	5000	$786.72
ISENTRESS	$ 959.29	22	22	$ 21,104.38	2740	5000	$959.29
KALETRA	$ 669.06	23	22	$ 15,388.38	2740	5000	$699.47
LEXIVA	$ 743.74	5	5	$ 3,718.70	2740	5000	$743.74
NORVIR	$ 301.29	87	85	$ 25,212.05	2740	5000	$308.38
PREZISTA	$ 980.88	24	24	$ 23,541.00	2740	5000	$980.88
REYATAZ	$ 949.38	61	59	$ 57,912.33	2740	5000	$981.56
SELZENTRY	$ 894.77	2	2	$ 1,789.54	2740	5000	$894.77
STAVUDINE	$ 86.02	5	4	$ 430.09	2740	5000	$107.52
SUSTIVA	$ 567.50	4	4	$ 2,270.00	2740	5000	$567.50
TRIZIVIR	$ 1,374.56	5	5	$ 6,872.80	2740	5000	$1,374.56
TRUVADA	$ 1,033.80	85	82	$ 87,873.30	2740	5000	$1,071.63
VIRACEPT	$ 722.04	6	5	$ 4,332.24	2740	5000	$866.45
VIRAMUNE	$ 412.10	5	4	$ 2,060.50	2740	5000	$515.13
VIREAD	$ 664.20	15	15	$ 9,962.98	2740	5000	$664.20
ZIAGEN	$ 530.76	5	5	$ 2,653.78	2740	5000	$530.76
ZIDOVUDINE	$ 69.44	4	4	$ 277.77	2740	5000	$69.44
				$ 419,106.97			

HIV MED COST PM/PM All Members $5.45

PM/PM Utilizing Members $1,949.33

UNIQUE UTILIZING MEMBERS = 215

JANUARY 2011 "LEGACY" MEDICAID HIV DRUG UTILIZATION

CHARTERED
HEALTH·PLAN

[redacted]

OMC/DC Chartered Monthly Meeting

September 15, 2011

CHARTERED HEALTH PLAN

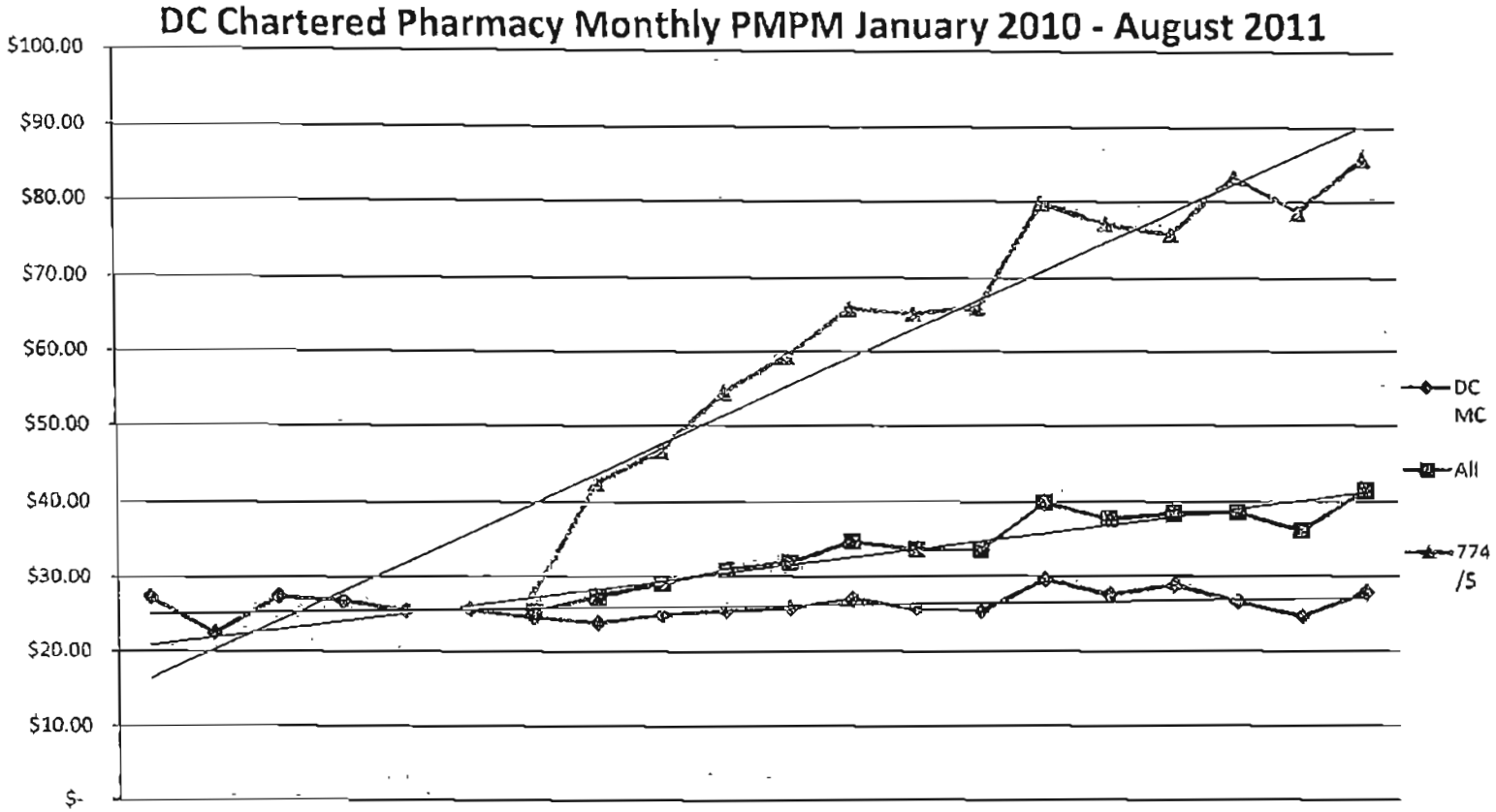
Agenda

- Pharmacy Management 774/775
- Pharmacy Changes Approved at P&T
- Enrollment Broker Transition
- Updates (Innovation and Community Engagement)
- Salazar Rate
- Follow-up Items from August 18th Meeting

CHARTERED HEALTH·PLAN

Variance

- Mercer data implied funding $23.16 PM/PM
- CHP trend average Mar. – Aug. 2011 $41.44 PM/PM
- CHP is underfunded by $18.28 PM/PM
- Implication for the months of August with a Medicaid membership of 97,354 is a loss of $1,779,630
- **Annualized loss of $21,355,572**



	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
DCMC	$27.	$22.	$27.	$26.	$25.	$25.	$24.	$23.	$24.	$25.	$25.	$27.	$25.	$25.	$29.	$27.	$28.	$26.	$24.	$28.0
All							$25.	$27.	$29.	$30.	$31.	$34.	$33.	$33.	$39.	$37.	$38.	$38.	$36.	$41.4
774/S							$27.	$42.	$46.	$54.	$59.	$65.	$65.	$65.	$79.	$77.	$75.	$83.	$78.	$85.8

Top 3 HIV Drug Spend

- 774/775
- Period: January to July 2011
- Average Membership: 19839
- Top 3 Drugs total spend: $2,924,484
- Average spend per month: $417,783
- Cost per member per month: $21.06

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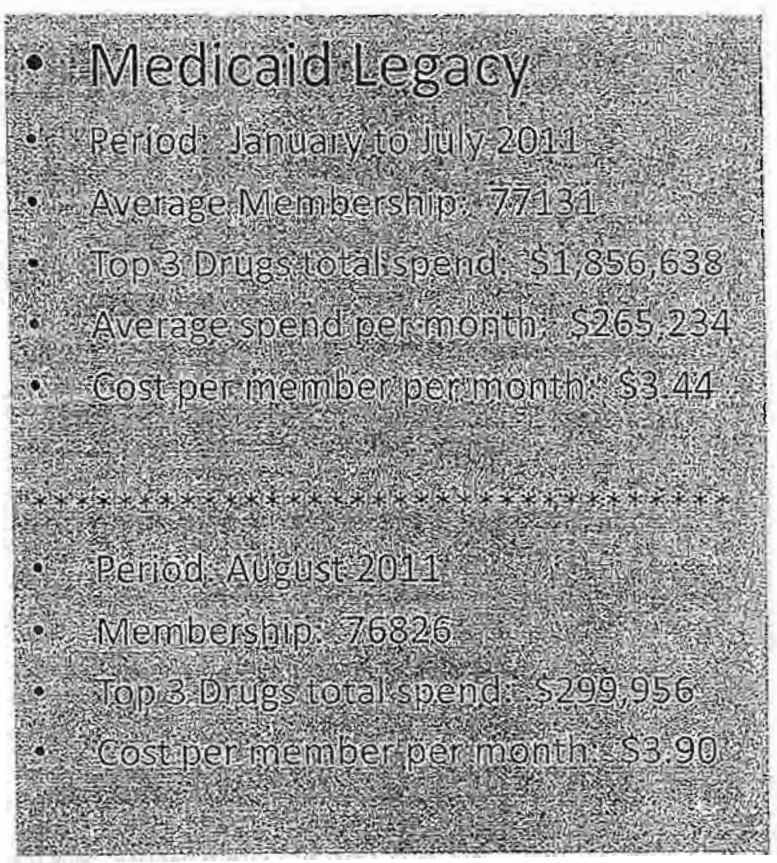
- Period: August 2011
- Membership: 20737
- Top 3 Drugs total spend: $502,374
- Cost per member per month: $24.23



CHARTERED HEALTH PLAN

Recommendation

[redacted]

Background

Alliance historically carved out with the exception of pharmacy overrides (DOD Pricing). Cost to CHP was only $1-2 PM/PM.

Recommendation: Carve out HIV Drugs for 774/775 population.

State	Partial Carve-Out
CA & MI	Mental Health, HIV/AIDS & Substance Abuse
OR	Mental Health
WA	HIV/AIDS (protease inhibitors only)
KS	Hemophilia
MD	Mental Health & HIV/AIDS
NJ	Mental Health (only atypical antipsychotics) & Substance Abuse

Source: Avalere analysis, updated July 2010

CHARTERED HEALTH PLAN

Rate Adjustment

- Section B.3.1 "In the event that the District ... adds, deletes, or changes any services to be covered by the Contractor under DCHFP or the Alliance Program the District will review the effect of the change and equitably adjust the capitation rate."
- Effective October 1, 2011 DHCF adjust the pharmacy PM/PM to accommodate the current overall trend for all Medicaid members by $18.00 PM/PM.
- A retroactive adjustment to accommodate the periods prior to October 1, 2011 and subsequent to July 1, 2010 for the actual cost experienced for all Medicaid members of a $12.28 PM/PM delta or $17,835,349.

CHARTERED HEALTH PLAN

Pharmacy Program Changes

Approved at P&T on 9/7/11

- Inhaled Steroid step therapy
- Removal of branded Proton Pump Inhibitor from the formulary (Nexium)
- Diabetic testing agent conversion
- Generic Antidepressant Step Therapy
- Lyrica Step Therapy
- Step Therapy for inhaled steroid/beta agonist therapy

CHARTERED HEALTH·PLAN

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- Collaboration Project with Chartered and Common HealthAction organization
  - Involve Community Health Workers (HIV Positive Women) and the Outreach Department
- Research indicates the Community Health Worker programs demonstrate improvement in the following outcome indicators
  - Domains of attitudes and cognition
  - HIV and use of Antiretroviral therapy
  - Sexual risk behaviors
  - Substance Abuse
- Community Health Worker Program as compared to current standards of care
  - Offers a practical and cost-effective alternative ----improve medication adherence------decrease HIV viral load & increased CD4 counts among HIV positive populations in the United States.

EXHIBIT 3

CHARTERED HEALTH PLAN

September 30, 2011

Mr. Wayne Turnage
Director
District of Columbia
Department of Health Care Finance
899 North Capital Street, NE, 6th Floor
Washington, DC 20002

RE: Pharmacy Cost for 774 and 775 Populations

Dear Mr. Turnage:

DC Chartered Health Plan, Inc. (Chartered) and appreciates your efforts to reestablish the positive partnership between Chartered and the Department of Health Care Finance. As you will recall, Chartered during the 2011-2012 Contract Year capitation rate negotiations, raised the issue regarding the escalating cost of providing pharmacy benefits to the 774 and 775 populations. At that time, we advised you that these groups were newly transferred from the Alliance Program to the Medicaid Managed Care Program and that initial indications were that the drug utilization greatly exceeded our experience with our legacy population. At that time, you promised that if this trend proved to be a problem, we could bring the matter back to you for further consideration. Chartered's experience with the 774 and 775 populations has continued to show that their pharmacy utilization will greatly exceed anything experienced by Chartered in the past and presents a serious, adverse financial exposure, and Chartered needs your assistance to help resolve this matter.

During Chartered's September 12th, regular monthly meeting with Lisa Truitt, we made a presentation that outlined the financial challenges presented by the pharmacy utilization of the 774 and 775 members. A copy of that presentation is enclosed. The 774 and 775 population has a high number of members who require HIV/AIDS drugs among other medications. In fact, Chartered's HIV/AIDS population more than doubled when these members were transferred from the Alliance Program. In the past, HIV/AIDS medications were provided through the Ryan White Program; however, once these individuals were transfer to Medicaid, the responsibility for providing these drugs was transferred to Chartered. The cost of providing these drugs has not been in Chartered's prior financial experience, and the result has been an unprecedented increase in pharmacy utilization and expense. As indicated in the enclosed presentation, it is our understanding that the capitation rates, as certified by Mercer, anticipated a pharmacy expenditure of $23.16 per member per month (pmpm). However, Chartered's expense between March and August has averaged $41.44 pmpm because of the cost of supplying these very expensive medications. Therefore, Chartered is underfunded by $18.23 pmpm. If let unaddressed, Chartered potentially will face an annual loss of $21,355,572. This trend does not

appear to be abating. In the month of August alone, Chartered experienced a $1,779,630 excess pharmacy cost.

Chartered, in conjunction with Caremark, our pharmacy benefit manager has taken every measure that it can, without compromising member care, to control our pharmacy spend. Nevertheless, this adverse pharmacy trend continues. In order to address this untenable situation, Chartered requires a capitation increase of $18.00 pmpm effective October 1, 2011 and to remediate the losses already sustained from the 774 and 775 pharmacy utilization, a lump sum payment of $17,835,349.

We urgently request a meeting with you to seek an expeditious resolution of this matter. I will contact your assistant to arrange this meeting. If, in the interim, you have any questions, please feel free to contact me.

Sincerely,

Maynard McAlpin
President and CEO

Enclosure

cc: Mr. Ganayswaran Nathan
Deputy Director
Medicaid Finance

Ms. Lisa Truitt
Associate Director
Medicaid Managed Care

CHARTERED
HEALTH·PLAN

OMC/DC Chartered Monthly Meeting

September 15, 2011

CHARTERED HEALTH PLAN

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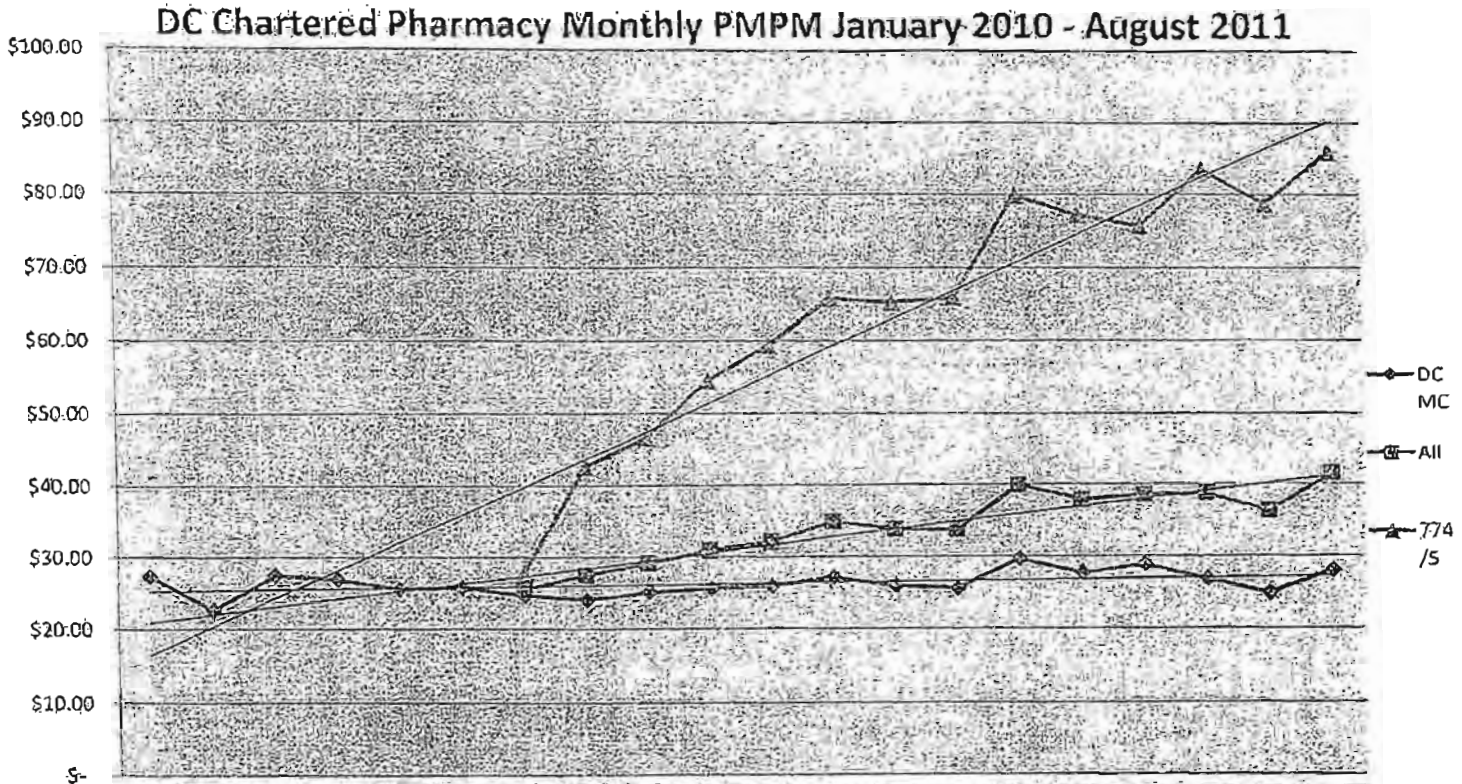
- **Annualized loss of $21,355,572**



	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11
DCMC	$27.	$22.	$27.	$26.	$25.	$25.	$24.	$23.	$24.	$25.	$25.	$27.	$25.	$25.	$29.	$27.	$28.	$28.	$24.	$28.0
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- Cost per member per month: $21.06

****

- Period: August 2011
- Membership: 20737
- Top 3 Drugs total spend: $502,374
- Cost per member per month: $24.23

- Medicaid Legacy
- Period: January to July 2011
- Average Membership: 77131
- Top 3 Drugs total spend: $1,856,638
- Average spend per month: $265,234
- Cost per member per month: $3.44

****

- Period: August 2011
- Membership: 76826
- Top 3 Drugs total spend: $299,956
- Cost per member per month: $3.90

CHARTERED HEALTH PLAN

Recommendation

Background

Alliance historically carved out with the exception of pharmacy overrides (DOD Pricing). Cost to CHP was only $1-2 PM/PM.

Recommendation: Carve out HIV Drugs for 774/775 population.

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CHARTERED HEALTH PLAN

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  - Substance Abuse
- Community Health Worker Program as compared to current standards of care
  - Offers a practical and cost-effective alternative ---improve medication adherence-----decrease HIV viral load & increased CD4 counts among HIV positive populations in the United States.

EXHIBIT 4

PHARMACY DEFICIT

To calculate the deficit in the Pharmacy component of Chartered's capitation rates, I reviewed Chartered's pharmacy experience from August 1, 2010 through July 31, 2011. During that time, Chartered spent **$38,353,291** or **$33.60** per member per month (PMPM) on pharmacy costs. Based upon the DCHF Databook issued in 2010 and the rates that Chartered ultimately received for the 2010-2011 Contract Year, we estimate that DHCF included $22.45 PMPM for pharmacy for the contract period August 1, 2010 through July 31, 2011. Therefore, I estimate that Chartered received **$25,625,934** for pharmacy over that time period. Chartered, then, was underfunded for its pharmacy costs by **$12,727,357** or **$11.14** PMPM. The pharmacy spend on our legacy Medicaid members averaged **$25.66** PMPM through July 31, 2011 while the average for the 774 and 775 group averaged **$69.06** PMPM. It follows that **$9,063,247.98** or **$7.94** PMPM (**$33.60 - 25.66 = 7.94 x 1,141,467 = $9,063,247.98**) represents the cost differential between providing the pharmacy benefit to Chartered's legacy Medicaid member and the 774 and 775 populations for the period August 1, 2010 through July 31, 2011.

For the period August 1, 2011-October 31, 2011, the problem is getting even more acute. Using the 2011 Databook and the rates that we received for the 2011-2012 Contract as a guide, Chartered estimates that it is now receiving $25.62 for Pharmacy. Therefore based upon our Medicaid membership, we received **$7,499,743** for the pharmacy component. Chartered spend for pharmacy for those two months was **$12,101,914** or **41.34** PMPM. This means that Chartered has spent **$4,602,171** more for pharmacy than it was paid since the new rates were put into effect on August 1st and that we are currently underfunded in the pharmacy component by **$15.72** PMPM. To make matters worse pharmacy cost are growing at an overall rate of almost 2% per month. Chartered had placed DHCF on notice that the pharmacy trend was significantly higher because of the 774 and 775 members, but to our knowledge this was not considered in setting the new rates. As a result, Chartered should be made whole for this entire loss.

In addition, going forward, Chartered needs a rate increase to prevent the growth of this deficit.


5

Period	Member Counts	PMPM	Pharmacy Cost	District Capitation Payment Pharmacy Component	Projected PMPM Allocation for Pharmacy in Capitation Payment from District	Loss due Pharmacy Actual Expense	% Change to Prior Month for Membership	% Change to Prior Month for Pharmacy Cost
Aug-10	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Sep-10	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Oct-10	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Nov-10	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Dec-10	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Jan-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Feb-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Mar-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Apr-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
May-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Jun-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Jul-11	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Aug-11	97854	$ 40.44	$ 3,937,354.00	$ 25.62	$ 2,494,209.48	$ (1,443,144.52)	100.68%	110.18%
Sep-11	97622	$ 41.32	$ 4,029,295.00	$ 25.62	$ 2,498,513.64	$ (1,530,781.36)	100.17%	102.34%
Oct-11	97668	$ 42.34	$ 4,135,265.45	$ 25.62	$ 2,502,261.41	$ (1,633,004.05)	100.15%	102.63%
Nov-11	97815	$ 43.39	$ 4,244,022.95	$ 25.62	$ 2,506,014.80	$ (1,738,008.14)	100.15%	102.63%
Dec-11	97962	$ 44.45	$ 4,355,640.74	$ 25.62	$ 2,509,773.87	$ (1,845,866.92)	100.15%	102.63%
Jan-12	98108	$ 45.56	$ 4,470,194.09	$ 25.62	$ 2,513,528.49	$ (1,956,665.61)	100.15%	102.62%
Feb-12	98256	$ 46.69	$ 4,587,760.20	$ 25.62	$ 2,517,308.79	$ (2,070,451.41)	100.15%	102.63%
Mar-12	98403	$ 47.85	$ 4,708,418.29	$ 25.62	$ 2,521,084.76	$ (2,187,333.54)	100.15%	102.63%
Apr-12	98553	$ 49.05	$ 4,832,249.68	$ 25.62	$ 2,524,865.38	$ (2,307,383.31)	100.15%	102.63%
Totals			$ 78,430,855.42		$ 48,213,505.73	$ (30,217,349.70)		

Adjustment Sept compared to Jan	Adjustment Sept compared to Jan
101.07%	123.68%
Average first 9 months	Average first 9 months
100.13%	103.04%

EXI T 6

Top 3 HIV Drug Spend

- 774/775
- Period: January to July 2011
- Average Membership: 19839
- Top 3 Drugs total spend: $2,924,484
- Average spend per month: $417,783
- Cost per member per month: $21.06

****

- Period: August 2011
- Membership: 20737
- Top 3 Drugs total spend: $502,374
- Cost per member per month: $24.23

- Medicaid Legacy
- Period: January to July 2011
- Average Membership: 77131
- Top 3 Drugs total spend: $1,856,638
- Average spend per month: $265,234
- Cost per member per month: $3.44

- Period: August 2011
- Membership: 76826
- Top 3 Drugs total spend: $299,956
- Cost per member per month: $3.90

EXHIBIT 7

HEALTH PRACTICE COUNCIL PRACTICE NOTE

August 2005

ACTUARIAL CERTIFICATION OF RATES FOR MEDICAID MANAGED CARE PROGRAMS

Developed by the
Medicaid Rate Certification Work Group of the
American Academy of Actuaries

AMERICAN ACADEMY *of* ACTUARIES

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The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the actuarial profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also supports the development and enforcement of actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

Members of the Medicaid Rate Certification Work Group include:

P. Anthony Hammond, Chairperson	M. Scott Lockwood
F. Kevin Russell, Vice Chairperson	Gary J. McCollum
Ben S. Brandon	Mary J. Murley
Thomas P. Carlson	David F. Ogden
April S. Choi	Herbert B. Olson
Robert M. Damler	Richard D. Pattinson
Timothy F. Harris	Robert Ruderman
Joann M. Hess	Martin E. Stachlin
Grace C. Kiang	Jill A. Stockard
Julia S. Lambert	Gordon R. Trapnell
Arlene E. Livingston	Todd W. Whitney

This group includes actuaries who have experience performing certifications to the Centers for Medicare and Medicaid Services (CMS) as either consultants to state Medicaid agencies or as state employees, and actuaries who have experience with Medicaid rates, as either employees of, or consultants to, HMOs that contract with states to provide managed health care to Medicaid populations. The work group acknowledges CMS actuary John D. Klemm for coordinating the efforts of the work group with CMS. The group would also like to thank staff at CMS who met with the work group including: Dianne Heffron, Ed Hutton, Brenda Jackson, Bruce Johnson, and Carrie Smith.

HEALTH PRACTICE NOTE 2005-1

August 2005

Actuarial Certification of Rates for Medicaid Managed Care Programs

Developed by the
Medicaid Rate Certification Work Group of the
American Academy of Actuaries

This practice note was prepared by a work group organized by the Health Practice Council of the American Academy of Actuaries. The work group was asked to:

> Review the Centers for Medicare & Medicaid Services (CMS) regulations that require certification of the "actuarial soundness" of Medicaid managed care premium rates;[1]
>
> Determine the extent to which the Academy has addressed the term "actuarial soundness" in any public statements (the Health Committee of the Actuarial Standards Board is reviewing the need for an Actuarial Standard of Practice on this topic); and
>
> Make a recommendation to the Health Practice Council about the best way to proceed on this issue. The work group's recommendation was to publish a practice note. The Health Practice Council approved this recommendation and directed the work to proceed with the drafting of the practice note.

The purpose of this practice note is to provide nonbinding guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs. Examples of responses to certain situations and issues are provided. However, no representation of completeness is made; other approaches may also be reasonable and may currently be in common use. Further, appropriate alternatives to these methods may develop over time and come into common use. Events occurring subsequent to the date of publication of this practice note may make the practices described herein irrelevant or inappropriate.

Since the purpose of this practice note is to provide nonbinding guidance, this practice note has not been promulgated by the Actuarial Standards Board nor by any other authoritative body of the American Academy of Actuaries. The information in this practice note is not binding on any actuary and is not a definitive statement as to what constitutes generally accepted practice in this area. Moreover, this practice note is based upon 42 CFR 438.6(c) and current CMS requirements. To the extent that the legal requirements of a particular state impose additional or conflicting requirements, practices described in this practice note may not be appropriate for actuarial practice in that state.[2]

Comments are welcome as to the appropriateness of the practice note, desirability of updates, substantive disagreements, etc. Comments should be sent to Holly Kwiatkowski, the Academy's senior health policy analyst (federal), at kwiatkowski@actuary.org or American Academy of Actuaries, 1100 17th St. NW, 7th floor, Washington, DC 20036.

1. In this setting, the term "premium rates" refers to all payments under risk contracts and all risk-sharing mechanisms (ref. 42 CFR 438.6(c)(2)). Lump sum payments in risk contracts (and all other payments) outside of premiums are also subject to actuarial soundness certification.
2. Since these situations may exist, it is important for the actuary to bring the specific situation(s) to the attention of the appropriate state officials so a dialogue can be established to find an equitable solution.

Health Practice Council

Practice Note — August 2005

Actuarial Certification of Rates for Medicaid Managed Care Programs

Table of Contents

I. Introduction

Medicaid is a program that provides health care to indigent people in the United States under Title XIX of the Social Security Act of 1965. Created at the same time as Medicare (Title XVIII), both programs are regulated by the Centers for Medicare and Medicaid Services (CMS), an agency of the federal Department of Health and Human Services. Medicaid is financed jointly by the states and the federal government from general tax revenue, with the federal share between 50 and 80 percent of costs. The Title XXI State Children's Health Insurance Program (SCHIP) has a federal share of up to 85 percent. Primary administrative responsibility for Medicaid belongs to the state, with federal oversight. Federal rules require certain populations to be covered and a core set of services to be covered. States are permitted to expand coverage to additional populations and additional services. Medicare, in contrast, is financed and administered federally, with funds from taxes on wages, premiums paid by (or on behalf of) beneficiaries, and general tax revenue. In Federal Fiscal Year 2002, Medicaid outlays ($259 billion federal and state combined) exceeded Medicare outlays ($257 billion) for the first time.[3]

Except for some small-scale voluntary HMO enrollment in a few areas, Medicaid operated almost exclusively on a fee-for-service (FFS) basis from its inception in the 1960s until 1982. Arizona, which until that time had remained outside the Medicaid program, requested a waiver from the requirement to operate Medicaid as an FFS program. The Health Care Financing Administration (HCFA), as CMS was then called, granted Arizona's request and permitted that state to operate its Medicaid program using managed care organizations (MCOs). Other states expressed interest in using MCOs to provide Medicaid benefits, and mandatory MCO enrollment was approved in certain metropolitan areas of Minnesota, Missouri, and Wisconsin. HCFA developed a waiver process by which states could do this, with the provision that the cost of the program under managed care could not exceed the cost, known as the Upper Payment Limit (UPL), of providing the same services on a FFS basis to an actuarially equivalent non-enrolled population group. (See 42 CFR 447.361, now repealed.)

Interest in waivers for Medicaid managed care plans increased throughout the 1990s. By the late 1990s, the UPL requirement was seen as problematic. For some states, Medicaid for certain populations had been delivered exclusively through MCOs for several years, rendering FFS claim experience data on those populations out-of-date. In addition, financial requirements based on a FFS delivery system that had low levels of medical screening, vaccination, and access to health care were seen as increasingly problematic for a managed care delivery system with increased access to necessary health care services and requirements for high levels of medical screening and vaccination.

In recognition of the problem with the UPL requirement, the new 42 CFR § 438.6(c) was enacted in June 2002 to be effective for rates covering periods of August 2003 and later (see Federal Register, Vol. 67, No. 115), and § 447.361 was repealed. In summary, the requirements as stated in § 438.6 (c) are as follows:

(2) *Basic requirements.*

(i) All payments under risk contracts and all risk sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

(3) *Requirements for actuarially sound rates.* In setting actuarially sound capitation rates, the state must apply the following elements, or explain why they are not applicable:

(i) Base utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population.

3 Testimony of Thomas Scully, Administrator, CMS on October 8, 2003, before the House Energy and Commerce Committee Subcommittee on Health.

(ii) Adjustments are made to smooth data and adjustments to account for such factors as medical trend inflation, incomplete data, MCO, PIHP [prepaid inpatient health plan], or PAHP [prepaid ambulatory health plan] administration, and utilization;

(iii) Rate cells are specific to the enrolled population, by—

(A) Eligibility category;

(B) Age;

(C) Gender;

(D) Locality/region; and

(E) Risk adjustments based on diagnosis or health status (if used).

(iv) Other payment mechanisms and utilization and cost assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

(4) *Documentation.* The state must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance that all payment rates are—

(A) Based only upon services covered under the state plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

(iii) The state's projection of expenditures under its previous year's contract (or under its FFS program if it did not have a contract in the previous year) compared to those projected under the proposed contract.

(iv) An explanation of any incentive arrangements, or stop-loss limits or other risk-sharing methodologies under the contract.

Section 438.6(c) defines "actuarially sound capitation rates" as capitation rates that:

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and
- have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Section 438.6(c) also specifies what is not "actuarially sound" under special contract provisions. (The practitioner may wish to refer to Sections III and IV of this practice note for additional information.) For example, the following conditions would result in payments that would not be considered "actuarially sound:"

i. If risk corridor arrangements result in payments that exceed the sum of:
   a. the amount Medicaid would have paid, on a FFS basis, for the state plan services, plus
   b. administrative costs directly related to the provisions of these services.

ii. If contracts with incentive arrangements provide for payment in excess of 105 percent of the approved capitation payments.

Section 438.6(c) requirements for "actuarial soundness" are thus a combination of two types of requirements. The first is the general requirement of being developed in accordance with generally accepted actuarial

principles and practices. The second is the potentially more restrictive requirement that CMS may impose on fiscal arrangements. This practice note concentrates on issues concerning the former. For issues concerning the latter, it is acknowledged that CMS or the states may impose additional restrictions, and this practice note, therefore, addresses only the potential areas of conflict between these requirements and generally accepted actuarial principles and practices.

In a regulation as published in the Federal Register, the section on "Comments and Responses" often is a valuable resource. This preliminary section includes such topics as CMS views on rate adequacy, the establishment of standards for risk and profit levels, and data integrity. Interpretations of these views are further detailed in Section III of this practice note.[4]

The checklist is a step-by-step tool that is expected to be used by the CMS Regional Offices to assess whether the capitation rates submitted by states are "actuarially sound" per the regulatory guidelines. For purposes of this practice note, the July 22, 2003 version of the checklist has been used. It is usually prudent to obtain the most current available version of the checklist when certifying Medicaid rates. Issues concerning risk adjustment techniques (section AA. 5.3 of the checklist) are not addressed at this time, pending the release by CMS of guidance on risk adjustment.

4. The work group that developed this practice note is fully aware of the sensitive issues surrounding the interaction of "actuarial soundness" and rate adequacy. The reader may choose to refer to Section III for a discussion of the issues that are likely to arise as one performs the task of certifying to "actuarial soundness" of rates.

II. Overview of Generally Accepted Actuarial Principles and Practices, and the Term "Actuarial Soundness"

In determining what constitutes generally accepted actuarial principles and practices, the Code of Professional Conduct and, by reference, the Actuarial Standards of Practice (ASOP) have the highest standing. Other items — such as practice notes, textbooks, examination study notes, and articles in professional journals — do not have the same standing. Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for rate certification. Such an ASOP would be unique among health ASOPs, in that it would address actuarial work performed for a *purchaser* of health plan benefit coverage. Other health-related ASOPs have scopes that apply specifically to actuarial work performed on behalf of health plans (the entities that bear the risks).[5] Some health-related ASOPs are general, so that they apply both to health actuarial work performed for health plans or to health actuarial work performed for purchasers of health plan services.[6] Certain other ASOPs are general and not specific to health work, so they could be applicable.[7] Note that ASOP 32 on Social Insurance does not apply to Medicaid. ASOP 32 applies to social insurance programs (such as Medicare, listed in the scope paragraph), which have broad-based eligibility requirements. Medicaid, which is conspicuously not included in the scope paragraph, is a public assistance program with strict income and asset eligibility requirements. The reader may wish to refer to *Social Insurance and Economic Security* by George E. Rejda, chapter 2, for more on the distinction between social insurance and public assistance.

In the ASOPs, there is only one place in which "actuarial soundness" is defined. ASOP 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Benefit Plans*. That standard states:

> Actuarial Soundness — Small employer health benefit plan premium rates are actuarially sound if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums in the aggregate, including expected reinsurance cash flows, governmental risk adjustment cash flows, and investment income, are adequate to provide for all expected costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, and the cost of capital.

The published comments on the exposure draft of ASOP 26 show that the issue of whether and how to describe "actuarial soundness" of small group premium rates was a significant portion of the work performed by the committee that drafted ASOP 26. That committee noted that "many applicable laws ... require the actuary to address *actuarial soundness*," so the committee found it appropriate to address the issue. Please note, however, that the definition of "actuarial soundness" in ASOP 26, like all of the definitions in all of the standards, is specific to that standard, and does not purport to provide a definition of "actuarial soundness" for all areas and types of actuarial practice.

The above discussion of "actuarial soundness" involves knowledge concerning the health benefit plan's expected costs. An actuary working on behalf of a state Medicaid agency to form an opinion concerning the "actuarial soundness" of rates offered to MCOs would not normally have MCO-specific knowledge like that of the actuary working on behalf of the MCO. A workable assessment of "actuarial soundness" for certifications performed on behalf of state Medicaid agencies would usually take into account the following:

1. The data available to develop rates for populations with current coverage:
    - FFS data for the overall program (before introduction of MCO coverage)

5. ASOPs 3, 6, 7, 8, 10, 11, 16, 18, 19, 22, 25, 26, 28, 31, 33, and 37, as well as Actuarial Compliance Guideline (ACG) 4.
6. E.g., ASOPs 5, 12, 23, and 42.
7. E.g., ASOPs 17 and 41.

- FFS data for all but those voluntarily enrolled in an MCO (choice of one or more MCOs and a Primary Care Case Management (PCCM) or other FFS program)
- FFS data for the months before all recipients are mandated to be enrolled in an MCO
- MCO financial data and/or encounter data (utilization and cost per unit service) from a voluntary MCO enrollment period
- MCO financial data and/or encounter data from a mandatory MCO enrollment period.

2. The types of rate negotiation methods that may be in use by states, such as:
   - The state develops a range for each rate category and negotiates with each potential MCO contractor to settle on a rate within the range. This may involve MCOs submitting bids to the state for each rate cell. This likely results in rates that vary among MCOs for the same rate cell. The state may offer inducements for an MCO to bid lower than the others, such as a larger market share of those recipients who decline to select a particular MCO and must therefore be assigned to one.
   - The state negotiates separately with each MCO contractor.
   - The state develops a set of rates and contracts with MCOs that accept these rates as long as these MCOs also satisfy other requirements. Rates do not vary among MCOs, except for risk-adjusted payment methods, such as the chronic illness and disability payment system (CDPS).

3. The financial condition and operations of participating MCOs:
   - Some MCOs may be Medicaid-only and one-state-only, with no other lines of business or states over which to allocate certain administrative costs. In contrast, some MCOs may have other lines of business (Medicare Advantage, commercial group, and commercial individual) or other states' Medicaid business.
   - Some MCOs may not have gained sufficient enrollment to realize efficiencies of administration, but participation of these MCOs may still be desirable for the appropriate functioning of the state's Medicaid managed care program.
   - Some MCOs may be completely independent financial entities, while others could be wholly owned by other corporations that could control a significant portion of the administrative and reinsurance expenses being allocated to their Medicaid-participating subsidiaries.
   - Some MCOs may be for-profit entities that seek to generate a return while others could be not-for-profit MCOs.
   - Some MCOs may have arms-length negotiations with providers, while other MCOs may be owned by facility and/or professional providers.
   - Some PIHPs are government owned and may not participate in competitive procurement.[8]

The work group developed, for purposes of this practice note, the following proposed definition of "actuarial soundness" to apply to Medicaid managed care rates developed on behalf of a state for submission to CMS (based on the description in ASOP 26 shown earlier):

> Actuarial Soundness—Medicaid benefit plan premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement

8. In these instances, while there would normally be an appropriate risk allowance, CMS also believes that it is usually appropriate to use an 'excess revenues – expenses' approach on prior-approved Medicaid waiver services to Medicaid eligibles or returned to the federal government rather than offsetting other taxpayer expenses that, by statute, should not be charged to the Medicaid program (e.g., roads, bridges, stadiums, care to non-Medicaid eligibles, non-Medicaid services under 1903(i)(17) of the SSA).

expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.[9]

This definition is only for purposes of this practice note. It is not applicable to any actuarial practice other than actuarial certification of rates for Medicaid managed care programs and does not have the binding authority of a definition in an ASOP.

Some differences between the proposed definition above and the language in ASOP 26 are addressed in the following paragraphs.

"Governmental stop-loss" is included in the practice note description of "actuarial soundness" in recognition of non-insured stop-loss programs funded by states to cover certain costs in excess of specified amounts, or for certain types of services, or for treatment of certain medical conditions.

The words "reasonable, appropriate, and attainable" clarify that the costs of the Medicaid benefit plan do not normally encompass the level of all possible costs that any MCO might incur, but only such costs as are reasonable, appropriate, and attainable for the Medicaid program. In addition, all expected costs directly related to the Medicaid benefit plan would normally be included.

An actuary may be asked to assist a MCO by providing an opinion as to whether the rates bid by the MCO or offered by a state are "actuarially sound" for that particular MCO.[10] The analysis forming the basis of such an opinion would usually include expected costs specific to that MCO. This is a separate and distinct analysis compared to the analysis performed by the actuary who, on behalf of a state, is forming an opinion concerning the "actuarial soundness" of rates to be offered to MCOs and for submission to CMS.

The paragraph above uses the words "'actuarially sound' for that particular MCO." There is no federal regulatory requirement that rates are to be "actuarially sound" for a particular MCO. However, some states may require MCOs that make rate bids or that accept offered rates to provide the state with an opinion as to the "actuarial soundness" (or an opinion addressing acceptability but not using the term "actuarial soundness") of the rates for that particular MCO. An MCO may reasonably decide to accept rates for a particular year while knowing that it expects an underwriting loss in that year. Such a decision may be a reasonable business decision, given that the MCO is entering a new market or expects underwriting gains to emerge in future periods.

Regardless of the method used to arrive at a contract between a state and an MCO, an actuary advising the MCO is usually prudent to make a reasonable effort to confirm that the MCO's management understands the risks inherent in such a contract. Some states require that MCOs produce an actuarial certification that the contracted rates are sufficient but not excessive. Some states have minimum loss ratio requirements that would apply to Medicaid MCO rates. Actuarial certifications for NAIC annual statements (and quarterly statements, in some states for some MCOs) would typically require the development of deficiency reserves if the Medicaid line of business is expected to operate at a loss until the next premium rate change. Numerous ASOPs apply to the actuarial work performed on behalf of MCOs that accept risk on Medicaid and other recipients.

The remainder of this practice note describes items an actuary may wish to consider when certifying that Medicaid rates meet CMS requirements. These include items from the regulation (including the section on "Comments and Responses") as published in the Federal Register and from the rate-setting checklist. Sample certification language is also included.

9. The work group is sensitive to the issue of, on the one hand, providing a road map to understand rate development, while on the other hand, preserving practitioners' freedom to use actuarial judgment in the setting of individual assumptions. For example, Section IV, Item AA.3.2 provides a more comprehensive list of the usual considerations for expense allowance and profit/risk levels.
10. There is no prohibition on a state relying upon an MCO actuary's opinion. In some competitive bidding instances, there may be times when the state chooses to accept and submit to CMS the plan's certification.

III. The Medicaid Managed Care Regulation (including the "Comments and Responses" section)

Overview

In developing rates for capitated Medicaid managed care programs, actuaries follow the regulatory requirements stated in 42 CFR § 438.6 (c) and are normally familiar with the guidelines stated in the CMS checklist. In particular, CMS recommends that the "Comments and Responses" section preceding the main body of the regulation be reviewed, since it represents CMS's interpretation of the statutory requirements.

This section provides additional clarification of the regulatory requirements, and identifies areas where they appear to conflict with actuarial practices and principles.

Regulatory Requirements and Issues:

1. **Section 438.6(c)(4)(ii) requires that all payment rates be based only upon services covered under the state plan (or costs directly related to providing these services).**

   What are some of the issues related to this requirement? What would CMS allow, and what would actuaries usually do?

We can classify the non-state plan services into the following categories:

a. Substituted services that cannot be built into the rate calculations;
b. Substituted services that require demonstration that their equivalent value in state plan services can be included in the rate calculations;
c. Additional services that cannot be included in the rate calculations; and
d. Additional Medicaid waiver services that can be built into the rate for individuals specifically covered in the waiver (i.e., 1115 or 1915(c) waiver) or into a separate rate for individuals under a 1915(b)(3) waiver."

In the "Comments and Responses" section, it is reported that there were concerns expressed regarding the rule that the state must exclude from the rate calculations any costs related to services that are not in the state plan. The "Comments and Responses" section includes a number of comments that favored the inclusion of these amounts. In general, these comments can be summarized by the statement, "MCOs must maintain the flexibility to be able to arrange for and provide whatever services most efficiently meet the needs of their members, and these alternative services may not be in the state plan." The position of CMS is that it will prevent states from obtaining federal financial participation (FFP) for things such as new b(3) services (a reference to the authorizing clause in Section 1915 of the Social Security Act) or other state-funded services, for which FFP would not ordinarily be available, by including them in an MCO, PIHP, or PAHP contract.

When discussing rates which are based on FFS data, the "Comments and Responses" section says that managed care contractors have the ability to provide services that are in the place of, or in addition to, services covered under the state plan and that these additional or alternative services do not affect the capitation rate paid to the MCO by the state.

In response to a comment about the use of encounter data for setting rates, CMS says, "actuaries must adjust the data to reflect FFS state plan services only. States cannot use ... services not part of the state plan to calculate "actuarially sound" rates. We are open to suggestions from states and their actuaries, but we will not modify the basic principle that rates be based only on services covered under the state plan."

11. Actuaries are normally prudent to verify both that the data are according to waiver/contract services and that they are appropriately interpreting policy and reflecting the impact in calculated rates.

CMS indicates that it will accept a demonstration of cost efficiency for services that are delivered at the health plan's option. For example, in the substitution of sub-acute days for inpatient days, the rate development would usually convert the non-plan services to plan services on a substitution basis. This process is based on detailed encounter data permitting a comparison of the unit cost of the substituted service with the unit cost of the state plan service. This requirement to demonstrate savings may be more difficult (and perhaps impossible) to comply with if services are offered by a health plan to replace other services but are expected to decrease *future* costs, rather than current costs. Prenatal classes might be an example of this type of service. CMS acknowledges that it is important to allow health plans and states the opportunity to justify offering services that are cost efficient. However, there may be services that are offered to provide a better product to members that cannot be easily justified on a cost efficiency basis. These services may be treated as an administrative expense, classified as member services, or viewed as marketing.[12]

The reader may also wish to refer to:

(a) Discussion in Federal Register, p. 41003.
(b) Checklist section 2.4
(c) Practice note, section IV— checklist discussion on AA. 2.4

2. **Section 438.6(c)(5)(iii) specifies that contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered "actuarially sound."**

   What are the issues and what will actuaries normally do to comply?

The requirement that the incentive arrangements may not provide for payment in excess of 105 percent of the approved cap payments is a compliance issue and, if violated, would likely result in the payments being considered by CMS as non-compliant.

3. **In the "Comments and Responses" section, there were discussions that highlight actuaries' concerns regarding "actuarial soundness" — specifically, rate adequacy vs. methodology and process.**

   How is rate adequacy normally addressed?

Rate adequacy is a component of "actuarial soundness."

State rate filings have frequently required an actuarial opinion stating that "the rates are not inadequate, excessive, or unfairly discriminatory." However, the actuary stating the opinion is normally hired by the company filing the rates, either as an employee or as a consultant, and usually has access to the data, assumptions, business plans, etc. that support those rates.

Rate adequacy for Medicaid would normally mean that rates calculated and paid by a state Medicaid agency are likely to cover the costs of the program. The actuary working for the state may only have access to publicly available financial information about the health plans that contract with the state.

12. These non-state plan services may also be covered under a b(3) waiver if the state had previously received one. These waivers were to provide FFP for non-state plan services that were paid for using savings realized in moving to managed Medicaid. However, CMS has taken the position that there will be no new b(3) waivers approved. Existing b(3) waivers have been grandfathered effective August 2003; however, CMS has stated that no new non-state plan services can be added, and that the average increase in costs for the b(3) services cannot exceed the average increases in costs for the state plan services.

It is generally difficult to set any specific administrative targets, either in percentage of capitation or amount per member per month (PMPM), without knowledge of the specific environment in each state – including such items as populations covered, services covered, medical costs, access to health care, and other factors.

The same concept applies to profit/risk levels. It is generally difficult to specify a precise value, and this practice note makes no attempt to do so. However, there would usually be appropriate profit/risk margins included in the capitation rates.

Provider reimbursement and medical management are also usually difficult for an outside observer to predict. Thus, the actuary may choose to make estimates based on what is publicly known about the level of Medicaid managed care in a specific state. The actuary may be able to reasonably estimate the level of management of health care from the encounter data.

The discussions on pp. 40998 and 41001 of the Federal Register contain information relevant to this issue.

4. **In the "Comments and Responses" section, the question is raised whether states will have the flexibility to take into account their FFS budgets, and managed care budget authority, when developing "actuarially sound" rates.**

   How would the actuary usually address this?

"Actuarially sound" rates or ranges of rates depend on the benefits provided and the population covered. These rates are normally independent of budget issues unless benefits or populations change.

In times of economic downturn, state budgets may exert pressure on rates that must be certified as "actuarially sound." This pressure can build as program expenditures are capped, yet "actuarially sound" rates are usually independently determined. In rate-setting, there is normally a range of reasonable assumptions. Budgetary constraints may influence the selection of certain assumptions toward the low end of the range. However, the actuary would usually be prudent to select assumptions that are individually reasonable and appropriate when deriving the final premium rates.

5. **Does the regulation require each rate cell to be "actuarially sound?"**

Section 438.6(c)(2) requires "all payments" to be "actuarially sound." Pages 40998–40999 of the "Comments and Response" section specifically state that "all payments" refers to individual rate cells. CMS appears to be looking for the certification of "actuarial soundness" to apply to each individual rate cell.

CMS also specifies requirements concerning the establishment of rate cells. Section 438.6(c)(3)(iii) requires states to establish rate cells by eligibility category, age, gender, region and risk adjustment (or explain why any of these factors is not applicable). Section AA.4.0 of the checklist indicates that the key principle is that rate cells should be developed *"whenever the average* [which we interpret as "expected"] *costs of a group of beneficiaries greatly differ from another group and that group can be easily identified."*

CMS expects that rates will usually be developed for appropriate rate cells, taking into account the credibility of the data for each rate cell. Where sufficient data are unavailable to establish a rate for a particular cell, the rate would normally be developed based on blended data from that cell and an adjacent cell. Further, separate rate cells would usually be established only where there is a meaningful difference in expected per capita costs.

6. **Section 438.6(c)(5)(ii) specifies that, if risk corridor arrangements result in payments that exceed the approved capitation rates, these excess payments *will not be considered "actuarially sound"* if they result in total payments that exceed the amount Medicaid would have paid, on a fee-for-service basis, for the state plan services actually furnished to enrolled individuals.**

   What are the issues related to this requirement, and what would actuaries normally do?

This requirement is a compliance issue and, if violated, would likely result in the payments being unable to be determined as "actuarially sound."

State payments under risk corridor arrangements in excess of those permitted by CMS do not meet regulatory requirements. Since the contracts involved put the MCO at risk, CMS has determined that a limit on total payments should be established. Therefore, in developing both base rates and risk corridors, the actuary would usually consider the potential range of variation in experience that may emerge, so that in the aggregate the contractual arrangement meets the regulatory requirement under likely scenarios.[13]

13. In situations where there is little or no data on which to base rates, and risk corridors are being used, discussions with CMS may be appropriate to support compliance.

IV. CMS Rate-setting Checklist

CMS provides materials for regional offices to utilize in reviewing and approving contracts and capitation rates associated with Medicaid managed care programs. One of these tools is a checklist to be used by the regional offices in reviewing and approving the rates under 42 CFR 438.6(c) for all Medicaid managed care programs, excluding the PACE capitated programs. An actuary preparing capitation rates for use in Medicaid managed care programs would usually review and become familiar with the most recent version of the checklist. This section of the practice note provides a general overview of the checklist, as well as an outline of areas of the checklist that may have a potential for misinterpretation or may be counter to generally accepted actuarial practice. The comments prepared in this section relate to the checklist entitled "Appendix A. PAHP, PIHP, and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03."

Overview

The checklist was developed by a CMS work group that had previously been involved in the development and/or review of capitation rates for managed care programs. Based on its own experience, as well as the regulatory requirements of 42 CFR 438.6(c), the work group prepared the checklist document to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care capitation rates.

The checklist has been separated into seven primary sections. The rate-setting actuary would usually review the checklist document to become broadly familiar with each of these items. In reviewing the checklist, the rate-setting actuary may find it helpful to recognize that some of the items outlined may not be found in the rate-setting methodology that was used. Several of the items that are identified in the checklist relate to contractual or state regulation. The actuary may want to discuss these items with state Medicaid personnel to identify any likely impact on the rate-setting methodology. The following provides a brief description and overview of each section.

AA.1.0 — *Overview of Rate-setting Methodology.* This section requires documentation regarding the general rate-setting methodology and contract procurement and the actuarial certification. Under the contract procurement section, two methodologies are outlined: open cooperative contracting and competitive procurement. Under the open cooperative contracting methodology, the actuary may establish a single rate for each rate cell the state would use in contracting with the MCOs. Under the competitive procurement methodology, the actuary may establish a range of rates for each rate cell.[14] The actuary's range of rates would normally be used as a guide for either contract negotiations by the state or for submission of bids by the MCOs. A sample of an actuarial certification has been provided in Section VI of this practice note.

AA.2.0 — *Base Year Utilization and Cost Data.* This section outlines the types of data and information that may be used in the establishment of the capitation rate. The checklist indicates that the base year utilization and cost data should be consistent with the Medicaid services and population that will be covered by the contract. With respect to the Medicaid population selection, the actuary would normally become familiar with the different populations that are included or excluded from the MCO contract, including dual-eligibles and spend-down recipients. The checklist allows for the use of Medicaid FFS data, Medicaid managed care data, or non-Medicaid data. The checklist describes the types of services that may be used in the analysis. The checklist provides a description of the requirement for inclusion of state plan services only and possible allowances for additional services.

14. CMS has received some rate ranges based upon "Degree of Health Care Management" whereby the actuary assumed a higher or lower level of "care management" to develop the rates. CMS usually expects to see justification as to why the state or actuary expects a range of rates to be appropriate (e.g., inflation, trend, utilization variances).

AA.3.0 — *Adjustments to the Base-Year Data.* The section outlines the types of adjustments that would be allowed on the base-year data to develop the capitation rates. The checklist provides a listing of many items concerning which the actuary would usually exercise professional judgment to determine the appropriateness of the adjustment based on the underlying base-year data chosen. This section of the checklist illustrates the desirability of a movement from the prior upper payment limit rate-setting calculation methodology to the development of a capitation rate that would be "actuarially sound." For example, the factors reflect adjustments to reimbursement per unit of service,[15] utilization rates, and contractual obligation or benefit differentials so that the rates are "actuarially sound" for the covered Medicaid population. The rate-setting actuary is challenged to develop a rate that would be "actuarially sound" for a third-party entity. Usually, each of the adjustments would be carefully reviewed for applicability. The outlined adjustments typically include one for the review of the financial experience of the health plans. The rate-setting actuary would normally be familiar with the process of reviewing financial statements and interpreting the results.

AA.4.0 — *Establish Rate Category Groupings.* This section of the checklist outlines different rate-setting categories that would normally be considered in the establishment of the capitation rates. The rate-setting categories include age, gender, locality/region, and eligibility categories. The checklist indicates that each of these components would normally be used in establishing rate-setting categories, unless omitting a component or combining a rate category with an adjacent category can be justified.

AA.5.0 – *Data Smoothing, Special Populations, and Catastrophic Claims.* This section of the checklist outlines methodologies that may be used in the examination and modification of the data to reflect any data distortions or special populations. The checklist indicates that it is usually preferable for the data smoothing techniques to be cost-neutral. The checklist provides a brief definition of cost-neutrality for the actuary to review. This section also briefly discusses the use of health status-based (or diagnosis-based) risk adjustment.

AA.6.0. — *Stop Loss, Reinsurance, or Risk sharing Arrangements.* This section of the checklist includes an outline of the use of reinsurance, either commercial or state-sponsored, in the determination of the capitation rate. The regulations call for inclusion of these provisions to be determined on an "actuarially sound" basis. The risk corridor limit compares total payments to MCO state plan services provided, priced at the Medicaid FFS fee schedule, plus an amount for MCO administrative costs. A risk corridor or risk sharing mechanism may involve the actuary comparing the cost of the managed care program to a FFS program before receiving approval from CMS for the inclusion of a risk corridor program. The checklist discusses the inclusion of a risk corridor program and provides an example.

AA.7.0 — *Incentive Arrangements.* This section of the checklist outlines the use of incentive arrangements in the contract between the state and the MCO. An incentive arrangement provides additional funds in excess of the capitation rates for meeting specified targets. The checklist states that the incentive arrangement payment may not increase total payments above 105 percent of the approved capitation rates. Additionally, all incentives are expected to be determined through the use of an "actuarially sound" methodology.

Considerations in Complying with the Checklist

This section of the practice note discusses items that may be considered by the rate-setting actuary when developing the capitation rates and complying with the checklist. The checklist is a general document and probably does not cover every circumstance the actuary may encounter. Should the actuary think it appropriate to deviate from the guidance provided in the checklist, he or she would usually be prudent to describe and explain the deviation.

15 One commenter noted that "adjustments to reimbursement per unit of service" for the impact of intergovernmental transfers have been particularly problematic in the development of rates.

Section AA.2.0 — *Base-Year Utilization and Cost Data.* This section states, "States without recent FFS history and no validated encounter data will need to develop other data sources for this purpose. States and their actuaries will have to decide which source of data to use for this purpose, based on which source is determined to have the highest degree of reliability, subject to RO approval."

Comment: The actuary should consider ASOP #23 (Data Quality) in the development of the base-year data. Generally, the actuary would consider all available data, including the Medicaid FFS data, Medicaid managed care encounter data, Medicaid managed care financial reports and Medicaid MCO financial statements. The actuary typically would compare data sources for reasonableness and check for material differences when determining the preferred source(s) for the base-period data.

The checklist refers to several data sources CMS would consider appropriate. The actuary typically would consider these data sources as well as the most recent available data that, in the actuary's professional judgment, appear to be reliable and well-suited to the assignment. The checklist acknowledges that there are instances where the commonly used data sources are unavailable.

Section AA.2.4 — *State Plan Services Only.* This section states, "The state must document that the actuarially sound capitation rates are appropriate for the services to be furnished under the contract and based only upon services covered under the state plan." Additionally, "Services provided by the managed care plan that exceed the services covered in the Medicaid state plan may not be used to set capitated Medicaid managed care rates."

Comment: The actuary may want to remove the value of non-state plan services and add in the value of any significant state-plan services that are not reflected in the data. Additionally, as FFS data erodes, data and information for developing the amount of the adjustment for substituted services may not be available.[16]

AA.3.0. — *Adjustments to Base-Year Data.* This section states, "The state made adjustments to the base period to construct rates to reflect populations and services covered during the contract period. These adjustments ensure that the rates are predictable for the covered Medicaid population."

This section includes adjustments that are more specific to the Medicaid rate-setting process than the rate-setting actuary will normally have encountered in the commercial or Medicare managed care environments. The rate-setting actuary is usually prudent to understand each of these adjustments and discuss these items with state Medicaid personnel as necessary. Additional comments related to the other adjustments are as follows.[17]

Pharmacy rebates – State Medicaid programs, which participate in the federal drug rebate program, receive additional rebates for prescribed medications. The rebates are generally greater than rebates received by managed care organizations through their prescription drug contracts.

Managed care adjustment – This adjustment may have a significant impact on the development of the capitation rate or rate ranges. The adjustment may be developed based on the reported experience of managed care organizations, be it publicly available or commercially available information. The managed care adjustments will usually affect both utilization rates and unit costs

16. Capitation rates may be based only on Medicaid state plan services to Medicaid covered eligibles, so an actuary would initially remove the value of non-state plan services. The actuary is usually careful to not reincorporate the value of these excluded services.
17. One commenter mentioned that managed care adjustment (initial or update) assumptions may also result from encounter data analysis benchmarking, or on-site operational reviews measuring the medical utilization and cost management effectiveness of the MCO(s). Assumptions could also be derived from state and/or MCO expectation of continuous improvement in the MCO's medical utilization and cost management.

Financial experience adjustment –This adjustment is most often used for a rate update approach, rather than a rate re-basing approach. These adjustments would usually arise only when calculating future rates based on prior rates.

AA.3.2. — *Administrative Cost Allowance Calculation.* This section says that the state must document that the rate was adjusted to account for MCO, PIHP, or PAHP administration.

In determining an appropriate level of an administrative cost allowance, the rate-setting actuary may want to consider the following items:

- Overall size across all lines of business
- Lines of business covered by the capitation
- Age of the health plan or years of participation in Medicaid
- Organizational structure
- Demographic mix of enrollees
- Marketing expenditures
- Claims processing expenditures
- Medical management expenditures
- Staff overhead expenses
- Member services
- Interpreter services

The section further notes, "CMS does not have established standards for risk and profit levels but does allow reasonable amounts for risk and profit to be included in capitated rates."

Comment: In the determination of an appropriate level of a profit and risk allowance, the rate-setting actuary may want to consider the following items:[18]

- Contingency margin
- Contribution to surplus
- Investment rate of return
- Profit margin

AA 3.7 — *Copayments, Coinsurance, and Deductibles in Capitated Rates.* This section says, "If the state uses FFS data as the base data to set rates and the state Medicaid agency chooses to not impose the FFS cost-sharing in its pre-paid capitation contracts with entities, the state must calculate the capitated payments to the organization as if those cost-sharing charges were collected."

Comment: When determining the appropriate adjustment for copayment amounts, an actuary considers an appropriate adjustment for a collection percentage associated with the copayment amounts.

AA.3.10 — *Medical Cost/Trend Inflation.* This section states, "Medical cost and utilization trend inflation factors are based on historical medical state-specific costs or a national/regional medical market basket applicable to the state and population. All trend factors and assumptions are explained and documented."

18. It may be appropriate for the actuary to consider the public nature of the venture (e.g., government owned PIHPs). Governmental entities without competitive procurement may not be permitted to have contribution to surplus, investment rate of return, or profit margin because this contributes to the federal Medicaid budget subsidiary programs not under Title XIX. Refer to OMB-A87 and 1903(i)(17) of the SSA. The actuary is usually prudent to have considered all relevant factors in selecting an appropriate level of profit and risk allowance.

Comment: The actuary may choose to consider a number of elements in establishing both utilization and unit cost trend rates. Utilization trend rates typically will be affected by changes in demographics, medical technology, benefit levels, and the degree and emphasis of medical management. Unit cost trends may be affected by changes in state-mandated fee schedules (if applicable), FFS cost levels, and provider contracting performed by the health plans. The contracted rates between the MCO and providers are potentially the most variable, by plan and by local market, and least likely to be known by the state's actuary. Therefore, a range of estimates may be more appropriate in accordance with the actuary's professional judgment. However, the rate-setting actuary may be requested to establish a single-point estimate for a cost trend.

Projection of future results through the projection of trend rates typically requires the most flexibility and judgment of any part of the rate analysis. Historical results from FFS or other data sources would normally be considered but not fully relied upon, because the mix of providers and services and the market landscape may have changed. In particular, FFS data may have deteriorated or may not apply in heavily managed care environments. Depending on the timing and impact of managed care implementation— and on market penetration and growth — increasing, flat, or decreasing trends may occur. Local market conditions are generally more important, but harder to determine, than statewide or nationwide trends.

Section AA.3.12 – Utilization and Cost Assumptions – This section states, "The State must document that the utilization and cost data assumptions for voluntary programs were analyzed and adjusted to ensure they are appropriate for populations to be covered if a healthier or sicker population voluntarily chooses to enroll."

Comment: The rate-setting actuary would normally consider the data used to develop the adjustment. If encounter data from the MCOs were used, the population may have shifted from the time of the base period to the time of the rate period. If some other base was used, the rate-setting actuary would usually verify that the adjustment appears to be appropriate. Examples of such adjustments would be those for a program change or expansion in the covered population.[19]

AA.5.2 – Cost-neutral data smoothing adjustment – This section states, "If the State determines that a small number of catastrophic claims are distorting the per capita costs then at least one of the following cost-neutral data smoothing techniques must be made."

Comment: The cost-neutral data smoothing techniques outlined call for the rate-setting actuary to balance the potential for adverse selection with the actual risk assumed by the managed care organizations. The checklist defines "cost neutral" as a process that results in no aggregate gain or loss across all payments categories. The rate-setting actuary may wish to select an appropriate methodology for pooling large claims or the inclusion of reinsurance.

AA.5.3 – Risk Adjustment – This section discusses the optional use of risk adjustment based upon enrollees' health status or diagnosis and requires that the risk adjustment be cost neutral.

Comment: The rate-setting actuary is usually prudent to be broadly familiar with the theory and statistical success as well as the inherent strengths and weaknesses of the risk adjustment model the state employs. Background materials on such models are frequently available through the Society of Actuaries and the American Academy of Actuaries, including several reports that outline the statistical characteristics of the models.

19. It is normally appropriate to include an analysis of whether or not the population covered under the contract has a different acuity than the data being used to set the rates.

The diagnosis-based risk adjustment methodologies generally utilize statistical models based on historical FFS or managed care base data. The reliance on diagnosis-specific data may be hindered by the capitation contracts that are often encountered in managed care programs. The capitation contracts may result in underreporting of encounter data to the managed care organization, and subsequently to the state Medicaid encounter system. The underreporting will usually result in a lower morbidity score than what might result from a review of all claims.

The rate-setting actuary would typically consider the adjustment technique that will be utilized in the rate-setting process. The diagnosis-based risk adjustment methods may be implemented using either concurrent or prospective adjustments. The actuary would usually consider the criteria for evaluating a risk adjustment mechanism that are identified by the Society of Actuaries and the American Academy of Actuaries in the reports mentioned above.

- AA.7.0 – Incentive Arrangements – This section states, "CMS will not consider payment rates to be actuarially sound if incentive arrangements provide for payment in excess of 105 percent of the approved capitation rate payments attributable to the enrollees or services covered by the incentive arrangements..."

Comment: The requirement that the incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments is a compliance issue, and if violated, would normally result in the payments being unable to be determined as "actuarially sound."

In determining an "actuarially sound" incentive, the actuary would normally consider the specific criteria associated with utilization targets established within the terms of the contract. The amount of the incentive would usually reflect the cost of providing the services specified in the incentive clause. For example, if there is an incentive payment associated with increasing the number of members receiving physical examinations, then the incentive payment typically would be based in part on the cost of providing the additional physicals.

The checklist is not clear if the 5 percent limitation is by rate cell or in total. As an illustration, in the example of providing physical examinations to adults, it is unclear if this particular incentive payment is limited to 5 percent of the adult capitation payments, or if it is only the sum of all incentive payments that is limited to 5 percent of the total capitation payment made to the health plan.

V. Documentation

This section provides an overview of documentation for Medicaid managed care rate development.[20] The actuary usually develops documentation in support of the actuarial work product. The extent of the documentation is normally appropriate to the circumstances for which the rates are developed. These items are indicated on the checklist. The documentation typically describes the relevant data, sources of data, material assumptions, methods and process by which the rates were developed with sufficient clarity that another qualified actuary practicing in the same field could make an objective evaluation of the reasonableness of the work product. Note that, for an actuary working on behalf of a state Medicaid agency, the regulation does not require that the documentation be shared with any party – such as a participating MCO – other than the actuary's client (i.e., the state).

The actuary normally explains the reason(s) for and describes the effect of any material changes in sources of data, assumptions or methods from the last analysis.[21]

Generally speaking, there are four key areas to be documented:

A. Data integrity

B. Experience period data

   1. Items related to claims data

   2. Items related to administrative cost allowance

C. Trend factors

D. Risk

The extent of the documentation would usually be, at a minimum, the level required in the checklist. The required documentation identified in the checklist includes the source(s) of data, material assumptions, the methods used, and the process by which the rates were developed. The actuary would usually explain the reason(s) for and describe the effect of any material changes in the source(s) of data, assumptions, or methods from the last rate-setting.

20. The documentation would usually include, at a minimum, the following five elements: 1) The state submits the actuarial certification for the final rates to be paid to the contractors; 2) Rates may be based only on Medicaid services; 3) Rates may only pay for services to Medicaid beneficiaries; 4) The state submits an expenditure projection comparing previous and proposed rates; and 5) The State explains any incentives or risk-sharing. Additional guidance on documentation may also be obtained from ASOP No. 31 Actuaries can appropriately prepare by examining approved Medicaid State Plans, waivers and contracts in order to understand the Medicaid services and Medicaid beneficiaries that are to be covered in the rates.

21. The documentation would usually be available to the actuary. The sharing of documentation is generally under the control of the actuary's client.

A. Documentation of Data Integrity.[22] The actuary normally documents how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Choice of experience period
- Choice of experience data
- Credibility/validation of data
- Adjustments and use of external data

1. Experience Period: For documentation purposes, an explanation of the basis by which the experience period was selected would usually be provided. For Medicaid ratemaking projects, the fiscal calendar may dictate the basic parameters of the project. The experience period will usually be selected to be the most recent, with sufficient time for reasonable runout to allow the rates to be determined in the fiscal process. If a different experience period than is normally used in the fiscal process is used, its use would typically be disclosed and explained.

2. Experience Data. Documentation would usually be provided so that only State Plan approved services that are the responsibility of the managed care organization are included in the base data (AA.2.4). A data book accompanies many managed Medicaid ratemaking projects. The data book typically provides a summary of the base data, often in sufficient detail to calculate experience period PMPM rates by rate cell.

3. Credibility/Validity: The methods and procedures used to validate the data would normally be documented.

4. Adjustments Made/Use of External Data: The source and relevance of any adjustments made or external data used in "completing" or enhancing the base data would usually be provided.

B. Documentation of the Development of Experience Period Costs. The actuary would usually document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Calculation of exposure units
- Adjustments to experience data
- Policy and provider contract provisions
- Mix of Business [23]

1. Items related to claims data

The majority of the discussion in the previous section was on claims experience, its analysis, use, and modification (or adjustment). The current section begins to make refinements to the claims data, to begin to put it in a framework of developing rates. The claims experience will generally be divided by exposure units. This step presumes an appropriate mechanism has been developed to establish rate category groupings.

22. CMS requires base utilization and cost data from a Medicaid population or similar population adjusted to reflect only Medicaid services and eligibles. CMS further requires actuaries to use actual databases instead of samples to create the base data
23. As the actuary examines splits of eligibles by demographic category, it might be determined that a mix of business adjustment would be beneficial between two rate cells due to shifts in exposure and cost.

- Exposure Units: This step is intended to encompass several items. The rate category groupings used would normally be documented, especially if there is a change from the prior structure. If specific population sub-groupings are expected to undergo special changes (due to program changes, redefinitions, or anticipated economic shifts), the actuary may choose to disclose how these factors adjusted the expected results. Documentation would usually include a description of the impact of retroactivity and plans' contractual responsibilities, when appropriate. Adjustments made to ensure that exposures are consistent with accepted base experience data (e.g., if a plan's encounter data were removed because they were considered invalid, also remove exposures) would also usually be documented (AA.3.4).

- Adjustments to Experience Data: To the extent adjustments differ between rate cells, documentation would normally reflect the differences.

- Operational/Benefit Changes: If an operational change is expected to impact the ratemaking, it would usually be described. Examples might include carving out a formerly covered service, or bringing a formerly carved out service back into the at-risk rates. A new type of service might be added or removed from covered services since the base year. An explanation of the change and its impact would usually be provided (AA.3.1).

- Investment Income: To the extent new benefits or new population groupings are added to the managed care program, or carved-out services are added back, there might be a lag in claims versus funding and an adjustment for investment income might be appropriate. An investment income adjustment can also be used when using FFS data. If used, disclosure and documentation are normally provided.

- Special populations adjustments: The checklist states that this adjustment can only be made if the population has changed since the base period experience data. If this occurs, an explanation of the adjustment would usually be provided (AA.3.3).

- The actuary usually discloses whether any DSH payments are included in the rates (AA.3.5); typically they are not.

- With respect to third-party liability, the actuary normally explains the TPL arrangement and documents any significant adjustments (AA.3.6).

- Policy and Provider Contract Provisions: To the extent that deductible, coinsurance, copays, coverage limitations and coordination of benefits impact the Medicaid managed care population or expanded populations, it may be appropriate to model policy and contract provisions against available data and their documented impact (AA.3.7). The Medicaid checklist discusses incentive arrangements, and requires the parameters of the program and its impact to be documented (AA.7.0).

- With respect to graduate medical education (GME), the actuary usually documents any material adjustments (AA.3.8).[24]

- With respect to FQHC/RHC, the actuary usually document any material adjustments (AA.3.9).[25]

- Smoothing/Large Claims (Shock Loss Claims): The effect of large claims, including the effect

24. States may pay GME outside of capitation rates only if these payments are excluded from the capitation rate and are not more than they would have been under FFS.
25. CMS has specific requirements that the actuary usually considers in the documentation of the appropriate treatment of services rendered by FQHC/RHCs.

of large claims on the experience period data and on the projection of historical data to the rating period, and how the cost of large claims is incorporated in the ratemaking process would normally be documented. The effect of reinsurance arrangements is often related to the discussion on large claims.

Smoothing can be used to reduce distortions in the data caused by a few large claims. The checklist requires smoothing to be cost-neutral. Documentation on the technique used would usually be provided.

- Any additional material adjustments would normally be explained.

2. Items related to expense allowance

   - Administrative Expenses: Expenses are usually an important part of the development of rates. In general terms, expenses are sometimes referred to as retention. Retention includes expenses, as well as risk charges (possibly for pooling or other contingencies), the cost of capital and the ability to support reserves (and capital) needs with a contribution to surplus. Assumptions used to adjust for each of these factors would normally be documented. (AA.3.2)

   - The documentation may address the treatment of other items of retention, including all provision for risk charges and the cost of capital and the ability to support reserves with a contribution to surplus.[26]

C. Documentation of Trending Factors. The actuary would typically document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Trend Measurement
- Claim Cost Trend Factors
- Other Trend Factors

The documentation of trend and its measurement and application can be a critical area to understand. The report would usually include a comparison of last year's trended rates to this year's estimates.

- Trend Measurement and Trend Selection: The method of developing cost and utilization trend factors would usually be documented in appropriate detail.
- Claim Cost Trend Factors: The factors affecting the change in claim costs over time would typically be discussed. Unless otherwise accounted for, these factors usually include, but are not limited to: general price inflation, leveraging, changes in provider contract, medical cost inflation, changes in medical practice, demographics, changes in policy provisions, and utilization.
- Other Trend Factors: The factors affecting the change of other ratemaking parameters over time would normally be disclosed.

D. Issues Related to Documentation of Risk. The actuary would normally document how the following issues are addressed in the ratemaking process, to the extent that they are relevant and material:

- Risk Provision: In an at-risk ratemaking process, there is typically an expectation that a participant should have a reasonable probability of achieving target-operating margins. The target-operating

26. Risk charges are also addressed in Section D, Issues Related to Documentation of Risk.

margin would usually be disclosed. If the target-operating margin is 0 percent for the entire system, one scenario is that 50 percent of the participants will exceed the target and 50 percent will not. In this simple example, for plans to achieve target-operating margins, the operation of the plans as a whole would usually be expected to achieve a more efficient delivery of care than the assumptions suggest. Many actuaries prefer the target-operating margin to be positive (i.e., rather than be 0 percent). They believe that this level of target margin would normally be achievable by a health plan operating in an efficient manner within the program guidelines.

- Stop Loss, Reinsurance, or other Risk Sharing: Rates would normally be adjusted to reflect the risk the State is willing to assume. Documentation on the effect to the rates would usually be provided. This risk factor is covered in Subsection 6.0 of the checklist.

- External Influences: This factor appears to describe the pressures that might be affecting state budgets. Refer to Section III, Item 4 of this draft, for guidance on this issue. Other external influences may come to the actuary's attention. Since these circumstances will most likely not have an existing body of knowledge or data available, discussion with CMS early in the process is recommended in most instances.

- Risk Classification Plan: The issue of risk classification is directly covered in the checklist at Subsection AA.5.3 The documentation would usually include:

    - An explanation of the risk assessment methodology chosen
    - Documentation on how payments will be adjusted
    - Demonstration of cost neutrality
    - Procedures for monitoring and re-basing

Conclusion

Normally, the actuary's documentation would address the reasonableness or appropriateness of the assumptions and methodology used in the ratemaking process. The chosen data, assumptions used, and adjustments made would usually be provided. The size and effect of any significant adjustments would usually be included, as well as a statement to the effect that the adjustments are mutually exclusive and are not being applied more than once if such a statement is accurate.

VI. Certification Language[27]

Sample Certification Language
State of XXXXX
Actuarial Certification

I, {your name}, am an employee of the Division of Medical Services of the State of XXXXX. {If a consulting actuary, the actuary would usually indicate the company affiliation.} I am a Member of the American Academy of Actuaries {mandatory} and an Associate / Fellow of the Society of Actuaries {if applicable}. I meet the qualification standards established by the American Academy of Actuaries and have followed the practice standards established from time-to-time by the Actuarial Standards Board. I have been employed {either as an employee or as a consultant} by the State of XXXXX for the past YY years and am generally familiar with the state-specific Medicaid program, eligibility rules, and benefit provisions.

The capitation rates provided with this certification are considered "actuarially sound" for purposes of 42 CFR 438.6(c), according to the following criteria:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the Medicaid populations to be covered, and Medicaid services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

The assumptions used in the development of the "actuarially sound" capitation rates have been documented in my correspondence with {either the state or the MCO}. The "actuarially sound" capitation rates / rate ranges that are associated with this certification are effective for the YY month period beginning July 1, 200X.

The "actuarially sound" capitation rates are based on a projection of future events. It may be expected that actual experience will vary from the experience assumed in the rates.

In developing the "actuarially sound" capitation rates, I have relied upon data and information provided by the State. I have relied upon the State for audit of the data. However, I did review the data for reasonableness and consistency (if applicable).

The capitation rates developed may not be appropriate for any specific health plan. An individual health plan will need to review the rates in relation to the benefits that it will be obligated to provide. The health plan should evaluate the rates in the context of its own experience, expenses, capital and surplus, and profit requirements prior to agreeing to contract with the State. The health plan may require rates above, equal to, or below the "actuarially sound" capitation rates that are associated with this certification.

_____ _____

John Q. Smith Date
Member, American Academy of Actuaries

27. This sample certification language is offered solely for educational purposes and is not intended to limit in any way the content of individual actuaries' certifications. The actuary is encouraged to develop appropriate language for each certification, and is under no obligation to make use of the sample language offered here.

AMERICAN ACADEMY *of* ACTUARIES

1100 Seventeenth Street NW
Seventh Floor
Washington, DC 20036
Telephone 202 223 8196
Facsimile 202 872 1948
www.actuary.org

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Income Maintenance Administration

MEMORANDUM

TO: All IMA Staff

FROM: Deborah A. Carroll
Administrator

DATE: August 26, 2010

SUBJECT: Correction for Childless Adult Medicaid

This memorandum corrects previous instructions regarding income eligibility for the new Childless Adult program. Effective immediately, persons who are over-income for Childless Adult (CA) Medicaid may NOT become eligible through the spend-down process. All other provisions of the previous instructions remain in effect.

Background

IMA implemented Childless Adult Medicaid in July. Instructions were given that persons with incomes above 133% of the Federal Poverty Level (FPL) were over-income for CA Medicaid. Staff were further instructed to send such applicants a notice telling them they could become eligible for CA Medicaid through the spend-down process.

The federal Centers for Medicaid and Medicare Services (CMS) has recently advised the District that persons who are over 133% of FPL can NOT spend-down to become eligible. Their applications must be denied.

Policy Changes

- Persons can only become eligible for CA Medicaid if they have income under 133% of FPL.
- There is no spend-down for the Alliance or for CA Medicaid.
- Disabled persons who are over-income for SR Medicaid and who are over-income for CA Medicaid may spend-down under the SR spend-down liability amount.

As stated in previous instructions, persons who are otherwise eligible but over-income for CA Medicaid can be eligible for the DC HealthCare Alliance if they meet Alliance criteria and have income under 200% of FPL.

Procedures

This correction changes the actions that staff should take based on the messages showing on the MCED screen in ACEDS. Effective August 27, 2010, the codes found in the MED ELIGIBILITY FIELD will be changed and mean the following:

- "P774" means the same as in previous instructions. The person has passed eligibility and is eligible for CA Medicaid.
- "ALLI" means that the person is eligible for the Alliance but not eligible for CA Medicaid. Make the person eligible for the Alliance and send an approval notice. Unlike previous instructions, if the person is over-income for CA Medicaid, do not send an over-income notice for CA Medicaid. If the applicant has been found to be disabled and meets non-financial criteria for SR, re-register the SR program and send an over-income notice for SR as well as the Alliance approval notice. If the person is not disabled, do not send any additional notice.
- The "SPEN" code has been eliminated.
- "FAIL" means the same as in previous instructions. The person has income above 200 FPL and does not meet the eligibility criteria for CA Medicaid not the HealthCare Alliance.
- "FMED" means the same as in previous instructions. The person has Medicare A and/or B and is not eligible for either the Alliance or CA Medicaid. QM eligibility should be tested.
- "FINS" means the person is not eligible for the ALLIANCE because they have health insurance and not eligible for CA Medicaid because they have income between 133 and 200 FPL. Unlike in previous instructions, do not send a spend-down notice to the customer. If the person has been found to be disabled, re-register the SR program and send an over-income notice for SR. If the person is not disabled, send a denial notice such as C705 "Denial" for being over-income. Do not send an A709 "Denial/Excess Income" or A719 "Cond.Den/Excess Income (Interim Change").

The "EXCESS" field on the MBCB screen will always display "0.00" and should NOT be used as an indicator of eligibility.

DPO should identify any cases that have already received over-income notices for CA Medicaid. Language for a corrected notice to affected customers will be provided in a separate memorandum. A policy update will be forthcoming.

If there are questions regarding this policy, please contact Richard Walker by e-mail at Richard.walker@dc.gov or by phone at (202) 698-3958.

ACS
DC OmniCaid MMIS DDI Project

Program Code Definition

Attribute Description	Value	Data Type
What Is the Program Code?	774	Character (4)
What Is the Program Begin Date?	May 1, 2010	Date (YYYY-MM-DD)
What is the Program End Date?	999999	Date (YYYY-MM-DD)
What is the Short Description?	Childless Adult SPA	Character (10)
What is the Long Description?	Adults without dependent children under age 65 whose income does not exceed 133% of the Federal Poverty Level; are not pregnant; and are not entitled to or enrolled in Medicare	Character (30)
What is the Medical Program Eligible Code?	MA-FPL	Character (20)
Does this program cover the Aged?	no	Character (1)
Does this program cover the Blind?	no	Character (1)
Does this program cover the Disabled?	no	Character (1)
Is this program for only adults or children?	adults	Character (1)
Age Limit 1, if there is and age limit	64	Numeric (3)
Age Operator Code 1 (for Age Limit 1)	LE	Character (2)
Age Limit 2, if there is a second age limit	21	Numeric (3)
Age Operator Code 2 (for Age Limit 2)	GE	Character (2)
Is this program for Medicare Buy-in?	no	Character (1)
Does this program cover Foster Care?	no	Character (1)
Is this program for Dual Eligibles?	no	Character (1)
Does this program cover Managed Care?	yes	Character (1)
What is the Recertification Period (in months)?	12	Numeric (3)
Is this program Medicaid Eligible?	yes	Character (1)
Is this program for Spenddown?	no	Character (1)
Does this program cover Transportation Broker?	yes	Character (1)
Does this program cover LTC / Nursing Home?	no	Character (1)
Does this program cover CHIP / SCHIP?	no	Character (1)
Is this an MRDD Waiver program?	no	Character (1)
Is this a Special Needs Waiver program?	no	Character (1)
Is this an EPD Waiver program?	no	Character (1)

Is this a TIC to Work Special Needs Demo program?	no	Character (1)
Is this a 1115 Special Needs Demo program?	no	Character (1)
Is this a TANF program?	no	Character (1)
Is this program for Refugee Aliens?	yes	Character (1)
Is this an SSI-C program?	[redacted]	Character (1)
Is this a General Public Assistance (GPA) program?	no	Character (1)
Is this a Fee for Service program?	no	Character (1)
Is this a Home and Community Based Services program?	no	Character (1)
Is this program for Pregnancy?	no	Character (1)
Is this a Family Planning program?	no	Character (1)
What is the Maintenance Assistance Status Code?	3	Character (1)
What is the Basis of Eligibility (BOE) Code?	5	Character (1)
What is the Major Program Code?	M	Character (1)
What is the Federal Match Code?	[redacted]	Character (1)
What is the Recipient Receiving/Eligible for Cash Grant or Medicare Programs description?	no	Character (120)
What is the Service Type Code?	M	Character (1)
What is the PBM Plan Code?	200	Character (3)

Valid Values

Open ended - 9999-12-31

See Valid Values worksheet
N, Y
N, Y
N, Y
See Valid Values worksheet

See Valid Values worksheet

See Valid Values worksheet
N, Y
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See Valid Values worksheet

See Valid Values worksheet
See Valid Values worksheet
Not used by the District

See Valid Values worksheet
See Valid Values worksheet

Government of the District of Columbia

Department of Insurance, Securities and Banking

William P. White
Acting Commissioner

BEFORE THE INSURANCE COMMISSIONER OF THE DISTRICT OF COLUMBIA

Re: Report on Limited Scope Financial Examination of
DC Chartered Health Plan Inc. – NAIC #95748

ORDER

A Limited Scope Financial Examination of the above referenced company ("the Company") has been conducted by the District of Columbia Department of Insurance, Securities and Banking ("Department").

It is hereby ordered on this 27th of November 2012, that the attached limited scope financial examination report be adopted and filed as an official record of this Department.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, this Order is considered a final administrative decision and may be appealed pursuant to Section 31-4332 of the D.C. Official Code.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the issuance of the adopted report, the Company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.

Pursuant to Section 31-1404(e)(1) of the D.C. Official Code, the Department will continue to hold the content of the report as private and confidential information for a period of 10 days from the date of this Order.

William P. White
Commissioner

Government of the District of Columbia

Department of Insurance, Securities and Banking

William P. White
Acting Commissioner

November 27, 2012

Maynard G. McAlpin
DC Chartered Health Plan, Inc.
1025 15th Street NW
Washington, DC 20005-2601

Dear Mr. McAlpin:

We are in receipt of your response to the Draft Report on Limited Scope Examination.

The adopted Report and the Order evidencing such adoption are enclosed. Pursuant to Section 31-1404(e)(1) of the D.C. Official Code, the adopted Report will be held private and confidential for a period of 10 days from the date of the Order evidencing such adoption. After this 10 day period has passed, the Report will be publicly available.

Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the date of the above-mentioned Order, affidavits executed by each director of the Company stating under oath that he or she has received a copy of the adopted examination Report and related Order shall be filed with this Department. Please send these affidavits to my attention here at the Department.

Please contact me at 202-442-7785 if you have any questions.

Sincerely,

Nathaniel Kevin Brown, CFE, CPA
Chief Financial Examiner

Enclosures

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

REPORT ON LIMITED SCOPE EXAMINATION

OF

DC CHARTERED HEALTH PLAN, INC.

NAIC #95748

TABLE OF CONTENTS

SALUTATION

Washington, D.C.
November 8, 2012

Honorable William P. White
Commissioner
Department of Insurance, Securities and Banking
Government of the District of Columbia
810 First Street, NE, Suite 701
Washington, D.C. 20002

Dear Commissioner White:

In accordance with the provisions of the District of Columbia Official Code Title 31, Chapter 14 (Law on Examinations), we have conducted a limited scope examination of certain activities of

DC CHARTERED HEALTH PLAN, INC. – NAIC #95748

hereinafter referred to as the "Company", or "DC Chartered", and the following Report on Examination is submitted. The Company is a licensed District of Columbia Medicaid Managed Care Organization ("MCO") that operates exclusively in the District of Columbia. The Company was organized and commenced business in 1986.

BACKGROUND

On February 25, 2008, DC Chartered entered into Contract DCHC-2008-D-5052 (the "Contract") with the District of Columbia Office of Contracting and Procurement ("DCOCP") to provide healthcare services to the Medicaid eligible population enrolled in the District of Columbia Healthy Families Program ("DCHFP") and to the Alliance eligible population enrolled in the DC Health Care Alliance Program ("Alliance Program"). The Contract is administered by the District of Columbia Department of Healthcare Finance ("DHCF") (formerly known as the Medical Assistance Administration).

In July 2010, the DHCF required the transfer of a population of former members of the Alliance Program to the DCHFP. That population, referred to as the "774 population", consisted of childless adults who had incomes at or below 133% of the federal poverty level.

In December 2010, the DHCF required the transfer of an additional population of former members of the Alliance Program to the DCHFP. That population, referred to as the "775 population", consisted of childless adults who had incomes at or below 200% of the federal poverty level.

The effect of the transfers was to provide increased benefit coverage, particularly pharmacy benefit coverage, to the 774/775 populations than was made available under the Alliance Program.

Pursuant to the Contract, the DHCF conducts an annual actuarial review of the Contract's capitation rates and establishes capitation rates for the 12-month period commencing each August 1. After the July and December, 2010 transfers of the 774 and 775 populations from the Alliance Program to the DCHFP, the DHCF conducted its actuarial review and established capitation rates for the August 1, 2011 – July 31, 2012 time period.

On November 30, 2011, the Company filed a claim with the Contracting Officer of the DCOCP for payment of $25,771,117. The Company contended that rate adjustments made by the DHCF after the 774/775 populations were added to the DCHFP were not actuarially sound, as required by the Contract, and resulted in losses to the Company.[1] The Contracting Officer failed to issue a decision within 120 days of receipt of the claim; thus, the claim was deemed denied as of March 29, 2012.

On April 9, 2012, the Company filed an appeal of the Contracting Officer's denial of its November 30, 2011 claim with the District of Columbia Contract Appeals Board ("Appeals Board"). Under the appeal, the Company is seeking:

> (1) a review of the capitation rate decision and the applicable assumptions as the rate chosen by the District is not actuarially sound or equitable, (2) a review of the annual

[1] The claim consisted of payments of approximately $13,665,419 for losses experienced by DC Chartered from August 1, 2010 to October 31, 2011and $12,105,699 for the losses DC Chartered projected it would experience for the period between November 1, 2011 and April 30, 2012.

adjustment to the rates and the applicable assumptions as the adjustment is not actuarially sound or equitable, (3) an adjustment to the capitated rate to make such rates actuarially sound; and in the alternative, (4) an equitable adjustment to the capitated rate due to significant increases in actual pharmacy benefit costs. [2]

In the specific counts of the appeal, the Company alleges breach of contract and an equitable adjustment due to the DHCF's failure to compensate the Company for its increased cost of performance due to changed circumstances. The Company seeks, among other things, payment of $25,771,117, plus accrued interest and reasonable attorneys' fees and costs. It is our understanding that a date has not been set for a ruling by the Appeals Board.

In the Company's Annual Statement as of December 31, 2011 (due March 1, 2012), the Company did not record a receivable for the $25,771,117 claim. However, in the Company's Quarterly Statement as of June 30, 2012 (due August 15, 2012), the Company established an accrued retrospective premium receivable ("premium receivable") of $24,060,016.[3]

In meetings and communications with the District of Columbia Department of Insurance, Securities and Banking ("DISB"), the Company and its consultants have contended that the Contract is a retrospectively rated contract, as defined in Statement of Statutory Accounting Principles No. 66 – Retrospectively Rated Contracts ("SSAP 66") of the NAIC *Accounting Practices and Procedures Manual*. As a result, the Company believes the amount it claims is due under the Contract represents an admitted asset under statutory accounting principles.

SCOPE OF EXAMINATION

Pursuant to the Memorandum of Understanding between Rector & Associates, Inc. and the DISB with respect to this limited scope examination, the scope of the examination is to review the information surrounding the inclusion of amounts in the financial statement related to DC Chartered's interpretation of the Medicaid contract as a retrospectively rated contact and the establishment of an asset in the financial statement as a result of the currently pending action with the Appeals Board. Should the conclusion be that the establishment of an asset is appropriate, the DISB does not need a determination as to whether the amount established by DC Chartered is appropriate given the circumstances.

The following materials were reviewed in the performance of the limited scope examination:

- Contract No. DCHC-2008-D-5052 (Medicaid Services contract between DCOCP and DC Chartered), and related attachments
- April 9, 2012 DC Chartered Appeal to the Appeals Board

[2] Based on the remedies sought by DC Chartered in the appeal, it is not clear whether the Appeals Board might award DC Chartered only a portion of its $25,771,117 claim if the Appeals Board finds in favor of DC Chartered on only certain of its requested remedies.

[3] Please note that we have been unable to determine why the Company recorded a receivable of $24,060,016, vs. the $25,771,117 claim that it filed with the Contracting Officer of the DCOCP and that it is claiming on appeal.

- Annual Statement as of December 31, 2011 and Quarterly Statement as of June 30, 2012 for DC Chartered
- District of Columbia Statutes and Regulations
- NAIC *Accounting Practices and Procedures Manual* (as of March 2012)
- Position papers titled "Accounting and Reporting for Pharmacy Retrospective Equitable Capitation Rate Adjustment (Retrospective Equitable Adjustment) for Costs Incurred" prepared on behalf of the Company by Millennium Consulting Services, LLC dated June 2012 ("June Position Paper") and July 2012 ("July Position Paper")
- Various electronic communications between the DISB and the Company related to discussion of the statutory accounting treatment of the premium receivable

In addition to the listed documents, several telephone conferences were held with members of the DISB to discuss matters relevant to the assessment of the Company's statutory accounting treatment of the receivable.

SUMMARY FINDINGS

Based on our analysis, we believe the relevant language Contract language supports DC Chartered's position that the Contract is a retrospectively rated contract and that DC Chartered's claim for additional premium payments is an asset in accordance with SSAP No. 66. In other words, we believe that it is reasonable to interpret the Contract to expect that DC Chartered could receive premium adjustments based on DC Chartered's loss experience relating to the Contract, including loss experience resulting from changes to the terms of the Contract.

It is important to point out that when DC Chartered takes the position that the Contract is a retrospectively rated contract, it should take into account its *entire* loss experience to determine its final policy premium, not just the loss experience resulting from the transfer of the 774 and 775 populations from the Alliance Program to the DCHFP. SSAP No. 66 makes clear that a retrospectively rated contract's final policy premium is calculated based on the loss experience of the insured during the term of the policy, not just the loss experience resulting from a contract change or a particular set of benefits.

Finally, as previously indicated, we were not asked as part of this limited scope examination to determine whether the amount of the premium receivable established by DC Chartered in its Quarterly Statement as of June 30, 2012 is appropriate. However, it is important to note that even if a reporting entity correctly admits an asset for statutory accounting purposes, the entity still must determine whether the asset is "impaired." Pursuant to statutory accounting principles, if it is probable that an impairment has occurred and the impairment can be measured, the asset must be reduced to its impaired value.

ANALYSIS

Relevant Statements of Statutory Accounting Principles

SSAP No. 66 defines a retrospectively-rated contract as follows:

A retrospectively rated contract is one which has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy or a formula required by law.

In addition, SSAP No. 66 provides that:

Amounts due from insureds and amounts due to insureds under retrospectively rated contracts meet the definitions of assets and liabilities as set forth in *SSAP No. 4—Assets and Nonadmitted Assets* and *SSAP No. 5R—Liabilities, Contingencies and Impairment of Assets* (SSAP No. 5R), respectively.

DC Chartered's Position on Premium Receivable

DC Chartered's analysis of the methodology behind its establishment of the premium receivable is described in the Position Papers and claim. DC Chartered's argument is two-fold:

- *Capitation Rate Retrospective Adjustment Due To Contract Change* -- First, DC Chartered appears to assert that when the DHCF transferred the 774 and 775 populations from the Alliance Program to the DCHFP in July 2010 and December 2010, respectively, the DHCF changed the services to be covered under the Contract. According to DC Chartered, this change should have triggered a retrospective upward adjustment to the Contract's capitation rate for the time period commencing on the dates of the transfers of the 774 and 775 populations.

- *Annual Capitation Rate Adjustment* -- Second, DC Chartered asserts that when the DHCF conducted its actuarial review and established capitation rates for the August 1, 2011 – July 31, 2012 time period, the DHCF should have taken into account the July 2010 and December 2010 transfers of the 774 and 775 populations from the Alliance Program to the DCHFP. Accordingly, DC Chartered believes that the capitation rates commencing on August 1, 2011 should have been adjusted upward to take into account the transfers of the 774 and 775 populations.

Capitation Rate Retrospective Adjustment Due To Contract Change

Contract Provisions. Section B.3.1 of the Contract states, in part:

In the event that the District, pursuant to the Changes Clause of the Standard Contract Provisions, adds, deletes, or changes any services to be covered by the Contractor under DCHFP or the Alliance Program the District will review the effect of the change and equitably adjust the capitation rate (either upward or downwards) if appropriate....

The "Changes Clause" referenced in Section B.3.1 of the Contract states, in part:

The Contracting Officer may, at any time, by written order, and without notice to the surety, if any, make changes in the contract within the general scope hereof. If such

change causes an increase or decrease in the cost of performance of this contract, or in the time required for performance, an equitable adjustment shall be made....

When read in conjunction with each other, these two sections of the Contract seem to require that if the Contract is changed to add, delete or change services covered by DC Chartered, the DHCF must review the effect of the change and equitably adjust the capitation rate.

As previously indicated, the Contract requires DC Chartered to provide healthcare services to the Medicaid eligible population enrolled in DCHFP and to Alliance Program members. In July 2010 and December 2010, the DHCF required the transfer of the 774 population and 775 population, respectively, of Alliance Program members to the DCHFP. It is our understanding that DC Chartered's position is that pursuant to Section B.3.1, these transfers resulted in a change to the Contract because the transfers added or changed the services to be covered by the Contract.

It could be argued that the DHCF *did not* add or change services to be covered by the Contract. Instead, the DHCF only transferred individuals who were already covered under the Contract from one category (Alliance Program members) to another category (DCHFP enrollees). Transferring individuals between categories of covered enrollees may not add or change services that were covered by the Contract since the same individuals were covered by the Contract both before and after the transfer.

However, DC Chartered claims in its appeal that the 774 and 775 populations previously were not eligible for pharmacy benefits that DCHFP enrollees are eligible to receive through the Medicaid managed care program. As a result, these populations received pharmacy benefits through the Alliance Program which were significantly more restrictive than the benefits DC Chartered was required to provide these populations after they were transferred to the DCHFP.

Based on our understanding of the effect of the 774 and 775 population transfers on the benefits DC Chartered was required to provide, it appears that DC Chartered was required to provide additional services in the form of increased pharmacy benefits. DC Chartered then argues that this change should have triggered a retrospective upward adjustment to the Contract's capitation rate for the time period commencing on the dates of the transfers of the 774 and 775 populations (July 1, 2010 and December 10, 2010, respectively).

Analysis of SSAP and Contract Provisions. As previously indicated, SSAP No. 66 defines a retrospectively-rated contract as a contract that has:

- A final policy premium calculated based on the loss experience of the insured during the term of the policy; and

- A stipulated formula set forth in the policy or a formula required by law.

First, the DHCF's review of the effect of the Contract changes can be viewed as determining the "final policy premium calculated based on the loss experience of the insured during the term

of the policy." In addition, the DHCF's equitable adjustment of the capitation rate can be viewed as "the stipulated formula set forth in the policy".

We recognize that simply requiring the DHCF to equitably adjust the capitation rate, if appropriate, is not the type of "stipulated formula" that normally is found in a retrospectively rated contract. However, it seems appropriate that in this type of contract, the "stipulated formula" is limited to determining the appropriate equitable adjustment to the capitation rate, rather than including a specific formula for changes in the capitated rate.

In addition, DC Chartered's July Position Paper points out that:

> The District's courts define an equitable adjustment as 'the difference between what it would have reasonably cost to perform the work as originally required and what it reasonably cost to perform the work as changed.' (Page 3, July Position Paper.)

Although rudimentary, the courts have essentially defined an equitable adjustment as the following "formula":

> Equitable Adjustment = Cost to perform work as changed +/- Cost of work as originally required

The DHCF's decision to redefine the 774/775 populations by transferring them from the Alliance Program to the DCHFP arguably triggered the Changes Clause and, accordingly, required the DHCF to assess the impact of the change and equitably adjust DC Chartered's capitation rate. In effect, the change created a liability for DHCF and an asset (premium receivable) for DC Chartered.

Annual Capitation Rate Adjustment

Contract Provisions. Sections B.3.2 and B.3.3 of the Contract provide:

> B.3.2 No later than twelve (12) months after the date of the Contract Award and annually thereafter, the District will conduct an actuarial review of the capitation rates in effect to determine the actuarial soundness of the rates paid to the Contractors. The actuarial review will be based upon the rates offered by Contractor and will take into account factors such as inflation, significant changes in the demographic characteristics of the member population, or the disproportionate enrollment selection of Contractor by members in certain rate cohorts.
>
> B.3.3 This actuarial review of the capitation rates may result in an annual adjustment, either increase or decrease, to the capitation rates. The District and Contractor shall negotiate the actual amount of the adjustment; however, the negotiated adjustment shall be actuarially sound in accordance with 42 C.F.R. 438.6(c).

Pursuant to these sections, the DHCF is required to review DC Chartered's capitation rates on an annual basis to determine if the rates are actuarially sound by taking into account, among other things, DC Chartered's loss experience.

DC Chartered argues that when the DHCF conducted its actuarial review and established capitation rates for the August 1, 2011 – July 31, 2012 time period, the DHCF should have taken into account the July 2010 and December 2010 transfers of the 774 and 775 populations from the Alliance Program to the DCHFP. Accordingly, DC Chartered argues that the capitation rates commencing on August 1, 2011 should have been adjusted upward to take into account the transfers of the 774 and 775 populations.

Analysis of SSAP and Contract Provisions. As previously indicated, SSAP No. 66 defines a retrospectively-rated contract as a contract that has:

- A final policy premium calculated based on the loss experience of the insured during the term of the policy; and

- A stipulated formula set forth in the policy or a formula required by law.

First, the DHCF's review of DC Chartered's capitation rates can be viewed as determining the "final policy premium calculated based on the loss experience of the insured during the term of the policy."

In addition, Sections B.3.2 and B.3.3 require that any changes to the capitation rate be actuarially sound, which is defined to be actuarial soundness in accordance with 42 C.F.R. 438.6(c). 42 C.F.R. 438.6(c) defines actuarially sound capitation rates to be rates that are:

- Developed in accordance with generally accepted actuarial principles and practices;
- Appropriate for the populations to be covered and the services to be furnished; and
- Certified by an actuary who meets the standards of the American Academy of Actuaries and uses practice standards established by the Actuarial Standards Board.

We recognize that simply requiring the DHCF to take into account actuarial soundness in determining capitation rates is not the type of "stipulated formula" that normally is found in a retrospectively rated contract. However, it is generally understood that actuarial principles and practices include the use of formulas to determine appropriate capitation rates.

Based on this analysis, we believe it is appropriate to consider the Contract to be a retrospectively rated contract due to the DHCF's required annual review of capitation rates in accordance with Sections B.3.2 and B.3.3. We note that if the DHCF failed to perform the required annual review or, alternatively, performed the review and failed to establish actuarially sound rates, the amount of the deficiency in the capitated rates would be a liability for the DHCF and an asset (premium receivable) for DC Chartered.

Determination of Retrospective Rate for Entire Contract

As previously indicated, the scope of our examination was limited to reviewing DC Chartered's interpretation of the Medicaid contract as a retrospectively rated contact and determining whether it was appropriate for DC Chartered to establish the premium receivable as an asset in its financial statements. Based on our analysis, we have found that relevant Contract language supports DC Chartered's position that the Contract is a retrospectively rated contract and that the premium receivable can be considered an asset in accordance with SSAP No. 66.

At the same time, it is important to point out that when DC Chartered takes the position that the Contract is a retrospectively rated contract, it should take into account its *entire* loss experience to determine its final policy premium, not just the loss experience resulting from the transfer of the 774 and 775 populations from the Alliance Program to the DCHFP. SSAP No. 66 makes clear that a retrospectively rated contract's final policy premium is calculated based on the loss experience of the insured during the term of the policy, not just the loss experience resulting from a contract change or a particular set of benefits.

In addition, we noted that the Contract states that the retrospective capitation rate adjustment could result in a downward adjustment, as described in Section B.3.1, and that the annual rate review could result in a decrease in the capitation rate, as described in Section B.3.3. In other words, the Contract language envisions that it might be necessary for DC Chartered to record a liability due to, as an example, a required premium refund to the DHCF.

Additional Considerations

We were not asked as part of this limited scope examination to determine whether the amount established by DC Chartered in its Quarterly Statement as of June 30, 2012 is appropriate. However, we believe the DISB should be aware of other statutory accounting guidance that might impact the amount of the accrued retrospective premium that could be considered to be impaired.

SSAP No. 5R requires reporting entities to perform an on-going assessment as to the possible impairment to assets. In other words, even if a reporting entity correctly admits an asset for statutory accounting purposes, the entity still must determine whether the asset is "impaired."

SSAP No. 5R defines an impairment of an asset as an existing condition, situation, or set of circumstances involving uncertainty as to a possible loss that ultimately will be resolved when one or more future events occur or fail to occur. In addition, three definitions are used to assess whether an asset is impaired:

a. Probable – The future event or events are likely to occur;
b. Reasonably Possible – The chance of the future event or events occurring is more than remote but less than probable;
c. Remote – The chance of the future event or events occurring is slight.

If it is probable that an impairment has occurred and the impairment can be measured, the asset must be reduced to its impaired value.

RECOMMENDATION

As previously noted in this Report, the Contract language does not set out a stipulated formula that is to be used to determine retrospective and annual premium adjustments or directly define what types of changes to DCHFP or the Alliance Program result in the addition, deletion or change in services to be covered by a contractor such as DC Chartered.

Accordingly, we recommend that to the extent possible, DC Chartered with the DCOCP and the DHCF develop language in their contracts to define and clarify a formula for calculating premium and capitation rate adjustments and the circumstances under which services are added, deleted, or changed. Clarifying the contract language will provide accurate calculation of any receivable/payable incurred under the contracts due to retrospective and annual premium adjustments.

SIGNATURES

In addition to the undersigned, the following examiners representing the District of Columbia Department of Insurance, Securities and Banking participated in certain phases of this examination:

Sarah W. Schroeder
Neil K. Rector

Respectfully submitted,

_____
Edward A. Dinkel
Rector & Associates, Inc.

Under the Supervision of,

_____
Nathaniel Kevin Brown, CFE, CPA
Chief Financial Examiner
District of Columbia Department of Insurance,
Securities and Banking

D

Jonathan C. Marsden, FSA, MAAA
Principal

333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
+1 612 642 8940
jonathan.marsden@mercer.com
www.mercer.com

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Ms. Tanya Ehrmann
District of Columbia Department of Health Care Finance
Office of Managed Care
4th Floor
825 North Capital Street, NE
Washington, D.C. 20002

June 22, 2010

FINAL & CONFIDENTIAL — NOT FOR PUBLIC DISCLOSURE

Subject: District of Columbia Healthy Families Program (DCHFP) Rate Development and Actuarial Certification for the Contract Period July 1, 2010 through April 30, 2011

Dear Tanya:

The District of Columbia (District) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges covering the July 1, 2010 to April 30, 2011 DCHFP contract period. This is the 10-month period covering the remaining time period of the third contract year. This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). This rate development process was based primarily on the managed care organization (MCO) encounter data supplemented by plan-reported financial data; therefore, this rate development process is characterized as a complete rebase of the capitation rates.

The District has chosen contract rates within the actuarially sound rate range and is finalizing agreements with each MCO. If any changes are made to the rates documented in this letter, the letter will be updated to certify the final rates are all within the actuarially sound rate range. The rates offered to each MCO are outlined in Attachment A and are within the actuarially sound rate range. These rates represent a 5.8% overall rate increase assuming full payment of the incentive arrangement. The rate ranges and associated budget projections are provided in Attachments A and B. Note the budget projections reflect an annual projection to allow for comparisons to past certifications. The projections are also based on the member months for the current DCHFP population and do not consider the additional enrolment related to the coverage expansion up to 133% of the federal poverty level (FPL).

Rate Methodology

Overview

Capitation rate ranges for DCHFP were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the rate range development was the base data. Mercer and the District discussed available data sources for rate range development. These include Medicaid encounter data and MCO reported DCHFP financial data. The encounter and financial data was equally weighted during this rate-setting exercise, as it has been determined that the encounter data is reasonably complete. Each data source was reviewed to ensure it matched the populations and benefit package defined in the State Plan and contract.

To develop capitation rates, adjustments were applied to the base data consistent with the CMS Rate-Setting Checklist:

- Completion factors to account for unpaid claims at the time of the data submission (AA.3.14)
- Adjustment to reflect the underreporting of encounter data (AA.3.14)
- Trend factors to forecast the expenditures and utilization to the appropriate contract period (AA.3.10)
- Prospective and historic program changes not reflected in the base data (AA.3.1)
- Data smoothing (AA.5.0)
- Administration loading (AA.3.2)

In the end, Mercer developed a rate range for each individual rate cell for the District to use in contracting with the MCOs for the DCHFP.

Base Data Development

The financial data received from the DCHFP MCOs was incorporated as one of the data sources for rate range setting. This data was certified as accurate by financial representatives of each current MCO. Financial data provides per member per month (PMPM) medical expenses by major category of service (COS) for each of the District's current rate cells. Mercer reviewed the MCO-reported data for accuracy and consistency of reporting. This review is discussed in more detail in the Financial Data section below.

The District has been working with the MCOs on encounter data submission over the past few years. Mercer reviewed the current encounter data submissions to determine the potential use for rate range development. The encounter data provides valuable information on the average utilization and unit cost of services covered under the contract. Encounter data is also recommended by CMS as a source of utilization data for rate development. The DCHFP encounter data has vastly improved over the last couple years and is now deemed reasonable to use as a companion data source to the financial data, receiving 50% of the weight for the medical services.

Financial Data

Mercer validated and incorporated the fiscal year (FY) August 1, 2007 through July 31, 2008 (FY 2008) and the FY August 1, 2008 through July 31, 2009 (FY09) financial data as a data source in this rate range setting process. The financial data reflects the actual medical expenses to the MCOs including the subcapitation payments to providers for each of the rate cells. The expenses are net of pharmaceutical rebates and third party liability. Mercer reviewed the financial data to ensure it was appropriate to incorporate into the rate development. Specifically, Mercer reviewed the following issues:

- Completeness and accuracy of the submitted financial reports
- Consistency between submitted financial data and annual Department of Insurance filings for calendar year (CY) 2009
- Assurance that pharmacy rebates were reasonable and removed from the data
- Assurance that reinsurance premiums and recoveries were accurately reflected in the financial data
- Assurance that submitted financial data was specific to State Plan services only
- Consistency of data among MCOs' submissions on a rate cell basis

Adjustments were made to the financial data to reflect the complete cost of an actuarially equivalent population for the DCHFP contract.

Incurred-but-not-Reported (IBNR) Claims Adjustments — Mercer reviewed the remaining liability associated with IBNR claims for FY 2008 and FY 2009 individually for each of the MCOs. The overall adjustments for FY 2008 and FY 2009, using paid claims data through September 2009, were 0.98% and 4.78%, respectively.

Redistribution of Subcapitation Payments — Since the MCOs reimburse providers using different payment arrangements, Mercer adjusted each MCO's reported financial data, as

necessary, to reflect a uniform payment methodology. Some MCO data needed to be adjusted for subcapitation arrangements to better allocate costs across the various rate cells. Since many of the subcapitation arrangements do not vary the rates by age/sex, the subcapitation expenditures were redistributed to each rate cell in a budget neutral fashion according to the cost distribution in the encounter data. This was a budget neutral adjustment.

The aggregate FY 2009 financial data submitted by the MCOs are included as Attachment C-1.

Encounter Data

To support the rate range development, Mercer summarized the District's encounter data from August 1, 2007 through July 31, 2008 (FY 2008) and August 1, 2008 through July 31, 2009 (FY 2009) by rate cell and COS. These data periods were selected because they are recent and the MCOs have made significant strides in improving the quality of their encounter data in recent years. In order to ensure the encounter data reflected all covered services, Mercer performed high-level validation checks on the data.

Mercer compared the encounter data to the historical financial data for the same time periods to ensure all costs were reflected. In total, the paid amounts (as reflected in the MCO_Paid amount field) in the encounter data are lower than the reported financial data for the corresponding time period. The final comparison, after the adjustments described in this section were applied, indicated approximately 93% of the financial expenses are reflected in the encounter data. The major difference is related to the subcapitation payments made versus the shadow-encounters reported. Pharmacy data was not included in the comparison because pharmacy encounter data is not currently being captured.

Certain covered expenses were not captured in the encounter data due to reporting or data collection issues. Mercer reviewed the additional data and made adjustments to include all services covered under the contract.

Recipient Claims Reported Outside of Encounter Data — A small subset of claims were submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for services such as dental, transportation and vision. The supplemental file identified the recipient associated with the encounter, so Mercer added these claims to the appropriate COS and rate cell.

Subcapitated Provider Data — Encounters for subcapitated providers are submitted with an MCO paid amount equal to zero. In order to assign a value to these valid encounters for rate-setting purposes, Mercer shadow-priced the subcapitated encounters. For each MCO and procedure code, Mercer calculated a ratio of the MCO paid amount to the Medicaid proxy amount (ACS_Paid_Amount) for the paid encounters with positive MCO paid amounts. For the subcapitated encounters, this ratio is multiplied by the Medicaid proxy amount (ACS_Paid_Amount) to assign a value to the subcapitated encounter.

Pharmacy Data — Currently, pharmacy data is not submitted through the encounter data collection system. Pharmacy data is, however, collected in the financial reports submitted by the MCOs. For this rate range development process, Mercer relied solely on the financial data for the pharmacy rate. Therefore, there are no expenses included for pharmacy in the encounter data exhibits.

Completion Factors — Since the encounter data has limited runout (two months), Mercer calculated completion factors to account for incurred claims not reflected in the encounter data. Due to dating conventions within the encounter data, Mercer relied on the financial lags as the source of the completion factors. Mercer estimated the incurred claims for FY 2008 and FY 2009 in the financial data and compared it to the total paid claims for services incurred during the same period in the financial data with similar runout. The ratio of paid claims to incurred claims in the financial data resulted in the completion factor for the encounter data. This ratio was calculated by major COS separately for each MCO's data. Mercer applied these completion factors to the encounter data by COS and MCO. In total, the IBNR adjustment for FY 2008 and FY 2009 resulted in an increase of 1.44% and 5.86%, respectively.

Adjustment for Missing Amerigroup Dental Data — Mercer noticed the dental encounters for Amerigroup had decreased substantially in 2008. Upon follow-up with Amerigroup, Mercer determined there was an issue with Amerigroup's dental vendor. Mercer applied an adjustment to the dental service costs to account for the missing dental data. This adjustment was calculated based off the historical portion of dental encounters attributable to Amerigroup. This adjustment was applied by month for November 2007 through June 2008. The overall adjustment to the FY 2008 dental data was 18%.

Net Reinsurance Costs — The MCOs have been purchasing reinsurance coverage for high cost inpatient claims. Mercer reviewed the historical experience from FY 2008 and FY 2009 to determine the average net reinsurance PMPM (premiums minus recoveries). Based on this review, Mercer applied reinsurance adjustment factors to the Inpatient — Physical

Health COS. The adjustments resulted in an increase of 0.5% and 1.11% in FY 2008 and FY 2009, respectively.

Encounter Data Underreporting Adjustment — The initial comparison of encounter data to financial data showed that 83% and 93% of the financial data was reflected in the encounter data in FY 2008 and FY 2009, respectively. The primary area of difference is related to services where MCOs have subcontracted providers such as physician services. In addition, the exiting of one of the MCOs from DCHFP led to the underreporting of encounter data, to some extent, in FY 2008. As a result, Mercer applied an encounter underreporting adjustment to the encounter data for this MCO to reflect what the expected service cost would have been had the MCO been reporting their encounters under normal conditions. After the underreporting adjustment was applied to FY 2008 data, the encounter data now reflects 88% of the financial data, which is more consistent with FY 2007 findings. Pharmacy data was not included in the comparison because pharmacy encounter data is not currently being captured.

The aggregate FY 2009 encounter data submitted by the MCOs is included as Attachment C-2.

Based on our review of the covered populations and covered services of DCHFP, the following issues do not impact the plan reported financial or encounter data. Therefore, no adjustments were made to the financial or encounter data for these issues.

Prior Periods of Coverage, Retroactive Eligibility and Enrollment Lag Periods (AA.3.4) — The base data was summarized to reflect the coverage period for the MCOs. These other eligibility periods were not reflected in the financial data and were excluded from the encounter data.

Non-covered Populations (AA.2.1, AA.2.2) — DCHFP covers individuals classified as temporary aid to needy families (TANF). Therefore, the base data is specific to the TANF population and excludes all other populations.

Non-covered Services (AA.2.4) — The DCHFP rates are based on State Plan-approved services covered under the DCHFP contract. All other services have been excluded from the base data. For example, the MCOs are not responsible for services delivered within the schools, thus these costs have been excluded from the rate base.

Client Participation Amounts (AA.2.3, AA.3.13) — Costs associated with "spenddown" and post-eligibility treatment of income are not included in the base data.

TPL (AA.3.6) — The base data does not include costs associated with TPL.

Excluding District Payments Made Outside of the Managed Care Program (AA.3.5, AA.3.8, AA.3.9) — The District makes payments for Graduate Medical Education (GME), Disproportionate Share Hospital (DSH) and Federally Qualified Health Center (FQHC) cost settlements outside of managed care. These expenses are not reflected in the financial or encounter data.

Copayments (AA.3.7) — The MCOs are not allowed to collect copayments from the DCHFP eligibles. Since the MCOs cannot collect copayments, the financial and encounter data reflects the total cost of providing the covered services.

The District does not cover any 1915(b)(3) services in this managed care program.

Rate Category Groupings

The base data sets are split into cohorts that represent different age/gender bands, which inherently represent different levels of risk. The following is a list of the historical 11 rate cells for DCHFP.

- Male & Female <1
- Male & Female 1-12
- Female 13-18
- Male 13-18
- Female 19-36
- Male 19-36
- Female 37+
- Male 37+
- Male & Female 50-64 Year-old Expansion population
- Infant's Month of Birth
- Mother's Month of Delivery

These cells were selected based on a review of the historical cost structures within these age/gender bands. The separate maternity payments reflect the increased cost and financial risk of these events. Effective July 1, 2010, the District will be expanding Medicaid eligibility to the population up to 133% of the FPL. As part of this State Plan Amendment under health care reform, the District's 1115 waiver, covering the 50-64 year-old expansion population, will end. In addition, many of the individuals currently covered through the District's Alliance program will become Medicaid eligible. As part of this rate-setting exercise, Mercer analyzed the rate cells to determine how to handle the population over age 50.

As can be seen in the table below, the population over age 50 has costs significantly higher than the 37-49 year old population. In addition, the females' PMPM cost exceeds the males'.

Age Group	Gender	FY 2008/2009 PMPM
37-49 Years	F	$258.34
37-49 Years	M	$169.05
50+	F	$363.28
50+	M	$281.07

Based on this analysis, Mercer and the District concluded a rate cell structure with separate rate cells for the 37-49 year old population and the 50+ population split by gender was the most appropriate. Therefore, the FY 2011 rates will now have 12 rate cells. The addition of the rate cells required adjustments to the current rate cells. These percentage adjustments were applied in a budget neutral fashion.

Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- Health care economic indices such as Consumer Price Index for the South-Atlantic region
- Mercer's regression analysis
- Trends exhibited in the financial data submitted by the MCOs
- Data related to issues raised by the DCHFP MCOs
- Trends in other State Medicaid programs for similar TANF populations

Mercer developed individual trends for each COS. Mercer's target trend can be found in the following table.

Major COS	Trend Assumption
Inpatient Hospital Services	4.5%
Physician Services	-2.0%
Outpatient Hospital Services	11.5%
Pharmacy Services	6.5%
Dental	10.5%
Mental Health Services	1.5%
Other Services	1.5%
Weighted Average Trend Factor	5.57%

The overall annual trend assumption for DCHFP was 5.57%. This reflects approximately 2.5% cost trend and 3% utilization trend.

Programmatic Changes/Rate Issues

Programmatic change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base year. Mercer will apply programmatic change adjustments to incorporate factors not fully reflected in the base data. These adjustments were mutually exclusive and made only once in the rate-setting process. Since the changes were effective after August 1, 2008, the impact was not fully reflected in the base data thus warranting consideration in the rate development.

Changes to the District's Medicaid Physician Fee Schedule — The District increased the Medicaid fee schedule for primary care and specialist physicians to the Medicare schedule in effect April 2009. In October 2010, the fee schedule will be set at 80% of Medicare. Mercer analyzed the encounter data to determine the impact of the Medicaid fee schedule changes on the MCOs. Mercer re-priced the encounters for primary care and specialist physicians based on the 2009 Medicare fee schedule for the District of Columbia. For procedure codes not on the Medicare fee schedule, the rates were left at the MCO rates. This results in an increase of 7.3% to physician costs in the base data.

Addition of Adult Dental to the Program — Effective May 1, 2009, the District modified the DCHFP contract to move the coverage of adult dental benefits from fee-for-service (FFS) to managed care, for DCHFP adults. Mercer summarized the FFS expenses incurred by

DCHFP adults from May 2007 through September 2008. The data suggested an increase in dental expenses in the more recent months, as individuals became more aware of the benefit. Mercer developed the base costs using the April 2008 through June 2008 expenses. Mercer and the District also incorporated an expansion adjustment to these costs of 30% to account for anticipated utilization increase upon the introduction of this benefit to the managed care networks. The base period data reflects three months of adult dental costs; therefore, the adjustment applied equates to $2.2M.

Ambulance Fee Schedule Change — The District increased the ambulance rates for DC Fire and Emergency Medical Services in FFS effective October 1, 2008. Mercer analyzed the encounter data to determine the impact of the increase to the Medicaid ambulance fee schedule change on the MCOs. Mercer applied the percentage increase in the ambulance rates to the encounters for ambulance services by procedure code. For procedure codes not impacted (non-emergent transportation), the rates were left at the MCO rates. The impact of this change increases the transportation cost in the base data by 16%.

Residential Treatment Center (RTC) Fee Increase — RTC fees are being increased from $250 to $343 per day. Based on 2008 data submitted by the MCOs, Mercer analyzed the impact of this rate change on the DCHFP rates. These costs are captured in either the Inpatient Hospital — Mental Health or the Residential Treatment Center category of the data book. The overall impact of this rate change on these expenses is a 6.2% adjustment to Inpatient Hospital — Mental Health and Residential Treatment Center costs.

The overall impact of programmatic changes on the base data is an upward adjustment of approximately 2.2%.

Data Smoothing

As part of the rate development process, Mercer reviewed data from multiple years (FY 2008 and FY 2009) of the program to arrive at the overall financial data source for rate setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially-sound capitation rates. Mercer has applied credibility weighting, as appropriate, to blend data from the two FYs focusing on the most recent year of data.

For the financial data, Mercer put the majority of the weight (70%) on the FY 2009 data and incorporated the FY 2008 data (30%) to smooth out fluctuation in inpatient hospital costs

from year to year. This enhanced the credibility of the data set and increased the stability of the rates. This process was cost neutral per step AA.5.2 of the CMS Rate-Setting Checklist. Similarly, Mercer blended the two years of encounter data by assigning 70% credibility to the FY 2009 data and 30% to the FY 2008 data.

Finally, Mercer blended the rates based on the financial and encounter data. As mentioned earlier, the encounter data has improved over the last couple of years. This warrants greater reliance on the encounter data. Thus, Mercer has blended the financial and encounter data by assigning 50% credibility to the financial data and 50% to the encounter data. The pharmacy rate component is entirely weighted on the financial data, since encounters are not currently collected for pharmacy services.

Managed Care Assumptions

In the development of the rate ranges, Mercer and the District discussed areas for improvements in managed care efficiency. The major consideration in the rate development was the exiting of one of the MCOs effective April 30, 2010. Mercer performed detailed analyses of the encounter data to identify efficiencies that are likely to be gained by transferring the exiting MCOs members to the remaining MCOs.

Mercer identified higher emergency room and outpatient costs for the exiting MCOs. Based on a review of the encounter data, Mercer determined the higher costs were due to higher cost per client served versus more clients served. In prior analysis, Mercer had performed a risk assessment analysis of the MCOs and concluded the exiting MCO had the lowest risk score, but the highest cost PMPM. As a result of these analyses, Mercer applied a downward efficiency adjustment of 7% to the outpatient and emergency room costs.

Mercer also made minor adjustments to categories with outliers for a particular MCO to further smooth the rates.

The overall impact of managed care assumptions was a reduction of 3.6% to the Target rates.

Commercial Reinsurance

To provide protection against the risk of catastrophic claims, the DCHFP MCOs may purchase reinsurance for inpatient hospital claims on the commercial market. The District

recognizes this reinsurance arrangement and considers the net costs associated with reinsurance in the rates. One of the MCOs received a waiver of the reinsurance requirement, and Mercer made an adjustment to account for this arrangement. For more information on the reinsurance costs, please refer to the adjustments discussed on Page 5 of this letter. This arrangement is allowable per subsection AA.6.0 of the CMS Rate-Setting Checklist.

Incentive Arrangements

DHCF has implemented a pay-for-performance program in the DCHFP contract. The MCOs have the opportunity to earn incentive payments by meeting various performance targets as defined in the contract. This incentive arrangement is funded through a 1% withhold from the capitation rates. Since DHCF chose to contract for certain rate cells at the bottom of the rate range, the withhold causes the interim rates for certain rate cells to fall below the range. In Mercer's actuarial opinion, this arrangement is actuarially sound as the overall weighted average rate after consideration of the withhold is within the actuarially sound rate range. The rates with and without the withhold are outlined in Attachment A. The total expenditures in Attachment B have been calculated assuming the entire withhold is paid out to the MCOst through the pay-for-performance program This arrangement is allowable per subsection AA.7.0 of the CMS Rate-Setting Checklist.

Administration and Profit and MCO Assessment

Mercer and the District reviewed the components of the administrative allowance to evaluate the administrative rates paid to the MCOs. The review focused on the reporting and organizational requirements detailed in the DCHFP contract. Mercer modeled the cost structure for these requirements to determine the administrative load necessary for an average plan in this program. Since this contract also includes the 50,000 members currently covered under the District's Health Care Alliance program, Mercer considered this enrolment along with the 90,000 current DCHFP members in assessing the administrative load. The exiting of one of the MCOs increases the enrolment of the other MCOs. Mercer's analysis concluded this should provide opportunities for economies of scale for the remaining MCOs. Based on the analysis and comparisons with other state Medicaid programs' administrative allowances, Mercer assumed an overall administration load of approximately 9.5% for the final premium rates. This percentage varied between the non-maternity (10%) and the maternity (6%) rate cells to account for the different premium levels.

In addition, Mercer included profit and margin considerations in the rate development explicitly through a load of 2% of premium. This is an acceptable rate consideration per AA.3.2 of the CMS Rate-Setting Checklist.

For many years, the Department of Insurance, Securities and Banking (DISB) in the District has imposed an assessment on Health Management Organizations (HMOs) and Preferred Provider Organizations (PPOs) for the privilege of operating in the District to cover insurance department costs. This HMO/PPO assessment has traditionally been waived for Medicaid-contracting insurers. In May 2010, the commissioner of insurance extended the application of this assessment to the Medicaid MCOs operating in the District and licensed by the DISB as HMOs. This is a uniform, broad-based fee imposed on all HMOs and PPOs and all lines of business. The assessment amounts to 2.0% of premiums.
This assessment is a legitimate cost of doing business in the District for Medicaid MCOs and reasonable to include in the consideration of actuarially sound capitation rate ranges. Since this is a cost of doing business in the District, Mercer included consideration for this assessment in the rate range development. The assessment is expressed as a percentage of the gross capitation rate (e.g., premium). Mercer applied a 2.0% adjustment consistent with the assessment that will apply to the MCOs.

In total, the overall load applied to the rates for administration, profit/contingencies and assessments was approximately 13.5%.

Rate Ranges

Mercer developed actuarially sound rate ranges for the District to use in rate negotiations with the MCOs. Mercer specifically priced the upper and lower bound of the rate ranges by varying the assumptions outlined above. Mercer varied the trend assumptions and the financial data adjustments to account for different levels of managed care efficiency and potential risk selection. The resulting rate range was approximately +/- 5% around the Target rate. As a result, the lower bound of the rate range represents a rate for a very efficient MCO and the upper bound represents the least amount of efficiency the District is willing to purchase. The final contract rates will be selected by the District in contracting with the MCOs. The rate ranges are included as Attachment A to this letter.

Rate Development Overview

To provide additional detail on the rate development, Mercer has provided an overview of the adjustments applied to each rate cell in Attachment D. This exhibit presents the breakdown of the assumptions used to calculate the Target rate within the actuarially sound rate range. The actual contract rates differ from the Target rates based on the District's contracting decisions, but all rates are within the actuarially sound range.

Family Planning Portion of the Rates

At the request of the District, Mercer has analyzed the component of the rates associated with family planning services so that the District may claim the enhanced federal match of 90% on these services. CMS issued a guide in June 2009 to assist States in determining which services are allowed to be claimed at the enhanced federal match rate. Specific details on codes used to identify family planning services can be found in the document accompanying this letter.
Attachment E contains the PMPMs associated with family planning that will be claimed at the enhanced match rate. Please note that these family planning PMPMs do not include load for administration, profit or the MCO assessment.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer has used and relied upon enrollment, encounter claims, reimbursement level, benefit design and financial data and information supplied by District of Columbia Department of Health Care Finance and its vendors. The District of Columbia Department of Health Care Finance and its vendors are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the July 2010 to April 2011 rate ranges in Attachment A were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of the District to demonstrate compliance with CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by MCOs for any purpose. Mercer recommends that any MCO considering contracting with the District should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges before deciding whether to contract with the District.

This certification letter assumes the reader is familiar with DCHFP, Medicaid eligibility rules and actuarial rating techniques. It is intended for the District and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at 612 642 8940.

Sincerely,

Jonathan C. Marsden, FSA, MAAA

An P. Danh, ASA, MAAA

Copy:
John McCarthy — DCHFP
Tom Steiner, Charles "Chip" Carbone — Mercer

Attachment A — DCHFP Rate Summary

Capitation Rates

Effective July 01, 2010 to April 30, 2011		Rates Before 1% Withhold		Rates After 1% Withhold		
Age/Sex Cell	Bottom of Rate Range	DC Chartered	Unison	DC Chartered	Unison	Top of Rate Range
< 1 Year, Male and Female	$ 304.18	$ 305.43	$ 305.43	$ 302.38	$ 302.38	$ 348.79
1 - 12 Years, Male and Female	$ 134.87	$ 135.43	$ 135.43	$ 134.07	$ 134.07	$ 150.75
13 - 18 Years, Female	$ 164.90	$ 165.58	$ 165.58	$ 163.92	$ 163.92	$ 182.46
13 - 18 Years, Male	$ 146.27	$ 146.87	$ 146.87	$ 145.40	$ 145.40	$ 161.32
19 - 36 Years, Female	$ 266.04	$ 292.03	$ 292.03	$ 289.11	$ 289.11	$ 292.03
19 - 36 Years, Male	$ 145.27	$ 167.69	$ 167.69	$ 166.02	$ 166.02	$ 167.69
37 - 49 Years, Female	$ 415.85	$ 453.86	$ 453.86	$ 449.32	$ 449.32	$ 453.86
37 - 49 Years, Male	$ 268.38	$ 292.45	$ 292.45	$ 289.52	$ 289.52	$ 292.45
50+ Years, Female	$ 610.53	$ 736.83	$ 736.83	$ 729.46	$ 729.46	$ 736.83
50+ Years, Male	$ 608.78	$ 614.03	$ 614.03	$ 607.89	$ 607.89	$ 614.03
Infant Month of Birth	$ 4,265.43	$ 4,302.99	$ 4,302.99	$ 4,259.96	$ 4,259.96	$ 4,667.53
Mother's Month of Delivery	$ 8,328.04	$ 8,362.17	$ 8,362.17	$ 8,278.55	$ 8,278.55	$ 9,068.03
Overall Weighted Average	$ 259.41	$ 272.85	$ 276.23	$ 270.12	$ 273.46	$ 288.88
Overall Rate Increase		5.9%	5.7%	4.8%	4.6%	

Attachment B — Projection of Expenditures

Age/Sex Cell	Projected July 2010 to April 2011 MMs	2009-2010 Rate*	2010-2011 Rates	2009-2010 Expenditures	2010-2011 Expenditures
< 1 Year, Male and Female	47,692	$ 333.33	$ 305.43	$ 15,897,229	$ 14,568,618
1 - 12 Years, Male and Fem	438,600	$ 127.74	$ 135.43	$ 56,025,872	$ 59,399,569
13 - 18 Years, Female	96,717	$ 148.77	$ 165.58	$ 14,388,735	$ 16,014,415
13 - 18 Years, Male	87,298	$ 144.84	$ 146.87	$ 12,644,064	$ 12,821,094
19 - 36 Years, Female	199,934	$ 270.97	$ 292.03	$ 54,176,095	$ 58,386,703
19 - 36 Years, Male	45,488	$ 132.74	$ 167.69	$ 6,038,076	$ 7,627,881
37 - 49 Years, Female	83,032	$ 464.45	$ 453.86	$ 47,029,607	$ 37,684,968
37 - 49 Years, Male	15,013	$ 347.36	$ 292.45	$ 8,023,213	$ 4,390,697
50+ Years, Female	24,275	$ 673.16	$ 736.83	$ 10,717,589	$ 17,886,718
50+ Years, Male	17,957	$ 673.16	$ 614.03	$ -	$ 11,026,037
Infant Month of Birth	4,079	$ 4,232.29	$ 4,302.99	$ 17,261,662	$ 17,550,016
Mother's Month of Delivery	3,808	$ 8,155.60	$ 8,362.17	$ 31,059,414	$ 31,846,105
Total*	1,056,004	$ 258.77	$ 273.86	$ 273,261,556	$ 289,200,823

*Rates are weighted averages of the individual MCO rates before the 1% withholdbased on annualized July 2010 to April 2011 MMs
The current rates have been in effect from May 2009 through June 2010

Note: The 2009-2010 expenses have been calculated based on enrollment summaries under the old rate cell structure.
The projected expenditures for 50+ females for 2009-2010 reflect the prior 50-64M&F expansion population rate cell.

MERCER

MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

June 22, 2010
Ms. Tanya Ehrmann
District of Columbia Department of Health Care Finance

Attachment C-1 — August 2008 – July 2009 Financial Data Reported by the DCHFP MCOs

STATEMENT FOR THE TIME PERIOD OF 08/01/2008 - 07/31/2009 FOR DC MCO FINANCIAL DATA

	<1 M&F	1-12 M&F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37+ FEMALE	37+ MALE	50-64 M&F Expansion	MONTH OF BIRTH	MONTH OF DELIVERY	TOTAL	Non-Delivery	Delivery
MEMBER MONTHS OR DELIVERIES	53,962	478,284	115,046	101,428	211,844	37,727	104,383	20,544	21,456	3,052	3,070	1,148,653	1,148,653	6,122
PMPM MEDICAL EXPENSES														
Inpatient Hospital - Physical Health	$ 145.07	$ 24.18	$ 22.63	$ 25.30	$ 50.75	$ 54.12	$ 118.84	$ 105.28	$ 161.14	$ 4,429.42	$ 8,345.22	$ 77.35	$ 48.63	$ 5,390.08
Inpatient Hospital - Mental Health	$ -	$ 2.43	$ 9.20	$ 11.02	$ 2.01	$ 0.75	$ 2.42	$ 0.84	$ 5.68	$ 23.34	$ 57.32	$ 3.77	$ 3.61	$ 30.35
Outpatient Hospital - Physical Health	$ 37.02	$ 22.37	$ 22.31	$ 16.20	$ 35.69	$ 17.50	$ 65.47	$ 47.21	$ 112.74	$ 141.03	$ 716.47	$ 33.38	$ 31.10	$ 428.58
Outpatient Hospital - Mental Health	$ 0.02	$ 0.27	$ 0.30	$ 0.36	$ 0.21	$ 0.24	$ 0.24	$ 0.14	$ 1.42	$ 1.87	$ 2.68	$ 0.29	$ 0.27	$ 2.17
Emergency Room	$ 28.41	$ 16.81	$ 17.52	$ 13.13	$ 32.49	$ 14.45	$ 33.74	$ 17.48	$ 19.85	$ 87.43	$ 249.77	$ 22.48	$ 21.58	$ 168.83
Physician - Physical Health	$ 57.45	$ 21.35	$ 21.46	$ 13.06	$ 43.35	$ 14.03	$ 62.27	$ 41.67	$ 54.69	$ 137.57	$ 337.54	$ 32.26	$ 30.63	$ 237.84
Physician - Mental Health	$ 0.02	$ 1.60	$ 1.45	$ 3.58	$ 1.02	$ 0.46	$ 1.52	$ 0.61	$ 1.86	$ 3.60	$ 6.84	$ 1.56	$ 1.52	$ 5.22
Pharmacy	$ 13.84	$ 10.07	$ 11.55	$ 11.77	$ 27.32	$ 10.44	$ 60.27	$ 36.38	$ 166.10	$ 2.28	$ 0.23	$ 21.66	$ 21.65	$ 1.25
Transportation	$ 2.82	$ 1.57	$ 2.06	$ 1.40	$ 3.93	$ 1.74	$ 5.59	$ 2.73	$ 2.05	$ 0.47	$ 2.66	$ 2.56	$ 2.56	$ 1.56
Dental	$ 1.93	$ 19.32	$ 25.81	$ 20.41	$ 5.28	$ 7.11	$ 2.80	$ 2.90	$ 7.55	$ 0.01	$ 0.21	$ 14.17	$ 14.16	$ 0.11
Other (DME, Home Health, Vision, Lab & X-Ray)	$ 5.44	$ 3.72	$ 7.00	$ 4.74	$ 12.67	$ 4.21	$ 15.90	$ 9.72	$ 14.42	$ 42.88	$ 118.70	$ 7.27	$ 7.34	$ 80.89
TOTAL MEDICAL EXPENSES	$ 291.81	$ 123.81	$ 141.06	$ 120.98	$ 214.72	$ 125.06	$ 370.87	$ 264.96	$ 545.29	$ 4,869.69	$ 7,837.62	$ 217.45	$ 193.62	$ 6,347.87

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MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

June 22, 2010
Ms. Tanya Ehrmann
District of Columbia Department of Health Care Finance

Attachment C-2 — August 2008 – July 2009 Encounter Data Reported by the DCHFP MCOs

STATEMENT FOR THE TIME PERIOD OF 08/01/2008 - 07/31/2009 FOR DC MCO ENCOUNTER DATA

	<1 M&F	1-12 M&F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37+ FEMALE	37+ MALE	50-64 M&F Expansion	MONTH OF BIRTH	MONTH OF DELIVERY	TOTAL	Non-Delivery	Delivery
MEMBER MONTHS OR DELIVERIES	58,210	468,995	113,054	99,963	209,268	35,521	109,426	22,545	15,958	3,071	3,011	1,152,945	1,152,845	6,082
PMPM MEDICAL EXPENSES														
Inpatient Hospital - Physical Health	$ 144.91	$ 15.65	$ 19.90	$ 22.22	$ 46.22	$ 56.40	$ 118.24	$ 112.19	$ 134.84	$ 3,466.18	$ 5,420.81	$ 67.87	$ 44.48	$ 4,433.85
Inpatient Hospital - Mental Health	$ -	$ 1.93	$ 8.93	$ 7.52	$ 2.51	$ 1.21	$ 3.25	$ 0.63	$ 3.54	$ -	$ 9.37	$ 3.26	$ 3.24	$ 4.64
Outpatient Hospital - Physical Health (ER Incl)	$ 28.43	$ 15.67	$ 24.36	$ 14.96	$ 47.76	$ 18.02	$ 79.93	$ 50.94	$ 69.85	$ 27.67	$ 302.15	$ 31.40	$ 30.54	$ 163.56
Outpatient Hospital - Mental Health	$ 0.02	$ 1.27	$ 0.37	$ 0.25	$ 0.23	$ 0.31	$ 0.46	$ 0.16	$ 1.48	$ -	$ 0.19	$ 0.72	$ 0.72	$ 0.09
Emergency Room	$ 40.56	$ 19.50	$ 18.21	$ 14.11	$ 29.15	$ 15.76	$ 26.54	$ 16.75	$ 29.12	$ 13.05	$ 36.74	$ 22.51	$ 22.39	$ 24.78
Physician - Physical Health	$ 44.24	$ 14.01	$ 15.40	$ 9.78	$ 25.83	$ 8.68	$ 38.35	$ 29.11	$ 38.42	$ 332.13	$ 1,526.18	$ 25.10	$ 20.23	$ 923.26
Physician - Mental Health	$ 0.48	$ 3.84	$ 3.62	$ 7.07	$ 1.41	$ 0.54	$ 2.20	$ 0.86	$ 2.00	$ 0.06	$ 14.29	$ 3.18	$ 3.15	$ 7.15
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Transportation	$ 2.22	$ 1.53	$ 1.93	$ 1.42	$ 3.63	$ 1.72	$ 5.31	$ 2.62	$ 3.35	$ 0.44	$ 37.77	$ 2.49	$ 2.39	$ 18.92
Dental	$ 0.25	$ 20.13	$ 27.59	$ 21.86	$ 6.17	$ 8.11	$ 5.80	$ 4.93	$ 5.34	$ 17.02	$ 18.89	$ 15.32	$ 15.23	$ 17.95
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 4.94	$ 2.87	$ 9.94	$ 5.70	$ 22.12	$ 4.24	$ 24.58	$ 15.58	$ 18.77	$ 5.56	$ 109.45	$ 10.28	$ 9.98	$ 56.99
TOTAL MEDICAL EXPENSES	$ 266.46	$ 99.43	$ 130.25	$ 104.89	$ 185.03	$ 114.00	$ 304.67	$ 233.78	$ 306.71	$ 3,862.10	$ 7,475.93	$ 182.14	$ 152.32	$ 5,651.19

Attachment D — Rate Development Overview

	Base Year	Target Rate Development Data Adjustments							10-11 Resulting Rate Range		
	A	B	C	D	E	F	G	H			
New Rate Cell Description	Base Year PMPM*	Trend **	Program Changes	Managed Care Adjustment	RC Adjustment	Administration ***	Profit ***	Assessment ****	Target Rate ***	Lower bound Rate	Upper bound Rate
< 1 Year, Male and Female	$ 279.20	5.2%	1.3%	-9.3%	0.0%	10.0%	2.0%	2.0%	$ 326.53	$ 304.18	$ 348.79
1 - 12 Years, Male and Female	$ 112.14	8.9%	1.4%	-3.8%	0.0%	10.0%	2.0%	2.0%	$ 143.42	$ 134.87	$ 150.75
13 - 18 Years, Female	$ 134.65	6.7%	1.5%	-2.3%	0.0%	10.0%	2.0%	2.0%	$ 174.54	$ 164.90	$ 182.46
13 - 18 Years, Male	$ 119.38	6.5%	1.5%	-2.6%	0.0%	10.0%	2.0%	2.0%	$ 154.41	$ 146.27	$ 161.32
19 - 36 Years, Female	$ 213.16	6.1%	4.4%	-2.7%	0.0%	10.0%	2.0%	2.0%	$ 279.90	$ 266.04	$ 292.03
19 - 36 Years, Male	$ 121.65	6.2%	4.5%	-4.4%	0.0%	10.0%	2.0%	2.0%	$ 157.27	$ 146.27	$ 167.59
37 - 49 Years, Female	$ 366.12	5.9%	2.9%	-2.3%	-8.0%	10.0%	2.0%	2.0%	$ 435.93	$ 415.85	$ 453.88
37 - 49 Years, Male	$ 271.37	5.7%	3.0%	-2.1%	-20.0%	10.0%	2.0%	2.0%	$ 281.08	$ 266.38	$ 292.45
50+ Years, Female	$ 522.78	6.2%	1.9%	-8.0%	8.0%	10.0%	2.0%	2.0%	$ 685.33	$ 610.53	$ 736.63
50+ Years, Male	$ 522.78	6.2%	1.9%	-8.0%	-10.0%	10.0%	2.0%	2.0%	$ 571.11	$ 508.78	$ 614.03
Infant Month of Birth	$ 3,970.26	2.5%	0.5%	-3.6%	0.0%	6.0%	2.0%	2.0%	$ 4,455.14	$ 4,285.43	$ 4,667.53
Mother's Month of Delivery	$ 7,638.88	2.8%	0.9%	-3.6%	0.0%	6.0%	2.0%	2.0%	$ 8,569.25	$ 8,328.04	$ 8,069.03
Overall	**$ 218.78**	**5.6%**	**2.2%**	**-3.6%**	**0.4%**	**9.3%**	**2.0%**	**2.0%**	**$ 275.04**	**$ 259.41**	**$ 288.88**

*Blend of 50% Financial Data and 50% Encounter Data
** The trend shown is annualized from the 22 month period July 1, 2010 to April 30, 2011
*** Shown as a % of the total rate before loading for premium tax.
**** Shown as a % of the gross premium.
***** Rate Development Formula: Lower Bound Rate = ((A*(1+B)^(22/12)*(1+C)*(1+D)*(1+E))/(1-F-G))/(1-H)

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GUY CARPENTER OLIVER WYMAN

Attachment E — Family Planning Rate Development

	Databook			Family Planning		Service Rate Range						Family Planning Rate Range		
New Rate Cell Description	Base Year PMPM	Base Year Rx	Base Year Medical	Family Planning Percentage	Base Year Family Planning PMPM	Lower bound Rate	Upper bound Rate	Rx Lower Bound	Rx Upper Bound	Medical Lower Bound	Medical Upper Bound	FP Lower Bound	FP Contract Rate	FP Upper Bound
< 1 Year, Male and Female	$ 279.20	$ 16.65	$ 262.55	0.0%	$ -	$ 262.33	$ 300.80	$ 18.08	$ 19.39	$ 244.27	$ 281.41	$ -	$ -	$ -
1 - 12 Years, Male and Female	$ 112.14	$ 9.93	$ 102.20	0.0%	$ 0.01	$ 116.51	$ 150.01	$ 10.78	$ 11.57	$ 105.54	$ 138.44	$ 0.01	$ 0.01	$ 0.01
13 - 18 Years, Female	$ 134.65	$ 11.48	$ 123.17	1.3%	$ 1.55	$ 142.21	$ 157.35	$ 12.48	$ 13.27	$ 129.76	$ 143.98	$ 1.83	$ 1.84	$ 1.81
13 - 18 Years, Male	$ 119.38	$ 11.35	$ 108.02	0.0%	$ 0.02	$ 126.14	$ 139.12	$ 12.31	$ 13.22	$ 113.83	$ 125.90	$ 0.02	$ 0.02	$ 0.02
19 - 36 Years, Female	$ 213.16	$ 27.56	$ 185.60	2.0%	$ 3.75	$ 229.43	$ 251.35	$ 29.90	$ 32.10	$ 199.64	$ 219.75	$ 4.03	$ 4.27	$ 4.44
19 - 36 Years, Male	$ 121.65	$ 9.84	$ 111.81	0.0%	$ 0.05	$ 126.14	$ 144.62	$ 10.67	$ 11.46	$ 115.47	$ 133.18	$ 0.06	$ 0.06	$ 0.06
37 - 49 Years, Female	$ 366.12	$ 62.00	$ 304.09	0.5%	$ 1.43	$ 358.63	$ 391.41	$ 64.91	$ 66.47	$ 296.71	$ 324.94	$ 1.40	$ 1.47	$ 1.53
37 - 49 Years, Male	$ 271.37	$ 39.94	$ 231.43	0.1%	$ 0.18	$ 231.43	$ 252.21	$ 34.65	$ 37.21	$ 196.78	$ 214.99	$ 0.14	$ 0.15	$ 0.15
50+ Years, Female	$ 522.78	$ 161.05	$ 361.73	0.0%	$ 0.04	$ 526.52	$ 635.44	$ 113.22	$ 182.34	$ 413.30	$ 453.10	$ 0.05	$ 0.05	$ 0.05
50+ Years, Male	$ 522.78	$ 161.05	$ 361.73	0.0%	$ 0.02	$ 438.77	$ 528.54	$ 94.35	$ 151.96	$ 344.42	$ 377.59	$ 0.01	$ 0.02	$ 0.02
Infant Month of Birth	$ 3,970.29	$ 1.21	$ 3,968.98	0.0%	$ 0.03	$ 3,853.74	$ 4,208.24	$ 1.58	$ 1.48	$ 3,852.36	$ 4,206.76	$ 0.02	$ 0.02	$ 0.03
Mother's Month of Delivery	$ 7,638.88	$ 5.42	$ 7,633.47	1.3%	$ 101.56	$ 7,508.56	$ 8,175.74	$ 5.88	$ 6.31	$ 7,502.69	$ 8,169.43	$ 95.82	$ 100.23	$ 106.69
Overall	$ 216.79	$ 21.78	$ 197.01	0.7%	$ 1.37	$ 229.64	$ 251.12	$ 23.17	$ 27.13	$ 202.37	$ 223.98	$ 1.39	$ 1.43	$ 1.53

Family Planning percentage was developed based on the encounter data. The percentage is applicable to the medical services. No pharmacy related expenses have been identified with respect to family planning.
The family planning rate is strictly a service rate. The District is not claiming for any administrative costs associated with family planning


E

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

April 4, 2011

To: Mayor Vincent Gray

From: Wayne Turnage

Through: Paul Quander, Interim Chief of Staff
Beatriz 'BB' Otero, Deputy Mayor

Subject: Issues at Department of Health Care Finance (DHCF)

The purpose of this memo is to provide a summary of the major issues at DHCF which have surfaced during the assessment of agency operations initiated shortly following my appointment on February 1, 2011. This assessment was conducted to identify a baseline of problems inherited from the previous Administration and to build a solutions oriented approach for addressing these issues as expeditiously as possible.

Issues of Concern at DHCF

For purposes of this memo the issues identified through this assessment have been grouped into three categories: (1) Reimbursement Problems; (2) Program Integrity Problems; and (3) Operations Problems. For each issue, this memo provides a description of the problem, the planned solution, and discusses potential budget implications.

Reimbursement. As shown in the Table on page 2, there are three significant reimbursement-related problems and each of these pose potential budget issues depending upon the manner in which they are resolved. The issues of most concern are the improper DRG payments *[Note: This is now resolved]*, unstable rates for Managed Care Organizations (MCOs), and problems with Disproportionate Share funding at Children's National Medical Center (CNMC). With the substantial benefit of hindsight, it can be said that the decisions (or inaction) that led to most of these problems were at-best ill-advised as the potential budget problems for the District under the described worst case scenarios would be serious.

DHCF is working to resolve these problems without major consequence to the District but frankly in the case of the improper DRG payments we must wait and hope for approval of the new rates from CMS. Staff inform me that approval is imminent but CMS has been sitting on this State Plan Amendment for nearly one year. In the case of DSH payments to CNMC, if the audit results stand, there is no apparent painless resolution at this time. With respect to MCOs, DHCF enters rate negotiations next

Issues of Concern	Worst Case Outcome	Solutions Underway	Budget Implications
Improper DRG Payments. In the 3rd quarter of FY10 DHCF developed a new DRG payment methodology for hospitals. Rather than wait for CMS approval, a decision was made to start paying the new rates in October 2010. That is illegal and CMS has yet to approve the new rates.	CMS could approve the rates and there would be no problem. However, if CMS decides to either reject the State Plan Amendment or significantly modify it, the rates DHCF are currently paying hospitals would be invalidated.	If CMS has not approved the new rates by June 1, 2011, the Director will rescind the new rates and order that payments cease until CMS makes a final decision. **RESOLVED as of May 1**	If DHCF's rate plan is not approved or is significantly modified, the agency faces potential disallowances because of the decision to pay the new rates before they were actually approved. This would add significantly to the $23.3 million in existing budget pressures for FY11 **(ISSUE HAS BEEN RESOLVED).**
Unstable MCO Rates. Previous agency leadership directed Mercer to set the MCO rates for the Alliance ***below*** the lowest level considered actuarially sound. The goal was to use higher rates on the Medicaid side to offset predicted Alliance losses. However, Medicaid expansion brought former Alliance members with higher health care costs into the Medicaid program and the expected margins on the Medicaid side have not materialized. Further, both MCOs have experienced substantial losses on their Alliance business. Additionally, DHCF is in negotiation with one MCO to settle a lawsuit filed alleging that rates paid in 2009 were actuarially unsound, costing the MCO nearly $20 million. While our actuary disagrees with the sum, they have informed us that the case has merit.	If actuarially sound rates are not established for FY12, one MCO is threatening to leave the program. This means DHCF will not have the required number of MCOs to retain the program and beneficiaries would have the freedom to receive health services through a fee-for-service arrangement and without the cost ceiling MCOs sometimes successfully impose on providers. This would undoubtedly increase cost beyond budgeted levels for the program in FY12. Further, should DHCF be advised to settle the lawsuit this will add to the unbudgeted pressures for FY12 Note: Rand conducted the one seminal study of the impact of MCOs and concluded that they lower costs by up to 25 percent. That a $125 million figure in DC	The Director is meeting with several companies that have expressed a desire to enter the District as an MCO. This is far from certain however and not a timely solution. In the interim, the Director will meet with Mercer to discuss the goals for FY12 rate setting. Data on MCO losses will be examined and we will seek to establish actuarially sound rates at the lowest possible level. Regarding the lawsuit, the agency is negotiating a settlement	In the Mayor's budget, significant savings were assumed on the premise that all MCO rates will be held flat. In light of this revelation and the lawsuit this assumption may no longer be realistic thus creating a budget pressure for FY12.
Disproportionate Share (DSH) Problems. Children's National Medical Center currently receives $12.5 million in DSH payments that are used to fund Department of Health nurses in the school system. Early indications from DSH audits are that the hospital does not provide the required level of uncompensated care to support this level of DSH payment.	CMS rules will require that these payments be terminated. Children's faces a possible disallowance for payments in FY11 that they will expect the District to cover. In addition, once these payments are terminated, the Department of Health will have up to a $12.5 million budget hole that will require either layoffs or additional funding for FY12.	If the preliminary audit results stand, there is no solution that would stave off termination of the DSH payments for Children's. However, rather than have the Department of Health absorb a $12.5 million cut, it might prove useful to bring DCPS into this discussion since the school system directly benefits from this program. Cutting the program would be devastating.	Depending on how this is resolved, DSH payments to Children's in FY11 – about $4 million at this point – will likely have to be returned and payments for FY12 of up to $12.5 million will not be made. This leaves a substantial budget problem for the Department of Health or potentially DCPS. We are trying several strategies to increase the reportable uncompensated care at Childrens .

Note: In the case of DSH funding, audits are underway to verify whether the reported high levels of uncompensated care used to support DSH allocations for two hospitals is matched by the actual experience at those facilities.

week and will attempt to resolve this problem in the District's favor but we face significant hurdles.

Not listed on the table is the reimbursement problem with ICF/MRs. When the rate structure for ICF/MRs was established in FY10, it covered only a portion of the 5.5% Stevie Sellow's tax. There is language in Statute that renders this tax uncollectible unless it is structured in a way that allows the District to collect FFP. This is not possible with current rate structure. The Mayor's budget for FY12 reflects the fact that the revenue from the Stevie Sellow's tax appears, at this point, to be uncollectible absent a change to the rate methodology. DHCF is pursuing the required change.

Program Integrity. There are significant program integrity issues at DHCF and some exist as a threat to the agency's budget. As the Table on page 4 indicates, these problems are the result of the agency's historical practice of paying for services in amount, duration, or scope that are beyond the levels allowed for in the existing State plan.

In terms of fiscal impact, the most problematic of these services is the ***optional*** Personal Care benefit. Over a rolling 12 month period, DHCF has paid $119.8 million for personal care services to 6,450 beneficiaries. [Note this figure does not include $57.8 million paid through the waiver program for persons who are elderly or disabled and the $9 million for persons in the DD waiver.] Although the State Plan limits this service to 1040 hours per recipient, the agency did not establish effective and permanent edits in the MMIS to deny payments beyond this limit. In addition, the process through which these services are authorized is lenient, and the agency has virtually no system in place to monitor whether the benefits being paid for are actually needed at the reimbursed levels.

Based on newspaper requests for information on this program, we expect a series of articles on the District's personal care program alleging substantial waste. I have ordered some short term solutions to slow spending in this area which we will implement immediately and a longer-term approach to bring this program in line with the actual level of need.

Individually, the other problems identified in the Table do not have the fiscal impact observed for personal care but, in the aggregate, pose significant risks to the District. DHCF staff have presently identified 15 services for which there is reason to believe that appropriate controls have never been established to guard the benefit. For the dental program, the absence of controls has resulted in more than $6 million in overpayments since FY10. This amount has been added to our FY11 spending pressure. I have directed staff to research each of these 15 issues immediately and establish the necessary protection in the Agency's claims payment system to prevent any future overpayments.

The last issue reported in the Table is a problem for DHCF that is created externally. The courts routinely order children into residential treatment programs with Medicaid as the payer. Unfortunately, federal audits have determined that many of the children who receive these placements do not meet the medical necessity requirements to support Medicaid reimbursement. As this problem is addressed across the District, agencies

Issues of Concern	Worst Case Outcome	Solutions Underway	Budget Implications
Personal Care Aide Medicaid benefit uncontrolled. The cost of the Medicaid Personal Care benefit is growing by 25 percent each year. There are strong indications that fraud is a key component of the growth. This benefit is offered as a State Plan Option service and is capped at 1040 hours. However, staff report that this limit has never been enforced and patient assessments are not used to determine the need for the service. A SPA was submitted to limit benefit to 520 hours but CMS has placed this request on hold pending discussion with DHCF of several concerns.	Current growth rate is not sustainable and there will likely be major news stories in the future about fraud in this program. News outlets have already begun FOIA requests for records on this program.	Rather than await CMS approval of the 520 limit the Director has instructed that the following actions be taken in the next 30 days: (1) Change the way in which the services are ordered by having physicians prescribe using a standard form that requires the doctor to give the diagnosis and patient functional limitations; (2) Adopt a new assessment tool to better determine exactly how many hours of PCA services a beneficiary requires; and (3) Require a stronger clinical review of all cases with request for more than1040 hours. In the long-term, the Director will require prior authorization before any PCA service is approved and plans to contract with an ASO to manage the entire process.	PCA savings are reflected in the budget for FY12. To ensure that these savings are realized the short term actions must be implemented immediately and the long-term plans must be initiated so that a program is in place by the last quarter of FY12.
Benefits Paid Outside of State Plan. The Medicaid program has been paying for numerous benefits beyond the legal limits established in the State Plan. Most notably, among these are dental services. However, staff have identified more than 15 problem areas that are believed to have longstanding overpayment problems.	Payments for all services that are not covered by the State Plan could be disallowed by CMS.	The Director has requested that a team be established to regularly identify problems of this nature and implement immediate fixes to DHCF policy and its payment system that will stop and prevent future overpayments. This group meets weekly and is required to prepare a status report on the progress being made in addressing problems.	The agency exposure for the dental problem is $3.7 million for FY10 and $2.8 million (thus far) in FY11. As a result, over $6 million was added to DHCF's FY11 spending pressure.
Payments made for Psychiatric Residential Treatment Facilities (PRTF) at risk. Payments have been made for PRTF services not established as medically necessary, most frequently because the service was court-ordered. System controls were not previously in place to prevent payment.	Payments identified by federal audits as having been made without established medical necessity will result in disallowances.	All current placements through a partnership with DMH and paid for by Medicaid are under medical necessity review. Beginning April 2011, all new placements will be reviewed and prior authorization numbers will be required before payment is made. The target start date for this change is June 1.	Due to this new policy, other child-serving agencies that have relied on Medicaid payment for residential services will have to pay for placement with local dollars if the case does not met medical necessity. This will create a spending pressure in FY12. Moreover, the District is at risk for disallowances if PRTF services from prior years are audited.

that have relied on Medicaid to pay for these placements will no longer be able to defray the cost of these services with federal dollars. This will obviously increase local spending pressures at a time when revenues are stressed.

Operations. As shown in the Table on pages 5 and 6, there are several outstanding operations issues that the agency must resolve to avoid negative budget consequences for the District. Of the six problems identified four -- MMIS certification, federally

Issues of Concern	Worst Case Outcome	Solutions Underway	Budget Implications
Work to ensure certification of MMIS certification is in catch-up mode. DHCF's MMIS system must be certified in the fall of 2011. When the system went live in 2010 it was under resourced, had more than 350 known defects, and had processed over $17 million in payments to providers who did not have a license on file. Leadership did not address any of these issues.	If the system is not certified by CMS according to schedule, DHCF's 75 percent match for all systems-related cost will be reduced to 50 percent creating a significant budget pressure.	The Director met with ACS national staff in February 2011 and secured increased resources for the project. A weekly monitoring process was put in place to alert the Director of continuing problems. While much work remains, the defects have been greatly reduced and documents from providers have been obtained to reduce a potential $17.5 million problem to less than $300,000.	The most significant budget implication associated with a failure to certify would be a loss of the 75% percent match rate for systems development which is being carried on the Agency's books.
Potential loss of Dept. of Defense discount pricing for HIV drugs for Medicaid beneficiaries. On December 31, 2010, the 1115 Waiver allowing the District to establish a closed network of pharmacies to dispense HIV antiretroviral medications to Medicaid FFS beneficiaries ended. Efforts by the previous leadership to resolve this problem prior to the end of the Waiver were not successful. The pharmacies in this network agreed to receive product replenishment by the DC Department of Health (DOH) Pharmaceutical Warehouse for the amount of HIV medications they dispensed in lieu of the normal pharmacy payment reimbursement.	If we do not receive CMS approval to continue this process, either one of two possible worst case outcomes will occur. 1) If any beneficiaries learned that DHCF continues to require that they receive drugs through a closed pharmacy network without official approval from CMS, the agency could be sued for free choice of provider. 2) If DHCF allowed or was forced to allow beneficiaries to receive these drugs from any pharmacy, the cost to the DC Medicaid program would be extremely high as the current discount is estimated at 60%.	DHCF and DOH meet weekly to discuss the new contracting. Also DHCF is in discussions with CMS on alternative ways to obtain CMS approval for selective contracting with pharmacies to allow the continuation of DOD pricing.	No estimate at present but lose of the network discount would be substantial.
Nationally required MMIS update substantially behind schedule. The District's federally mandated updates to all Medicaid MMIS systems were never contractually initiated and the work has yet to start. The deadline for completion of this work is 1-2012. Many States put contracts in place in 2010 and are now in the testing phase for the new systems.	If this work is not completed on 1-2012 DHCF will not be able to send or receive over 80% of our claims to and from any Medicaid provider. (80% of all claims are submitted electronically to DHCF)	DHCF is currently working with the Office of Contracts and Procurement to modify the ACS contract. The package requires Council approval. In the interim, the Director has requested that ACS use hours in its existing contract to bring in programmers and begin the work. These hours will be replenished once the contract is approved.	No budget impact but massive program failure as 80% of claims – roughly $1.8 billion – will either have to be paid manually or providers will not be reimbursed.

mandated changes to MMIS, potential loss of DoD pricing for antiretroviral drugs, failure to collect MCO drug rebates -- have budget consequences if not successfully resolved. Based on recent staff efforts to address these problems, I am encouraged about the prospects for success. Moving forward, we have established a process to monitor progress on these projects with steps to alert senior management at DHCF if problems resurface.

Issues of Concern	Worst Case Outcome	Solutions Underway	Budget Implications
MCO Drug Rebates not being collected. Effective March 23, 2010 new legislation required manufacturers that participate in Medicaid Drug Rebate Program to pay rebates for drugs dispensed to MCO enrollees. Previous leadership never authorized the technical work on the MMIS to capture these rebates. As a result, monies owed to the District are now being held by the pharmacies retroactive to 10-2010. The deadline for implementation was October 1, 2010.	DHCF has to retroactively ask pharmacies to provide information on drug utilization back to Oct 1, 2010. However, if we do not complete the required technical work the rebates will continue to sit with the pharmacies.	We are in the process of modifying the ACS contract and ACS will modify the MMIS system to receive pharmacy encounters. MCO contracts needs to be modified to require them to give the District pharmacy encounters from their PBM's. This process is now underway. Once completed, we will go back to 10/1/2010 to get monies from drug companies.	There should be no adverse impact once we successfully complete the work required to draw the rebates. Until such time the revenue is temporarily lost to the District.
Electronic Health Records Incentive Program not pursued. CMS issued guidance on the establishment of an incentive program to provide payment to certain eligible providers who adopt and become meaningful users of electronic health records. In August 2010 DHCF was awarded approximately $990K to develop the plan. DHCF was required submit the plan to CMS in late 2010 to facilitate a 2011 start date. The plan was never submitted	Without this program providers will not receive their incentive payment for adopting, implementing or upgrading electronic health record systems. Could result in a significant public relations problem.	DHCF has asked for and received an extension to use the funds through May 31, 2011. The agency has submitted to CMS a plan to carry out the steps in phases through August.	Adverse budget impact has been temporarily averted.
Restoring Cancelled Unity Pharmacy. The RX contract for Alliance Beneficiaries was cancelled last year, to be effective 4-30-2011 and no alternative was established.	Without resolution, 23,000 Alliance beneficiaries would have no access to drugs on May 1, 2011	Director considered having MCO's manage this benefit under an ASO arrangement but concern about unbudgeted costs in FY12 led to a last hour agreement with Unity.	Adverse outcome averted. No additional budget impact for FY12 anticipated.

Conclusion

Over the next months, DHCF staff will work diligently to address these problems. At the same time I have instructed staff to surface any additional problems that are uncovered as we handle the daily press of work. Should other issues arise that warrant the attention of the Mayor's office we will provide timely notice.

Managed Care Rate Setting For The District's Health Care Programs: Process and Outcomes

Presentation for the:

District Council

Department of Health Care Finance

June 24, 2011
Washington DC

Presentation Outline

- ☑ **Background on District's Managed Care Program**
  - *Federal Requirements Governing Rate Setting*
  - *District Methodology For Rate Setting*
- ☐ Rates Established For Medicaid and Alliance In FY11
  - *Timing Problems Between Rate Setting and Budget Process*
  - *Rates Approved By District Council in FY11*
  - *DHCF Modifications to Approved Rates*
- ☐ Rate Setting Approach Employed By The District in FY12
  - *Assumptions in Mayor's Budget*
  - *Rates Recommended By Actuary and Proposed By DHCF*
- ☐ Factors Driving $32 Million Local Impact

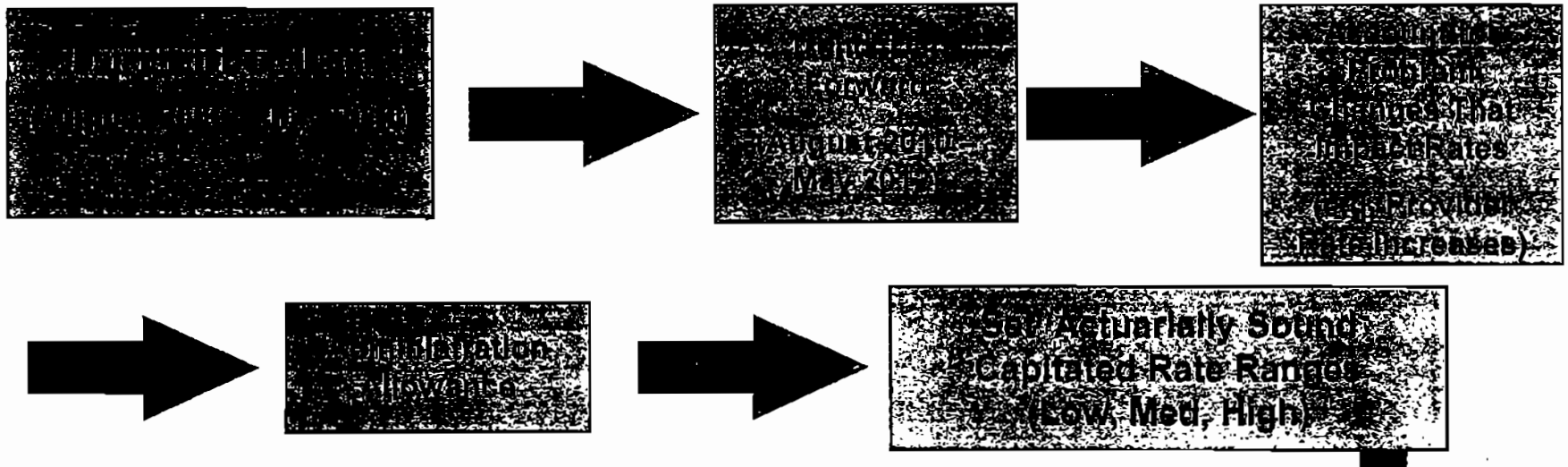
DHCF's Managed Care Program Governed By Federal Regulations

- DHCF's Managed Care Program for Medicaid and Alliance
  - Established in 1998 for Medicaid
  - Alliance moved from fee-for-service to managed care in 2006
  - Two managed care providers – Chartered and United
  - Agency recruiting a 3rd plan through CMS human care agreement

- Medicaid managed care governed by federal regulations
  - Rates must be actuarially sound, developed by a credentialed actuary – we use Mercer Consulting – and 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 is not a requirement
  - Failure to establish actuarial sound rates will produce losses

How Managed Care Rates Are Set



Medical trend is the projection of utilization and cost changes over time

*Trend Sources
- Annual trend exhibited in the health plans financial data
- Issues raised by managed care plans
- National trend indices
- Trends in neighboring State Medicaid programs

Presentation Outline

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- ☐ Factors Driving $32 Million Local Impact

DHCF's Rate Negotiation Process Not Aligned With District's Budget Calendar

Timeline	Executive Budget Process	DHCF Rate Setting Process
February	Agency budget proposals submitted to Mayor's Budget Review Team	No Activity
April	Mayor submits budget to Council on April 1st	DHCF rate setting process typically kicks off
May	No Activity	Mercer provides DHCF with actuarially sound rate range (low, medium, and high) for Medicaid and Alliance
June	No Activity	DHCF rate negotiation process is completed

Council Established Rates For Medicaid And Alliance Program In 2011 – Rates Were Changed By DHCF Leadership In June 2010

Program	Council-Approved Rates	Rates Set By DHCF Leadership
Medicaid	$212.02	*$262.32
Alliance	$194.38	*$147.77

*Rates were changed by DHCF leadership in June 2010 to maximize federal match. Gains from higher Medicaid margins were predicted to offset expected losses from lower Alliance rates. The strategy failed because it coincided with a policy that moved many Alliance members to the Medicaid program. Medicaid margins did not materialize and Alliance losses were significant.

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DHCF's Rate Negotiation Process Was Not Complete Until Two Months After Mayor's Budget Was Submitted

Timeline	Executive Budget Process	Rate Setting Process
February 17th	DHCF budget proposal submitted to Mayor's Budget Review Team	No Activity
April 1st	Mayor submits budget to Council	No Activity
April 4th	No Activity	Rate Setting Kickoff Meeting
May 23rd	No Activity	Mercer provides DHCF with actuarially sound rate range (low, medium, and high) for Medicaid and Alliance
June 1st	No Activity	DHCF submits final rate offer to managed care plans

Actuarial Soundness Requires Rates Higher Than Assumed In Mayor's Budget

Program	Rates In Mayor's Budget Submitted For FY12	Proposed FY12 Rates Following Mercer's Actuarial Analysis	Impact of +2 % Performance Incentive
Medicaid	*$257.52	**$289.82	$295.62
Alliance	$147.77	**$188.77	n/a
Estimated Total Local Cost	$179,304,121	$206,245,832	$211,349,093

*Rate is blended for Medicaid and Children's Health Program. **Rates were set at actuarially sound lower bound.

Note: Incentives will only be paid if MCOs successfully reduce adverse birth outcomes over previous year's performance, decrease their members use of the emergency room for non-emergency services, and decrease the number of inpatient admissions for low-acuity patients. Over time, savings from successful performance in these areas will pay for the cost of the incentive program.

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  - *Rates Recommended By Actuary and Proposed By DHCF*
- ☑ **Factors Driving $32 Million Local Impact**

Factors Impacting Additional Local Cost Estimate For Managed Care Rates

- Rate increases do not provide $32 million of profit to the District's two managed care companies

- Three factors are driving increase in local cost
  - Projected increases in enrollment
  - Movement to actuarially sound rates for both Medicaid ***and*** Alliance
  - Increase among beneficiaries in higher cost rate cells

- Managed Care companies must cover cost of beneficiaries health care with the approved capitated rates


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Jonathan C. Marsden, FSA, MAAA
Principal

MERCER

Government Human Services Consulting
333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
+1 612 642 8800
jonathan.marsden@mercer.com
www.mercer.com

Ms. Lisa Truitt
Office of Managed Care
District of Columbia Department of Health Care Finance
899 North Capital Street, NE
5th Floor
Washington, DC 20002

July 8, 2011

FINAL & CONFIDENTIAL — NOT FOR PUBLIC DISCLOSURE

Subject: District of Columbia Healthy Families Program (DCHFP) Rate Development and Actuarial Certification for the Contract Period August 1, 2011 through April 30, 2012

Dear Lisa:

The District of Columbia (District) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges covering the August 1, 2011 to April 30, 2012 DCHFP contract period. This is the 9-month period covering the remaining time period of the fourth contract year. This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). This rate development process was based primarily on the managed care organization (MCO) financial data supplemented by detailed encounter data; therefore, this rate development process is characterized as a complete rebase of the capitation rates.

The District has chosen contract rates within the actuarially sound rate range and is finalizing agreements with each MCO. If any changes are made to the rates documented in this letter, the letter will be updated to certify the final rates are all within the actuarially sound rate range. The rates offered to each MCO are outlined in Attachment A and are within the actuarially sound rate range. These rates represent a 0.9% overall rate increase before consideration of the incentive arrangement. The rate ranges and associated budget projections are provided in Attachments A and B. Note the budget projections reflect an annual projection to allow for comparisons to past certifications.

Rate Methodology

Overview

Capitation rate ranges for DCHFP were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the rate range development was the base data. Mercer and the District discussed available data sources for rate range development. These include Medicaid encounter data and MCO reported DCHFP financial data. The encounter and financial data were weighted 25% on the encounters and 75% on the detailed financial data during this rate-setting exercise, due to completeness issues with recent encounter data due to the District's implementation of the OMNICAID Medicaid Management Information System (MMIS) and the exiting of an MCO. Each data source was reviewed to ensure it matched the populations and benefit package defined in the State Plan and contract.

To develop capitation rates, adjustments were applied to the base data consistent with the CMS Rate-setting Checklist:

- Completion factors to account for unpaid claims at the time of the data submission (AA.3.14)
- Adjustment to reflect the underreporting of encounter data (AA.3.14)
- Trend factors to forecast the expenditures and utilization to the appropriate contract period (AA.3.10)
- Prospective and historic program changes not reflected in the base data (AA.3.1)
- Data smoothing (AA.5.0)
- Administration loading (AA.3.2)

In the end, Mercer developed a rate range for each individual rate cell for the District to use in contracting with the MCOs for the DCHFP.

Base Data Development

The financial data received from the DCHFP MCOs was incorporated as one of the data sources for rate range setting. This data was certified as accurate by financial representatives of each current MCO. Financial data provides per member per month (PMPM) medical expenses by major category of service (COS) for each of the District's current rate cells. Mercer reviewed the MCO-reported data for accuracy and consistency of reporting. This review is discussed in more detail in the Financial Data section below.

The District has been working with the MCOs on encounter data submission over the past few years. Mercer reviewed the current encounter data submissions to determine the potential use for rate range development. The encounter data provides valuable information on the average utilization and unit cost of services covered under the contract. Encounter data is also recommended by CMS as a source of utilization data for rate development. The DCHFP encounter data had completeness issues during fiscal year (FY) 2010, due to the OMNICAID implementation and the exiting of an MCO from the program. Therefore, the weighting on the encounters has been reduced to 25% for this rate-setting exercise.

Financial Data

Mercer validated and incorporated the FY August 1, 2008 through July 31, 2009 (FY 2009) and the FY August 1, 2009 through July 31, 2010 (FY 2010) financial data as a data source in this rate range setting process. The financial data reflects the actual medical expenses to the MCOs, including the subcapitation payments to providers for each of the rate cells. The expenses are net of pharmaceutical rebates and third party liability (TPL). Mercer reviewed the financial data to ensure it was appropriate to incorporate into the rate development. Specifically, Mercer reviewed the following issues:

- Completeness and accuracy of the submitted financial reports
- Consistency between submitted financial data and annual Department of Insurance filings for calendar year (CY) 2010
- Assurance that pharmacy rebates were reasonable and removed from the data
- Assurance that reinsurance premiums and recoveries were accurately reflected in the financial data
- Assurance that submitted financial data was specific to State Plan services only
- Consistency of data among MCOs' submissions on a rate cell basis

Adjustments were made to the financial data to reflect the complete cost of an actuarially equivalent population for the DCHFP contract.

Incurred-but-not-Reported (IBNR) Claims Adjustments

Mercer reviewed the remaining liability associated with IBNR claims for FY 2009 and FY 2010 individually for each of the MCOs. The overall adjustments for FY 2009 and FY 2010, using paid claims data through September 2010, were -0.14% and 3.69%, respectively.

Redistribution of Subcapitation Payments

Since the MCOs reimburse providers using different payment arrangements, Mercer adjusted each MCO's reported financial data, as necessary, to reflect a uniform payment methodology. Some MCO data needed to be adjusted for subcapitation arrangements to better allocate costs across the various rate cells. Since many of the subcapitation arrangements do not vary the rates by age/sex, the subcapitation expenditures were redistributed to each rate cell in a budget-neutral fashion according to the cost distribution in the encounter data. This was a budget-neutral adjustment.

Adjustment for Missing Health Right Financial Data

Health Right's contract with DHCF ended April 30, 2010. As such, Health Right was not in operation when the financial data request was distributed in October 2010. Therefore, the FY 2009 and FY 2010 data from Health Right was not available for the development of this Data Book. To account for the missing Health Right data, Mercer analyzed the PMPM relationships in the encounter data by service category with and without the Health Right data. Based on these comparisons, the following adjustments were applied to the financial data for FY 2009 and FY 2010, 4.1% and 2.5%, respectively. The lesser adjustment for FY 2010 reflects the transition of the former Health Right members to the other MCOs for the last three months of the study period.

The aggregate FY 2010 financial data submitted by the MCOs are included as Attachment C-1.

Encounter Data

To support the rate range development, Mercer summarized the District's encounter data from August 1, 2008 through July 31, 2009 (FY 2009) and August 1, 2009 through July 31, 2010 (FY 2010) by rate cell and COS. In order to ensure the encounter data reflected all covered services, Mercer performed high-level validation checks on the data.

Mercer compared the encounter data to the historical financial data for the same time periods to ensure the majority costs were reflected. In total, the paid amounts (as reflected in the MCO_Paid amount field) in the encounter data are lower than the reported financial data for the corresponding time period. The final comparison, after the adjustments described in this section were applied, indicated approximately 93% of the financial expenses are reflected in the encounter data. The major difference is related to the subcapitation

payments made versus the shadow encounters reported. Pharmacy data was not included in the comparison because pharmacy encounter data is not currently being captured.

Certain covered expenses were not captured in the encounter data due to reporting or data collection issues. Mercer reviewed the additional data and made adjustments to include all services covered under the contract.

Recipient Claims Reported Outside of Encounter Data

A small subset of claims were submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for services such as dental, transportation and vision. The supplemental file identified the recipient associated with the encounter so Mercer added these claims to the appropriate COS and rate cell.

Subcapitated Provider Data

Encounters for subcapitated providers are submitted with an MCO paid amount equal to zero. In order to assign a value to these valid encounters for rate-setting purposes, Mercer shadow-priced the subcapitated encounters. For each MCO and procedure code, Mercer calculated a ratio of the MCO paid amount to the Medicaid proxy amount (ACS_Paid_Amount) for the paid encounters with positive MCO paid amounts. For the subcapitated encounters, this ratio is multiplied by the Medicaid proxy amount (ACS_Paid_Amount) to assign a value to the subcapitated encounter.

Pharmacy Data

Currently, pharmacy data is not submitted through the encounter data collection system. Pharmacy data is, however, collected in the financial reports submitted by the MCOs. For this rate range development process, Mercer relied solely on the financial data for the pharmacy rate. Therefore, there are no expenses included for pharmacy in the encounter data exhibits.

Completion Factors

Since the encounter data has limited runout (two months), Mercer calculated completion factors to account for incurred claims not reflected in the encounter data. Due to dating conventions within the encounter data, Mercer relied on the financial lags as the source of the completion factors. Mercer estimated the incurred claims for FY 2009 and FY 2010 in the

financial data and compared it to the total paid claims for services incurred during the same period in the financial data with similar runout. The ratio of paid claims to incurred claims in the financial data resulted in the completion factor for the encounter data. This ratio was calculated by major COS separately for each MCO's data. Mercer applied these completion factors to the encounter data by COS and MCO. In total, the IBNR adjustment for FY 2009 and FY 2010 resulted in an increase of 0.01% and 4.37%, respectively.

Net Reinsurance Costs

The MCOs have been purchasing reinsurance coverage for high-cost Inpatient claims. Mercer reviewed the historical experience from FY 2009 and FY 2010 to determine the average net reinsurance PMPM (premiums minus recoveries). Based on this review, Mercer applied reinsurance adjustment factors to the Inpatient Hospital — Physical Health COS. The adjustment for FY 2009 was 1.02% to Inpatient Hospital — Physical Health and the adjustment for FY 2010 was 1.19%.

Encounter Data Underreporting Adjustment

After applying completion factors and the adjustments outlined above, Mercer reviewed the monthly incurred amounts captured in the encounter data to determine whether there were gaps in the encounter reporting due to the exiting of Health Right as an MCO or to the switch in the District's MMIS to OMNICAID. Mercer noticed significant differences between FY 2009 and FY 2010. The Health Right encounter data for FY 2010 was significantly lower than previous years. There were other minor gaps in the encounter data for other MCOs, which were assumed to be related to the OMNICAID implementation. To address this issue, Mercer and the District decided to apply an encounter underreporting adjustment to the encounter data to bring the monthly FY 2010, especially the months from December 2009 to April 2010, costs up to levels consistent with prior months. Minor discrepancies were also noticed for Health Right in FY 2009 and adjusted for. Specific adjustments were applied by MCO and claim type for institutional and professional encounters.

For dental encounters, Mercer noticed the encounters for Health Right had decreased substantially in FY 2009 and FY 2010. Mercer applied an adjustment to the dental service costs to account for the missing data. For the last portion of the Health Right contract, dental encounters were not captured in the data. Since the monthly incurred amounts were zero, a Health Right-specific adjustment was not feasible. Alternatively, this adjustment was applied by month for August 2009 through April 2010 and applied to all dental encounters.

In total, the underreporting adjustment for FY 2009 and FY 2010 resulted in an base data increase of 0.39% and 7.24%, respectively.

The aggregate FY 2010 encounter data submitted by the MCOs is included as Attachment C-2.

Based on our review of the covered populations and covered services of DCHFP, the following issues do not impact the plan reported financial or encounter data. Therefore, no adjustments were made to the financial or encounter data for these issues.

Prior Periods of Coverage, Retroactive Eligibility and Enrollment Lag Periods (AA.3.4)
The base data was summarized to reflect the coverage period for the MCOs. These other eligibility periods were not reflected in the financial data and were excluded from the encounter data.

Non-covered Populations (AA.2.1, AA.2.2)
DCHFP covers individuals classified as temporary aid to needy families (TANF). Therefore, the base data is specific to the TANF population and excludes all other populations.

Non-covered Services (AA.2.4)
The DCHFP rates are based on State Plan-approved services covered under the DCHFP contract. All other services have been excluded from the base data. For example, the MCOs are not responsible for services delivered within the schools; therefore, these costs have been excluded from the rate base.

Client Participation Amounts (AA.2.3, AA.3.13)
Costs associated with "spenddown" and post-eligibility treatment of income are not included in the base data.

TPL (AA.3.6)
The base data does not include costs associated with TPL.

Excluding District Payments Made Outside of the Managed Care Program (AA.3.5, AA.3.8, AA.3.9)

The District makes payments for Graduate Medical Education (GME), Disproportionate Share Hospital (DSH) and Federally Qualified Health Center (FQHC) cost settlements outside of managed care. These expenses are not reflected in the financial or encounter data.

Copayments (AA.3.7)

The MCOs are not allowed to collect copayments from the DCHFP eligibles. Since the MCOs cannot collect copayments, the financial and encounter data reflects the total cost of providing the covered services.

The District does not cover any 1915(b)(3) services in this managed care program.

Rate Category Groupings

The base data sets are split into cohorts that represent different age/gender bands, which inherently represent different levels of risk. The following is a list of the historical 12 rate cells for DCHFP:

- Male & Female <1
- Male & Female 1-12
- Female 13-18
- Male 13-18
- Female 19-36
- Male 19-36
- Female 37-49
- Male 37-49
- Female 50+
- Male 50+
- Infant's Month of Birth
- Mother's Month of Birth

These cells were selected based on a review of the historical cost structures within these age/gender bands. The separate maternity payments reflect the increased cost and financial risk of these events. The 50+ categories were established during the last rate-setting process to better account for the cost differentials of the population enrolling in Medicaid as a result of the State Plan Amendment to extend Medicaid eligibility up to 200% of the Federal Poverty Level (FPL). Further analysis has shown that the newly eligible Medicaid adults have incurred lower costs than the current Medicaid adults in those rate cells. This has necessitated an adjustment to the PMPMs, which is described further below.

Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- Health care economic indices such as Consumer Price Index for the South-Atlantic region
- Mercer's regression analysis
- Trends exhibited in the financial data submitted by the MCOs
- Data related to issues raised by the DCHFP MCOs
- Trends in other state Medicaid programs for similar TANF populations

Mercer developed individual trends for each COS. Mercer's target trend can be found in the following table.

Major COS	Trend Assumption
Inpatient Hospital Services	4.0%
Physician Services	4.5%
Outpatient Hospital Services	5.0%
Pharmacy Services	6.5%
Dental	8.5%
Mental Health Services	4.5%
Other Services	4.5%
Weighted Average Trend Factor	4.9%

The overall annual trend assumption for DCHFP was 4.9%. This reflects approximately 2.5% cost trend and 2.4% utilization trend.

Programmatic Changes/Rate Issues

Programmatic change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base year. Mercer will apply programmatic change adjustments to incorporate factors not fully reflected in the base data. These adjustments were mutually exclusive and made only once in the rate-setting process. Since the changes

were effective after August 1, 2009, the impact was not fully reflected in the base data thus warranted consideration in the rate development.

Changes to the District's Medicaid Physician Fee Schedule

The District increased the Medicaid fee schedule for primary care and specialist physicians to the Medicare schedule in effect April 2009. Based on the State Plan Amendment submitted in February 2011, the fee schedule will be set at 80% of Medicare. Mercer analyzed the encounter data to determine the impact of the Medicaid fee schedule changes on the MCOs. Mercer re-priced the encounters for primary care and specialist physicians based on the 2009 Medicare fee schedule for the District. For procedure codes not on the Medicare fee schedule, the rates were left at the MCO rates. Since FY 2010 data reflects payments at the 100% of Medicare level, Mercer calculated a downward adjustment of 15% to account for the reduction to the fee schedule.

Children's Dental Fee Schedule Decrease

DHCF granted the MCOs flexibility to implement an alternative Dental fee schedule for children in late 2010. As of February 2011, both MCOs had implemented an alternative fee schedule based on regional average Dental fees. This schedule will remain in place through September 2011 and is understood to continue assuming no significant drop in Dental utilization. Mercer analyzed the impact of this change on the MCOs and calculated a -22% adjustment to the Dental costs in the rates for the children's rate cells compared to the base data.

Adult Dental Fee Schedule Decrease

DHCF will implement a reduction to the Medicaid fee-for-service (FFS) fee schedule for Adult Dental services effective July 2011. Mercer analyzed the impact of this change on the MCOs and calculated a -15% adjustment to the Dental costs in the rates for the adult rate cells compared to the base data.

Hospital Diagnosis-related Group (DRG) Reimbursement Change

Effective April 1, 2010, the District re-based the DRG weights and rates for the hospitals in the District. For FFS, this change was implemented in a cost-neutral manner. The MCOs presented information indicating this change increased the costs of their hospital contracts based on higher utilization of Children's National Medical Center. Based on the submitted data and the proportion of the Inpatient claims impacted, Mercer calculated an adjustment

for the missing DRG impact. The estimated adjustment for this change, which will be applied in the rates, is 2.9% to Inpatient Hospital expenses in the rates.

MH Cost Increases

The MCOs have been experiencing increasing utilization for the Behavioral Health services, especially since May 2010. Mercer calculated an adjustment to reflect the higher PMPM expense levels from the May 2010 through December 2010 period. This resulted in an estimated financial impact of 25% adjustment to the Mental Health services.

Pharmacy Rebate Changes

Under PPACA, DHCF has the ability to seek Medicaid FFS level rebates for the drugs administered under managed care. The MCOs presented information on the impact of their Pharmacy contracts related to the reduction in rebates available to the MCOs as a result of this change. Based on information received from the MCOs and Mercer's experience in other states, it is estimated that 60% of the historical rebates will no longer be available to the MCOs. As a result, Mercer calculated an adjustment of 2.4% to the Pharmacy expenses in the rates.

Alliance Member Transition to DCHFP

Effective July 1, 2010, DHCF implemented a State Plan Amendment which resulted in approximately 30,000 former Alliance members attaining Medicaid eligibility for the DCHFP program. Based on data submitted by the MCOs, Mercer analyzed the costs for the Alliance transfer population compared to the 'legacy' Medicaid population by rate cell for July 2010 through December 2010. Across the adult rate cells, the overall impact of this transfer was a slight reduction on a PMPM basis. However, within the rate cells, especially for the adult males, the Medicaid PMPMs generally increased. Based on the rate cell specific analysis, the specific adjustments were applied by rate cell. This has approximately a -1% downward impact on the rates.

The overall impact of programmatic changes on the base data is a downward adjustment of approximately -3.2%.

Data Smoothing

As part of the rate development process, Mercer reviewed data from multiple years (FY 2009 and FY 2010) of the program to arrive at the overall financial data source for rate

setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound capitation rates. Mercer has applied credibility weighting, as appropriate, to blend data from the two FYs, focusing on the most recent year of data.

For the financial data, Mercer put the majority of the weight (70%) on the FY 2010 data and incorporated the FY 2009 data (30%) to smooth out fluctuation in Inpatient Hospital costs from year to year. This enhanced the credibility of the data set and increased the stability of the rates. This process was cost neutral per step AA.5.2 of the CMS Rate-setting Checklist. Similarly, Mercer blended the two years of encounter data by assigning 70% credibility to the FY 2010 data and 30% to the FY 2009 data except for the Infant's Month of Birth rate cell, which was entirely based on FY 2009 data due to reporting issues in FY 2010.

Finally, Mercer blended the rates based on the financial and encounter data. As mentioned earlier, the encounter data required significant adjustments due to certain completeness issues related to the OMNICAID implementation and the exiting of an MCO. This warrants greater reliance on the financial data for this exercise with the expectation that future rate-setting analyses will be based more heavily on the encounter data. Thus, Mercer has blended the financial and encounter data by assigning 75% credibility to the financial data and 25% to the encounter data. The Pharmacy rate component is entirely weighted on the financial data, since encounters are not currently collected for Pharmacy services.

Managed Care Assumptions

In the development of the rate ranges, Mercer and the District discussed areas for improvements in managed care efficiency. As part of the rate development, Mercer performed specific analyses related to the efficiency of Pharmacy benefit contracting and management, the MCO management of potentially preventable admissions, and the MCO management of low-acuity, non-emergent emergency room visits. No adjustments were incorporated into the rate ranges for these issues although the findings will be used to inform measures for the performance incentive program.

Commercial Reinsurance

To provide protection against the risk of catastrophic claims, the DCHFP MCOs may purchase reinsurance for Inpatient Hospital claims on the commercial market. The District recognizes this reinsurance arrangement and considers the net costs associated with

reinsurance in the rates. One of the MCOs received a waiver of the reinsurance requirement and Mercer made an adjustment to account for this arrangement. For more information on the reinsurance costs, please refer to the adjustments discussed on Page 5 of this letter. This arrangement is allowable per subsection AA.6.0 of the CMS Rate-setting Checklist.

Incentive Arrangements

DHCF has implemented a pay-for-performance program in the DCHFP contract. The MCOs have the opportunity to earn incentive payments by meeting various performance targets as defined in the contract. This incentive arrangement is funded through a 2% bonus above the contracted capitation rates. This 2% bonus payment is within the 105% limit established by CMS related to incentive arrangements. In Mercer's actuarial opinion, this arrangement is actuarially sound. The total expenditures in Attachment B have been calculated without consideration for the 2% bonus payment. This arrangement is allowable per subsection AA.7.0 of the CMS Rate-setting Checklist.

Administration and Profit and MCO Assessment

Mercer and the District reviewed the components of the administrative allowance to evaluate the administrative rates paid to the MCOs. The review focused on the reporting and organizational requirements detailed in the DCHFP contract and the historical PMPM administrative costs incurred by the MCOs. Mercer also modeled the cost structure for these requirements to determine the administrative load necessary for an average plan in this program. Since this contract also includes the 25,000 members currently covered under the District's Health Care Alliance program, Mercer considered this enrollment, along with the 130,000 current DCHFP members, in assessing the administrative load. The exiting of one of the MCOs increases the enrollment of the other MCOs. Mercer's analysis concluded this should provide opportunities for economies of scale for the remaining MCOs. Based on the analysis and comparisons with other state Medicaid programs' administrative allowances, Mercer assumed an overall administration load of approximately 9.6% for the final premium rates. This percentage varied between the non-maternity (10%) and the maternity (6%) rate cells to account for the different premium levels.

In addition, Mercer included profit and margin considerations in the rate development explicitly through a load of 2% of premium. This is an acceptable rate consideration per AA.3.2 of the CMS Rate-setting Checklist.

For many years, the Department of Insurance, Securities and Banking (DISB) in the District has imposed an assessment on Health Management Organizations (HMOs) and Preferred Provider Organizations (PPOs) for the privilege of operating in the District to cover insurance department costs. This HMO/PPO assessment had traditionally been waived for Medicaid contracting insurers. In May 2010, the commissioner of insurance extended the application of this assessment to the Medicaid MCOs operating in the District and licensed by the DISB as HMOs. This is a uniform, broad-based fee imposed on all HMOs and PPOs and all lines of business. The assessment amounts to 2.0% of premiums.

This assessment is a legitimate cost of doing business in the District for Medicaid MCOs and reasonable to include in the consideration of actuarially sound capitation rate ranges. Since this is a cost of doing business in the District, Mercer included consideration for this assessment in the rate range development. The assessment is expressed as a percentage of the gross capitation rate (e.g., premium). Mercer applied a 2.0% adjustment consistent with the assessment that will apply to the MCOs.

In total, the overall load applied to the rates for administration, profit/contingencies and assessments was approximately 13.5%.

Rate Ranges

Mercer developed actuarially sound rate ranges for the District to use in rate negotiations with the MCOs. Mercer specifically priced the upper and lower bound of the rate ranges by varying the assumptions outlined above. Mercer varied the trend assumptions and the financial data adjustments to account for different levels of managed care efficiency and potential risk selection. The resulting rate range was approximately +/- 6% around the Target rate. As a result, the lower bound of the rate range represents a rate for a very efficient MCO and the upper bound represents the least amount of efficiency the District is willing to purchase. The final contract rates will be selected by the District in contracting with the MCOs. The rate ranges are included as Attachment A to this letter.

Rate Development Overview

To provide additional detail on the rate development, Mercer has provided an overview of the adjustments applied to each rate cell in Attachment D. This exhibit presents the breakdown of the assumptions used to calculate the Target rate within the actuarially sound

rate range. The Actual contract rates differ from the Target rates based on the District's contracting decisions, but all rates are within the actuarially sound range.

Family Planning Portion of the Rates

At the request of the District, Mercer has analyzed the component of the rates associated with Family Planning services so that the District may claim the enhanced federal match of 90% on these services. CMS issued a guide in June 2009 to assist States in determining which services are allowed to be claimed at the enhanced federal match rate. Specific details on codes used to identify Family Planning services can be found in the document accompanying this letter.

Attachment E contains the PMPMs associated with Family Planning that will be claimed at the enhanced match rate. Please note that these Family Planning PMPMs do not include load for administration, profit or the MCO assessment.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer used and relied upon enrollment, encounter claims, reimbursement level, benefit design and financial data and information supplied by District of Columbia Department of Health Care Finance and its vendors. The District of Columbia Department of Health Care Finance and its vendors are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the August 2011 to April 2012 rate ranges in Attachment A were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges

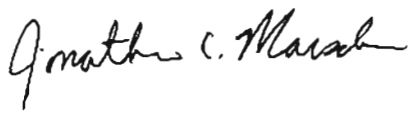
on behalf of the District to demonstrate compliance with CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance, and Mercer disclaims any responsibility for the use of these rate ranges by MCOs for any purpose. Mercer recommends that any MCO considering contracting with the District should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges before deciding whether to contract with the District.

This certification letter assumes the reader is familiar with DCHFP, Medicaid eligibility rules and actuarial rating techniques. It is intended for the District and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at 612 642 8940.

Sincerely,



Jonathan C. Marsden, FSA, MAAA
Principal

Copy:
Wayne Turnage; Gnayswaran Nathan — DHCF
Tom Steiner; Sudha Shenoy — Mercer

Attachment A — DCHFP Rate Summary

Capitation Rates

Effective August 01, 2011 to April 30, 2012

Age/Sex Cell	Bottom of Rate Range	DC Chartered	United	Top of Rate Range
< 1 Year, Male and Female	$ 298.32	$ 298.32	$ 298.32	$ 329.04
1 - 12 Years, Male and Female	$ 145.17	$ 145.17	$ 145.17	$ 160.10
13 - 18 Years, Female	$ 180.21	$ 180.21	$ 180.21	$ 199.09
13 - 18 Years, Male	$ 154.78	$ 154.78	$ 154.78	$ 170.13
19 - 36 Years, Female	$ 266.27	$ 266.27	$ 266.27	$ 294.80
19 - 36 Years, Male	$ 170.47	$ 170.47	$ 170.47	$ 187.91
37 - 49 Years, Female	$ 477.94	$ 477.94	$ 477.94	$ 529.07
37 - 49 Years, Male	$ 295.31	$ 295.31	$ 295.31	$ 325.69
50+ Years, Female	$ 716.84	$ 716.84	$ 716.84	$ 796.82
50+ Years, Male	$ 479.70	$ 479.70	$ 479.70	$ 527.59
Infant Month of Birth	$ 4,598.05	$ 4,598.05	$ 4,598.05	$ 4,980.20
Mother's Month of Delivery	$ 8,916.90	$ 8,916.90	$ 8,916.90	$ 9,754.00
Overall Weighted Average	$ 289.82	$ 289.82	$ 289.82	$ 319.90
Overall Rate Increase		1.3%	0.0%	

Attachment B — Projection of Expenditures

Age/Sex Cell	Annualized January to March 2011 MMs	2010-2011 Rate*	2011-2012 Rates	2010-2011 Expenditures	2011-2012 Expenditures
< 1 Year, Male and Female	62,572	$ 305.43	$ 298.32	$ 19,111,366	$ 18,666,479
1 - 12 Years, Male and Fem	523,252	$ 135.43	$ 145.17	$ 70,864,018	$ 75,960,493
13 - 18 Years, Female	105,860	$ 165.58	$ 180.21	$ 17,528,299	$ 19,077,031
13 - 18 Years, Male	93,316	$ 146.87	$ 154.78	$ 13,705,321	$ 14,443,450
19 - 36 Years, Female	297,172	$ 281.04	$ 266.27	$ 83,517,219	$ 79,127,988
19 - 36 Years, Male	155,288	$ 161.38	$ 170.47	$ 25,060,377	$ 26,471,945
37 - 49 Years, Female	133,516	$ 436.77	$ 477.94	$ 58,315,783	$ 63,812,637
37 - 49 Years, Male	101,944	$ 281.44	$ 295.31	$ 28,691,119	$ 30,105,083
50+ Years, Female	89,472	$ 709.09	$ 716.84	$ 63,443,700	$ 64,137,108
50+ Years, Male	91,540	$ 590.90	$ 479.70	$ 54,090,986	$ 43,911,738
Infant Month of Birth	3,364	$ 4,302.99	$ 4,598.05	$ 14,475,258	$ 15,467,840
Mother's Month of Delivery	3,268	$ 8,362.17	$ 8,916.90	$ 27,327,572	$ 29,140,429
Total*	1,657,296	$ 287.29	$ 289.82	$ 476,131,019	$ 480,322,222

*Rates are weighted averages of the individual MCO rates based on annualized January 2011 to March 2011 MMs

The current rates have been in effect from July 2010 through July 2011

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Attachment C-1 — August 2009 through July 2010 Financial Data Reported by DCHFP MCOs

STATEMENT FOR THE TIME PERIOD OF 08/01/2009 - 07/31/2010 FOR DC MCO FINANCIAL DATA

	< 1 M&F	1-12 M&F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37-49 FEMALE	37-49 MALE	50+ FEMALE	50+ MALE	MONTH OF BIRTH	MONTH OF DELIVERY	TOTAL	Non-Delivery	Delivery
MEMBER MONTHS OR DELIVERIES	48,037	429,801	96,960	86,764	203,486	60,718	82,066	20,166	30,212	20,632	2,686	2,769	1,074,375	1,068,539	5,456
PMPM MEDICAL EXPENSES															
Inpatient Hospital - Physical Health	$ 112.98	$ 24.78	$ 27.03	$ 26.96	$ 39.64	$ 41.10	$ 96.03	$ 66.44	$ 231.65	$ 158.36	$ 3,060.72	$ 6,100.24	$ 70.64	$ 47.32	$ 4,603.60
Inpatient Hospital - Mental Health	$ 0.05	$ 3.54	$ 15.13	$ 15.95	$ 3.59	$ 4.11	$ 4.20	$ 1.84	$ 3.35	$ 1.12	$ -	$ -	$ 5.43	$ 5.45	$ -
Outpatient Hospital - Physical Health	$ 23.64	$ 15.81	$ 16.37	$ 12.25	$ 24.35	$ 11.90	$ 62.54	$ 24.79	$ 142.27	$ 73.20	$ 69.24	$ 1,014.09	$ 28.53	$ 25.80	$ 548.95
Outpatient Hospital - Mental Health	$ 0.03	$ 0.01	$ 0.00	$ 0.02	$ 0.01	$ 0.02	$ 0.02	$ 0.02	$ 0.01	$ 0.06	$ -	$ -	$ 0.01	$ 0.01	$ -
Emergency Room	$ 42.73	$ 24.77	$ 21.12	$ 16.61	$ 45.20	$ 22.17	$ 43.67	$ 26.12	$ 78.12	$ 51.60	$ 131.79	$ 362.48	$ 33.07	$ 31.88	$ 248.68
Physician - Physical Health	$ 47.15	$ 24.61	$ 23.99	$ 16.92	$ 53.34	$ 20.09	$ 58.14	$ 37.87	$ 130.52	$ 76.10	$ 151.64	$ 559.95	$ 39.48	$ 37.77	$ 354.33
Physician - Mental Health	$ 0.09	$ 0.30	$ 0.42	$ 1.33	$ 0.37	$ 0.42	$ 0.68	$ 0.73	$ 0.81	$ 0.75	$ 0.50	$ 0.81	$ 0.47	$ 0.46	$ 0.66
Pharmacy	$ 11.89	$ 10.68	$ 11.82	$ 14.28	$ 25.89	$ 16.79	$ 73.56	$ 37.25	$ 98.14	$ 58.09	$ 1.11	$ 4.16	$ 23.25	$ 23.30	$ 2.65
Transportation	$ 2.09	$ 1.42	$ 1.79	$ 1.37	$ 3.24	$ 1.65	$ 4.18	$ 2.16	$ 4.82	$ 3.43	$ 2.04	$ 4.70	$ 2.21	$ 2.20	$ 3.39
Dental	$ 3.01	$ 20.61	$ 30.21	$ 22.93	$ 15.20	$ 11.43	$ 15.42	$ 12.59	$ 13.81	$ 12.17	$ -	$ 0.91	$ 18.46	$ 18.51	$ 0.46
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 9.27	$ 6.41	$ 10.33	$ 5.97	$ 18.51	$ 6.61	$ 22.46	$ 13.36	$ 36.66	$ 24.03	$ 42.01	$ 123.28	$ 11.73	$ 11.33	$ 83.27
TOTAL MEDICAL EXPENSES	$ 262.93	$ 132.16	$ 168.21	$ 134.68	$ 229.34	$ 136.35	$ 389.90	$ 223.16	$ 741.17	$ 458.97	$ 3,459.06	$ 8,161.69	$ 233.30	$ 204.04	$ 5,848.19

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Attachment C-2 — August 2009 through July 2010 Encounter Data Reported by DCHFP MCOs

STATEMENT FOR THE TIME PERIOD OF 08/01/2009 - 07/31/2010 FOR DC MCO ENCOUNTER DATA

	<1 MAF	1-12 MAF	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37-49 FEMALE	37-49 MALE	50+ FEMALE	50+ MALE	MONTH OF BIRTH	MONTH OF DELIVERY	TOTAL	Non-Delivery	Delivery
MEMBERMONTHS OR DELIVERIES	57,582	508,552	113,416	101,398	232,890	57,377	94,258	23,394	34,721	24,708	3,112	2,904	1,251,408	1,248,286	6,015
PMPM MEDICAL EXPENSES															
Inpatient Hospital - Physical Health	$ 136.45	$ 19.92	$ 22.88	$ 22.86	$ 32.41	$ 35.10	$ 66.30	$ 69.25	$ 175.63	$ 107.06	$ 1,708.78	$ 5,326.57	$ 57.33	$ 40.82	$ 9,455.13
Inpatient Hospital - Mental Health	$ 0.01	$ 1.14	$ 6.65	$ 5.30	$ 2.11	$ 2.94	$ 2.26	$ 1.30	$ 2.25	$ 1.51	$ -	$ 1.07	$ 2.29	$ 2.29	$ 0.52
Outpatient Hospital - Physical Health (ER Incl)	$ 31.30	$ 18.49	$ 24.61	$ 15.84	$ 45.60	$ 17.47	$ 71.44	$ 34.57	$ 87.54	$ 49.89	$ 17.52	$ 249.42	$ 31.84	$ 31.30	$ 129.46
Outpatient Hospital - Mental Health	$ 0.19	$ 0.69	$ 0.29	$ 0.22	$ 0.44	$ 0.41	$ 0.50	$ 0.18	$ 0.55	$ 1.14	$ -	$ 0.28	$ 0.50	$ 0.50	$ 0.13
Emergency Room	$ 43.47	$ 19.96	$ 18.03	$ 14.29	$ 27.52	$ 16.43	$ 25.74	$ 19.93	$ 24.66	$ 21.55	$ 18.82	$ 36.67	$ 22.33	$ 22.25	$ 27.33
Physician - Physical Health	$ 49.70	$ 16.11	$ 18.06	$ 10.86	$ 31.17	$ 12.28	$ 48.70	$ 31.78	$ 71.25	$ 49.47	$ 326.55	$ 1,577.89	$ 29.40	$ 24.99	$ 930.56
Physician - Mental Health	$ 0.72	$ 3.88	$ 7.75	$ 10.92	$ 1.87	$ 1.90	$ 2.61	$ 1.15	$ 2.68	$ 1.43	$ 0.30	$ 9.54	$ 3.90	$ 3.88	$ 4.95
Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Transportation	$ 3.88	$ 2.08	$ 2.97	$ 1.97	$ 4.91	$ 2.72	$ 5.65	$ 2.92	$ 5.98	$ 3.88	$ 1.54	$ 64.55	$ 3.37	$ 3.22	$ 31.96
Dental	$ 0.22	$ 19.20	$ 27.55	$ 20.90	$ 13.96	$ 10.22	$ 13.46	$ 9.94	$ 13.60	$ 10.59	$ -	$ 5.03	$ 16.87	$ 16.90	$ 2.43
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 13.04	$ 7.00	$ 23.94	$ 11.28	$ 48.78	$ 12.23	$ 52.82	$ 25.18	$ 65.42	$ 46.96	$ 18.22	$ 242.22	$ 23.98	$ 23.45	$ 123.76
TOTAL MEDICAL EXPENSES	$ 279.57	$ 108.25	$ 162.92	$ 114.68	$ 208.76	$ 111.08	$ 309.49	$ 196.20	$ 449.56	$ 293.27	$ 2,086.53	$ 7,513.61	$ 191.81	$ 169.61	$ 4,709.26

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Attachment D — Rate Development Overview

	Base Year	Target Rate Development Data Adjustments						11-12 Resulting Rate Range		
	A	B	C	D	F	G	H			
Rate Cell Description	Base Year PMPM*	Trend **	Program Changes	Managed Care Adjustment	Administration ***	Profit ***	MCO Tax ****	Target Rate*****	Lower bound Rate	Upper bound Rate
< 1 Year, Male and Female	$ 256.31	4.6%	-1.8%	0.0%	10.0%	2.0%	2.0%	$ 317.58	$ 298.32	$ 329.04
1 - 12 Years, Male and Female	$ 127.37	5.5%	-5.0%	0.0%	10.0%	2.0%	2.0%	$ 154.97	$ 145.17	$ 160.10
13 - 18 Years, Female	$ 155.81	5.6%	-3.9%	0.0%	10.0%	2.0%	2.0%	$ 192.23	$ 180.21	$ 199.09
13 - 18 Years, Male	$ 130.95	5.5%	-2.3%	0.0%	10.0%	2.0%	2.0%	$ 164.14	$ 154.78	$ 170.13
19 - 36 Years, Female	$ 230.71	5.1%	-2.7%	0.0%	10.0%	2.0%	2.0%	$ 285.58	$ 268.27	$ 294.80
19 - 36 Years, Male	$ 133.89	5.1%	6.5%	0.0%	10.0%	2.0%	2.0%	$ 181.41	$ 170.47	$ 187.91
37 - 49 Years, Female	$ 392.60	5.1%	2.5%	0.0%	10.0%	2.0%	2.0%	$ 512.15	$ 477.94	$ 529.07
37 - 49 Years, Male	$ 232.52	5.1%	6.5%	0.0%	10.0%	2.0%	2.0%	$ 314.81	$ 295.31	$ 325.69
50+ Years, Female	$ 684.84	4.9%	-11.2%	0.0%	10.0%	2.0%	2.0%	$ 771.02	$ 716.84	$ 796.82
50+ Years, Male	$ 457.86	4.4%	-11.1%	0.0%	10.0%	2.0%	2.0%	$ 511.65	$ 479.70	$ 527.59
Infant Month of Birth	$ 4,040.13	2.7%	1.8%	0.0%	6.0%	2.0%	2.0%	$ 4,797.21	$ 4,598.05	$ 4,980.20
Mother's Month of Delivery	$ 7,968.81	3.1%	0.6%	0.0%	6.0%	2.0%	2.0%	$ 9,417.54	$ 8,916.90	$ 9,754.00
Overall	**$ 253.24**	**4.9%**	**-3.2%**	**0.0%**	**9.6%**	**2.0%**	**2.0%**	**$ 309.47**	**$ 289.82**	**$ 319.90**
							Rate Change	7.7%	0.9%	11.3%

*Blend of 75% Financial Data and 25% Encounter Data
** The trend shown is annualized from the 22.5 month period August 1, 2011 to April 30, 2012
*** Shown as a % of the total rate before loading for premium tax.
**** Shown as a % of the gross premium.
***** Rate Development Formula: Lower Bound Rate = ((A*(1+B)^(22.5/12)*(1+C)*(1+D)*(1+E))/(1-F-G))/(1-H)

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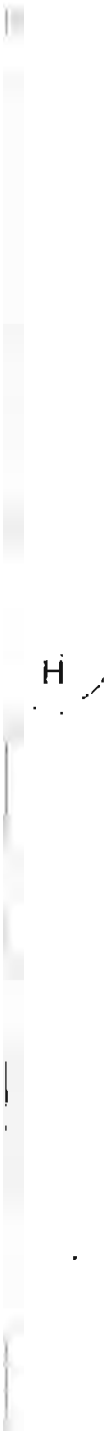
Attachment E — Family Planning Rate Development

	Databook			Family Planning		Service Rate Range						Family Planning Rate Range		
Rate Cell Description	Base Year PMPM*	Base Year Rx	Base Year Medical	Family Planning Percentage	Base Year Family Planning PMPM	Lower bound Rate	Upper bound Rate	Rx Lower Bound	Rx Upper Bound	Medical Lower Bound	Medical Upper Bound	FP lower Bound	FP Contract Rate	FP Upper Bound
< 1 Year, Male and Female	$ 258.31	$ 11.50	$ 244.81	0.0%	$ -	$ 257.27	$ 283.76	$ 12.02	$ 13.64	$ 244.36	$ 270.12	$ -	$ -	$ -
1 - 12 Years, Male and Female	$ 127.37	$ 10.84	$ 116.53	0.0%	$ 0.01	$ 125.19	$ 138.07	$ 12.18	$ 12.86	$ 113.02	$ 126.22	$ 0.01	$ 0.01	$ 0.01
13 - 18 Years, Female	$ 155.81	$ 12.18	$ 143.63	1.3%	$ 1.81	$ 155.41	$ 171.70	$ 13.65	$ 14.44	$ 141.73	$ 157.25	$ 1.76	$ 1.76	$ 1.98
13 - 18 Years, Male	$ 130.95	$ 13.88	$ 117.07	0.0%	$ 0.02	$ 133.49	$ 146.72	$ 15.59	$ 16.46	$ 117.89	$ 130.26	$ 0.02	$ 0.02	$ 0.03
19 - 36 Years, Female	$ 230.71	$ 27.15	$ 203.56	2.0%	$ 4.11	$ 229.63	$ 254.24	$ 30.49	$ 32.20	$ 189.14	$ 222.04	$ 4.02	$ 4.02	$ 4.48
19 - 36 Years, Male	$ 133.83	$ 16.15	$ 118.75	0.0%	$ 0.06	$ 147.02	$ 162.06	$ 18.36	$ 19.41	$ 128.83	$ 142.64	$ 0.06	$ 0.06	$ 0.07
37 - 49 Years, Female	$ 382.60	$ 75.63	$ 317.07	0.5%	$ 1.50	$ 412.17	$ 458.27	$ 88.24	$ 93.17	$ 323.93	$ 363.11	$ 1.53	$ 1.53	$ 1.71
37 - 49 Years, Male	$ 232.52	$ 41.86	$ 190.66	0.1%	$ 0.14	$ 254.68	$ 280.68	$ 50.79	$ 53.62	$ 203.89	$ 227.25	$ 0.14	$ 0.14	$ 0.16
50+ Years, Female	$ 684.84	$ 97.09	$ 587.82	0.0%	$ 0.07	$ 618.20	$ 687.17	$ 88.09	$ 103.57	$ 520.11	$ 583.61	$ 0.06	$ 0.06	$ 0.07
50+ Years, Male	$ 457.86	$ 69.85	$ 388.00	0.0%	$ 0.02	$ 413.70	$ 455.00	$ 70.62	$ 74.58	$ 343.08	$ 380.43	$ 0.01	$ 0.01	$ 0.02
Infant Month of Birth	$ 4,040.13	$ 1.62	$ 4,038.50	0.0%	$ 0.03	$ 4,145.60	$ 4,490.15	$ 1.82	$ 1.99	$ 4,143.78	$ 4,488.23	$ 0.03	$ 0.03	$ 0.03
Mother's Month of Delivery	$ 7,968.81	$ 2.94	$ 7,965.87	1.3%	$ 105.98	$ 8,039.48	$ 8,794.21	$ 3.30	$ 3.48	$ 8,036.18	$ 8,790.72	$ 106.92	$ 106.92	$ 116.96
Overall	$ 263.24	$ 39.47	$ 223.77	0.8%	$ 1.21	$ 261.00	$ 277.03	$ 32.71	$ 34.64	$ 218.29	$ 242.48	$ 1.19	$ 1.19	$ 1.83

Family Planning percentage was developed based on the FY09 encounter data. The percentage is applicable to the medical services. No pharmacy related expenses have been identified with respect to family planning.
The family planning rate is strictly a service rate. The District is not claiming for any administrative costs associated with family planning.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MERCER

Jonathan C. Marsden, FSA, MAAA
Principal

Government Human Resources Consulting
333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
+1 612 642 8600
jonathan.marsden@mercer.com
www.mercer.com

Ms. Lisa Truitt
Office of Managed Care
District of Columbia Department of Health Care Finance
899 North Capital Street, NE
5th Floor
Washington, DC 20002

May 1, 2012

Subject: District of Columbia Healthy Families Program Rate Development and Actuarial Certification for the Contract Period May 1, 2012 through April 30, 2013

Dear Lisa:

The District of Columbia (District) contracted with Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC, to develop actuarially sound capitation rate ranges covering the May 1, 2012 to April 30, 2013 District of Columbia Healthy Families Program (DCHFP) contract period. This letter presents an overview of the methodology used in Mercer's managed care rate development for the purpose of satisfying the requirements of the Center for Medicare and Medicaid Services (CMS). This rate development process was based primarily on the managed care organization (MCO) financial data supplemented by detailed encounter data; therefore, this rate development process is characterized as a complete rebase of the capitation rates.

The DCHFP program covers individuals who meet the eligibility requirements for the District's Temporary Assistance for Needy Families (TANF) program, including the individuals who transitioned into the Medicaid program from the Alliance program. The childless adults were added to the DCHFP program effective July 2010, for individuals up to 133% of the federal poverty level (FPL). These adults are identified by program code 774. Collectively, this group is referred to as the Legacy Medicaid population. Program code 775 is associated with childless adults with incomes between 134% and 200% FPL who were enrolled in the MCOs, effective December 2010. These adults are funded out of the District's Disproportionate Share Hospital (DSH) funding through a waiver program. Based on a review of the service utilization and cost for this population during this rate-setting cycle, Mercer has determined that separate rate cells are appropriate for the adults in program code 775. These rate category groupings are described further below.

The District has chosen contract rates within the actuarially sound rate range and reached contract agreements with each MCO. The DCHFP Legacy Medicaid population rates reflect a 7.2% increase overall to the current rates. The 775 population group rates reflect a 48.8%

increase overall to the current rates. The rate ranges and associated budget projections are provided in Attachments A and B. Note the budget projections reflect an annual projection to allow for comparisons to past certifications.

Rate Methodology

Overview

Capitation rate ranges for DCHFP were developed in accordance with rate-setting guidelines established by CMS. One of the key considerations in the rate range development was the base data. Mercer and the District discussed available data sources for rate range development. These include Medicaid encounter data and MCO reported DCHFP financial data. The encounter and financial data were weighted 25% on the encounters and 75% on the detailed financial data during this rate-setting exercise, due to completeness issues with recent encounter data due to the District's implementation of the OMNICAID Medicaid Management Information System (MMIS) and the exiting of an MCO. Each data source was reviewed to ensure it matched the populations and benefit package defined in the State Plan and contract.

To develop capitation rates, adjustments were applied to the base data consistent with the CMS Rate-setting Checklist:

- Completion factors to account for unpaid claims at the time of the data submission (AA.3.14)
- Adjustment to reflect the underreporting of encounter data (AA.3.14)
- Trend factors to forecast the expenditures and utilization to the appropriate contract period (AA.3.10)
- Prospective and historic program changes not reflected in the base data (AA.3.1)
- Data smoothing (AA.5.0)
- Administration loading (AA.3.2)

In the end, Mercer developed a rate range for each individual rate cell for the District to use in contracting with the MCOs for the DCHFP.

Base Data Development

The financial data received from the DCHFP MCOs was incorporated as one of the data sources for rate range setting. This data was certified as accurate by financial representatives of each current MCO. Financial data provides per member per month (PMPM) medical expenses by major category of service (COS) for each of the District's current rate cells. Mercer reviewed the

MCO-reported data for accuracy and consistency of reporting. This review is discussed in more detail in the Financial Data section below.

The District has been working with the MCOs on encounter data submission over the past few years. Mercer reviewed the current encounter data submissions to determine the potential use for rate range development. The encounter data provides valuable information on the average utilization and unit cost of services covered under the contract. Encounter data is also recommended by CMS as a source of utilization data for rate development. The DCHFP encounter data had completeness issues during fiscal year (FY) 2010 (August 1, 2009 through July 1, 2010), due to the OMNICAID implementation and the exiting of an MCO from the program. Therefore, the weighting on the encounters has been set at 25% for this rate-setting exercise.

Financial Data

Mercer validated and incorporated the FY 2010 and the FY 2011 (August 1, 2010 through July 31, 2011) financial data as a data source in this rate range setting process. The financial data reflects the actual medical expenses to the MCOs, including the subcapitation payments to providers for each of the rate cells. The expenses are net of pharmaceutical rebates and third party liability (TPL). Mercer reviewed the financial data to ensure it was appropriate to incorporate into the rate development. Specifically, Mercer reviewed the following issues:

- Completeness and accuracy of the submitted financial reports
- Consistency between submitted financial data and annual Department of Insurance filings as of September 30, 2011
- Assurance that pharmacy rebates were reasonable and removed from the data
- Assurance that reinsurance premiums and recoveries were accurately reflected in the financial data
- Assurance that submitted financial data was specific to State Plan services only
- Consistency of data among MCOs' submissions on a rate cell basis

Adjustments were made to the financial data to reflect the complete cost of an actuarially equivalent population for the DCHFP contract.

Incurred-but-not-Reported (IBNR) Claims Adjustments

Mercer reviewed the remaining liability associated with IBNR claims for FY 2010 and FY 2011 individually for each of the MCOs. The overall adjustments for the Legacy Medicaid population for

FY 2010 and FY 2011, using paid claims data through September 2011, were 0.32% and 3.26%, respectively. The overall adjustment for the 775 population for December 2010 to July 2011, using paid claims data through September 2011, was 4.07%

Redistribution of Subcapitation Payments
Since the MCOs reimburse providers using different payment arrangements, Mercer adjusted each MCO's reported financial data, as necessary, to reflect a uniform payment methodology. Some MCO data needed to be adjusted for subcapitation arrangements to better allocate costs across the various rate cells. Since many of the subcapitation arrangements do not vary the rates by age/sex, the subcapitation expenditures were redistributed to each rate cell in a budget-neutral fashion according to the cost distribution in the encounter data. This was a budget-neutral adjustment.

Adjustment for Missing Health Right Financial Data
Health Right's contract with DHCF ended April 30, 2010. As such, Health Right was not in operation when the financial data request was distributed in October 2011. Therefore, the FY 2010 data from Health Right was not available for the development of this Data Book. To account for the missing Health Right data, Mercer analyzed the PMPM relationships in the encounter data by service category with and without the Health Right data. Based on these comparisons, an upward adjustment of 0.9% was applied to the financial data for FY 2010 to account for the missing data.

The aggregate FY 2011 financial data submitted by the MCOs are included as Attachment C-1.

Encounter Data
To support the rate range development, Mercer summarized the District's encounter data from FY 2010 and FY 2011 by rate cell and COS. In order to ensure the encounter data reflected all covered services, Mercer performed high-level validation checks on the data.

Mercer compared the encounter data to the historical financial data for the same time periods to ensure the majority costs were reflected. In total, the paid amounts (as reflected in the MCO_Paid amount field) in the encounter data are lower than the reported financial data for the corresponding time period. The final comparison, after the adjustments described in this section were applied, indicated approximately 89% of the financial expenses are reflected in the encounter data. The District continues to work with the MCOs to identify the reasons for the

difference and work to improve encounter data reporting and collection for future rate-setting analyses.

Certain covered expenses were not captured in the encounter data due to reporting or data collection issues. Mercer reviewed the additional data and made adjustments to include all services covered under the contract.

Recipient Claims Reported Outside of Encounter Data
A small subset of claims was submitted in an Excel workbook due to provider difficulties with the HIPAA 837 format of the encounter records. These claims included expenses for services such as transportation and vision. Please note that Chartered started submitting vision claims as encounter data starting in FY 2011. The supplemental file identified the recipient associated with the encounter, so Mercer added these claims to the appropriate COS and rate cell.

Subcapitated Provider Data
Encounters for subcapitated providers are submitted with an MCO paid amount equal to zero. In order to assign a value to these valid encounters for rate-setting purposes, Mercer shadow-priced the subcapitated encounters. For each MCO and procedure code, Mercer calculated a ratio of the MCO paid amount to the Medicaid proxy amount (ACS_Paid_Amount) for the paid encounters with positive MCO paid amounts. For the subcapitated encounters, this ratio is multiplied by the Medicaid proxy amount (ACS_Paid_Amount) to assign a value to the subcapitated encounter.

Pharmacy Data
Currently, pharmacy data is not submitted through the encounter data collection system. Pharmacy data was, however, collected by Mercer from the MCOs to support other District analyses. For this rate range development process, Mercer incorporated the pharmacy claims received from the MCOs and summarized the data by rate cell. As this data was claims data, Mercer incorporated an adjustment to account for historical pharmacy rebates collected outside the claims systems based on information captured in the financial data. The adjustment for FY 2010 was -3.96% and the adjustment for FY 2011 was -2.03%.

Completion Factors
Since the encounter data has limited runout (two months), Mercer calculated completion factors to account for incurred claims not reflected in the encounter data. Due to dating conventions within the encounter data, Mercer relied on the financial lags as the source of the completion factors.

Mercer estimated the incurred claims for FY 2010 and FY 2011 in the financial data and compared it to the total paid claims for services incurred during the same period in the financial data with similar runout. The ratio of paid claims to incurred claims in the financial data resulted in the completion factor for the encounter data. This ratio was calculated by major COS separately for each MCO's data. Mercer applied these completion factors to the encounter data by COS and MCO. In total, the IBNR adjustment for the Legacy Medicaid population for FY 2010 and FY 2011 resulted in an increase of 0.23% and 4.60%, respectively. The overall adjustment for the 775 population for December 2010 to July 2011 was an increase of 6.94%

Net Reinsurance Costs

The MCOs have been purchasing reinsurance coverage for high-cost Inpatient claims. Mercer reviewed the historical experience from FY 2010 and FY 2011 to determine the average net reinsurance PMPM (premiums minus recoveries). Based on this review, Mercer applied reinsurance adjustment factors to the Inpatient Hospital — Physical Health COS. The adjustment for FY 2010 was 0.87% to Inpatient Hospital — Physical Health and the adjustment for FY 2011 was 0.78%.

Encounter Data Underreporting Adjustment

After applying completion factors and the adjustments outlined above, Mercer reviewed the monthly incurred amounts captured in the encounter data to determine whether there were gaps in the encounter reporting due to the exiting of Health Right as an MCO or to the switch in the District's MMIS to OMNICAID. Mercer noticed significant differences between FY 2009 and FY 2010. The Health Right encounter data for FY 2010 was significantly lower than previous years. There were other minor gaps in the encounter data for other MCOs, which were assumed to be related to the OMNICAID implementation. To address this issue, Mercer and the District decided to apply an encounter underreporting adjustment to the encounter data to bring the monthly FY 2010, especially the months from December 2009 to April 2010, costs up to levels consistent with prior months. Specific adjustments were applied by MCO and claim type for institutional, professional, and dental encounters. In total, the underreporting adjustment for FY 2010 resulted in a base data increase of 2.76%.

The aggregate FY 2011 encounter data submitted by the MCOs is included as Attachment C-2.

Based on our review of the covered populations and covered services of DCHFP, the following issues do not impact the plan reported financial or encounter data. Therefore, no adjustments were made to the financial or encounter data for these issues.

Prior Periods of Coverage, Retroactive Eligibility and Enrollment Lag Periods (AA.3.4)
The base data was summarized to reflect the coverage period for the MCOs. These other eligibility periods were not reflected in the financial data and were excluded from the encounter data.

Non-covered Populations (AA.2.1, AA.2.2)
DCHFP covers individuals classified as TANF. Therefore, the base data is specific to the TANF population and excludes all other populations.

Non-covered Services (AA.2.4)
The DCHFP rates are based on State Plan-approved services covered under the DCHFP contract. All other services have been excluded from the base data. For example, the MCOs are not responsible for services delivered within the schools; therefore, these costs have been excluded from the rate base.

Client Participation Amounts (AA.2.3, AA.3.13)
Costs associated with "spenddown" and post-eligibility treatment of income are not included in the base data.

TPL (AA.3.6)
The base data does not include costs associated with TPL.

Excluding District Payments Made Outside of the Managed Care Program (AA.3.5, AA.3.8, AA.3.9)
The District makes payments for Graduate Medical Education (GME), DSH and Federally Qualified Health Center (FQHC) cost settlements outside of managed care. These expenses are not reflected in the financial or encounter data.

Copayments (AA.3.7)
The MCOs are not allowed to collect copayments from the DCHFP eligibles. Since the MCOs cannot collect copayments, the financial and encounter data reflects the total cost of providing the covered services.

The District does not cover any 1915(b)(3) services in this managed care program.

Rate Category Groupings

The base data sets are split into cohorts that represent different age/gender bands, which inherently represent different levels of risk. The following is a list of the 12 rate cells for the DCHFP program reflecting the changes that went into effect July 1, 2010. The Medicaid adults with program code 774 are included in the respective age/gender cells outlined below.

- Male and Female < 1
- Female 13–18
- Female 19–36
- Female 37–49
- Female 50+
- Mother's Month of Delivery
- Male and Female 1–12
- Male 13–18
- Male 19–36
- Male 37–49
- Male 50+
- Infant's Month of Birth

These cells were selected based on a review of the historical cost structures within these age/gender bands. The separate maternity payments reflect the increased cost and financial risk of these events. Based on a review of the service utilization and cost for this population during this rate-setting cycle, Mercer has determined that separate rate cells are appropriate for the adults in program code 775 with incomes between 134% and 200% FPL. Therefore, the following six rate cells were added specific to program code 775.

- Female 19–36 (775)
- Female 37–49 (775)
- Female 50+ (775)
- Male 19–36 (775)
- Male 37–49 (775)
- Male 50+ (775)

Trend Development

Trend is an estimate of the change in the overall cost of providing health care benefits over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Mercer reviewed a variety of sources to develop the trend assumptions. These sources included, but were not limited to:

- CMS Medicare Economic Index
- Mercer's regression analysis
- Trends exhibited in the financial data submitted by the MCOs
- Data related to issues raised by the DCHFP MCOs
- Trends in other state Medicaid programs for similar TANF populations

Mercer developed individual trends for each COS, separately for child and adult rate cells. Mercer's target trend can be found in the following table.

Major COS	Legacy Children Trend Assumption	Legacy Adult Trend Assumption	775 Adult Trend Assumption
Inpatient Hospital Services	5.0%	7.0%	5.5%
Physician Services	2.0%	2.0%	2.0%
Outpatient Hospital Services	8.0%	5.0%	5.0%
Pharmacy Services	3.0%	10.0%	7.0%
Dental	6.0%	6.0%	6.0%
Mental Health Services	2.0%	9.0%	3.0%
Other Services	3.0%	3.0%	3.0%

The overall annual trend assumption at the target rate was 5.4% and 5.2% for the DCHFP Legacy Medicaid population and the 775 population, respectively.

Programmatic Changes/Rate Issues

Programmatic change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base year. Mercer will apply programmatic change adjustments to incorporate factors not fully reflected in the base data. These adjustments were mutually exclusive and made only once in the rate-setting process. Since the changes were effective after August 1, 2009, the impact was not fully reflected in the base data thus warranted consideration in the rate development.

Note these rate ranges do not account for the fee schedule change for primary care physicians effective January 1, 2013 as promulgated in Section 1202 of the health reform legislation. A

separate analysis of this issue is being undertaken and a revised rate range will be submitted later in 2012 to document the adjustment and certify to the revised rate ranges effective January 2013.

Changes to the District's Medicaid Physician Fee Schedule

The District has received approval of a State Plan Amendment (SPA), effective retroactive to February 2011, to decrease the Medicaid fee schedule for primary care and specialist physicians to 80% (from 100% of 2009 Medicare) of the Medicare schedule indexed to the Medicare fee schedule in effect, currently 2012. Mercer analyzed the impact of this change on the MCOs and calculated a -2.6% adjustment to the physician costs in the rates compared to the base data.

Children's Dental Fee Schedule Decrease

DHCF granted the MCOs flexibility to implement an alternative Dental fee schedule for children in late 2010. As of February 2011, both MCOs had implemented an alternative fee schedule based on regional average Dental fees. This schedule will remain in place through September 2011 and is understood to continue assuming no significant drop in Dental utilization. Mercer analyzed the impact of this change on the MCOs and calculated a -5% adjustment to the Dental costs in the rates for the children's rate cells compared to the base data.

Adult Dental Fee Schedule Decrease

DHCF will implement a reduction to the Medicaid fee-for-service (FFS) fee schedule for Adult Dental services effective July 2011. Mercer analyzed the impact of this change on the MCOs and calculated a -14% adjustment to the Dental costs in the rates for the adult rate cells compared to the base data.

Hospital Diagnosis-related Group (DRG) Reimbursement Change

Based on a recently approved SPA, retroactive to April 1, 2010, the District re-based the DRG weights and rates for the hospitals. For FFS, this change was implemented in a cost neutral manner. The MCOs presented information indicating this change increased the costs of their hospital contracts based on higher utilization of Children's National Medical Center. Mercer analyzed the impact of this change on the MCOs and calculated a 3% adjustment to the Inpatient Hospital — Physical Health costs in the rates compared to the base data.

Pharmacy Rebate Changes

Under the Patient Protection and Affordable Care Act, DHCF has the ability to seek Medicaid FFS level rebates for the drugs administered under managed care. The MCOs presented information

on the impact of their pharmacy contracts related to the reduction in rebates available to the MCOs as a result of this change. Based on information received from the MCOs and Mercer's experience in other states, it is estimated that 60% of the historical rebates will no longer be available to the MCOs. As a result, Mercer calculated an adjustment of 1.2% to the pharmacy expenses in the rates.

The overall impact of programmatic changes on the base data at the target rate was 0.0% and 0.3% for the DCHFP Legacy Medicaid population and the 775 population, respectively.

Data Smoothing

As part of the rate development process, Mercer reviewed data from multiple years (FY 2010 and FY 2011) of the program to arrive at the overall financial data source for rate setting. The goal of the blending process is to obtain a set of base data that has sufficient credibility and reasonableness to develop actuarially sound capitation rates. Mercer has applied credibility weighting, as appropriate, to blend data from the two FYs, focusing on the most recent year of data.

For the financial data, Mercer put the majority of the weight (70%–85%, depending on rate cell) on the FY 2011 data and incorporated the FY 2010 data (15%–30%) to smooth out fluctuation in Inpatient Hospital costs from year to year. This enhanced the credibility of the data set and increased the stability of the rates. This process was cost neutral per step AA.5.2 of the CMS Rate-setting Checklist. Similarly, Mercer blended the two years of encounter data using the same credibility weightings.

Finally, Mercer blended the rates based on the financial and encounter data. As mentioned earlier, the encounter data required significant adjustments due to certain completeness issues related to the OMNICAID implementation and the exiting of an MCO. This warrants greater reliance on the financial data for this exercise with the expectation that future rate-setting analyses will be based more heavily on the encounter data. Thus, Mercer has blended the financial and encounter data by assigning 75% credibility to the financial data and 25% to the encounter data, with the exception of the Infant's Month of Birth rate cell, which was entirely based on financial data.

Managed Care Assumptions

In the development of the rate ranges, Mercer and the District discussed areas for improvements in managed care efficiency. No adjustments were incorporated into the rate ranges for additional managed care efficiencies in the development of the target rates.

Commercial Reinsurance

To provide protection against the risk of catastrophic claims, the DCHFP MCOs may purchase reinsurance for Inpatient Hospital claims on the commercial market. The District recognizes this reinsurance arrangement and considers the net costs associated with reinsurance in the rates. One of the MCOs received a waiver of the reinsurance requirement, and Mercer made an adjustment to account for this arrangement. For more information on the reinsurance costs, please refer to the adjustments discussed on Page 6 of this letter. This arrangement is allowable per subsection AA.6.0 of the CMS Rate-setting Checklist.

Administration and Profit and MCO Assessment

Mercer and the District reviewed the components of the administrative allowance to evaluate the administrative rates paid to the MCOs. The review focused on the reporting and organizational requirements detailed in the DCHFP contract and the historical PMPM administrative costs incurred by the MCOs. Mercer also modeled the cost structure for these requirements to determine the administrative load necessary for an average plan in this program. Mercer considered total program enrolment consisting of the 140,000 current DCHFP members as well as the 25,000 Alliance members, in assessing the administrative load. Based on the analysis and comparisons with other state Medicaid programs' administrative allowances, Mercer assumed an overall administration load of approximately 9.7% for the final premium rates. This percentage varied between the Non-maternity (10%) and the Maternity (6%) rate cells to account for the different premium levels.

In addition, Mercer included profit and margin considerations in the rate development explicitly through a load of 2% of premium. This is an acceptable rate consideration per AA.3.2 of the CMS Rate-setting Checklist.

For many years, the Department of Insurance, Securities and Banking (DISB) in the District has imposed an assessment on Health Management Organizations (HMOs) and Preferred Provider Organizations (PPOs) for the privilege of operating in the District, to cover insurance department costs. This HMO/PPO assessment had traditionally been waived for Medicaid contracting

insurers. In May 2010, the commissioner of insurance extended the application of this assessment to the Medicaid MCOs operating in the District and licensed by the DISB as HMOs. This is a uniform, broad-based fee imposed on all HMOs and PPOs and all lines of business. The assessment amounts to 2.0% of premiums.

This assessment is a legitimate cost of doing business in the District for Medicaid MCOs and reasonable to include in the consideration of actuarially sound capitation rate ranges. Since this is a cost of doing business in the District, Mercer included consideration for this assessment in the rate range development. The assessment is expressed as a percentage of the gross capitation rate (e.g., premium). Mercer applied a 2.0% adjustment consistent with the assessment that will apply to the MCOs.

In total, the overall load applied to the rates for administration, profit/contingencies and assessments was approximately 13.4%.

Rate Ranges

Mercer developed actuarially sound rate ranges for the District to use in rate negotiations with the MCOs. Mercer specifically priced the upper and lower bound of the rate ranges by varying the assumptions outlined above. Mercer varied the trend assumptions and the financial data adjustments to account for different levels of managed care efficiency and potential risk selection. As a result, the lower bound of the rate range represents a rate for a very efficient MCO and the upper bound represents the least amount of efficiency the District is willing to purchase.

The overall rate range for the Legacy rates ranged from $305.26 at the lower bound to $334.38 at the upper bound, or approximately 10% wide. Compared to the current rates, the lower bound reflects a 7.0% rate increase, whereas the upper bound reflects a 17.2% rate increase. The overall rate range for the 775 rates ranged from $609.05 at the lower bound to $657.13 at the upper bound, or approximately 8% wide. Compared to the current Legacy rates, the lower bound reflects a 37.6% increase, whereas the upper bound reflects a 48.5% increase. The final contract rates selected by the District are within these rate ranges. The rate ranges are included as Attachment A to this letter.

Rate Development Overview

To provide additional detail on the rate development, Mercer has provided an overview of the adjustments applied to each rate cell in Attachments D-1 and D-2. These exhibits presents the

breakdown of the assumptions used to calculate the Target rates within the actuarially sound rate ranges. The actual contract rates differ from the target rates based on the District's contracting decisions, but all rates are within the actuarially sound range.

Family Planning Portion of the Rates

At the request of the District, Mercer has analyzed the component of the rates associated with Family Planning services so that the District may claim the enhanced federal match of 90% on these services. CMS issued a guide in June 2009 to assist States in determining which services are allowed to be claimed at the enhanced federal match rate. Specific details on codes used to identify Family Planning services can be found in the document accompanying this letter.

Attachment E contains the PMPMs associated with Family Planning that will be claimed at the enhanced match rate. Please note that these Family Planning PMPMs do not include load for administration, profit or the MCO assessment.

Certification of Final Rate Ranges

In preparing the rate ranges shown in Attachment A, Mercer used and relied upon enrollment, encounter claims, reimbursement level, benefit design and financial data and information supplied by the District's Department of Health Care Finance (DHCF) and its vendors. DHCF and its vendors are responsible for the validity and completeness of this supplied data and information. Mercer has reviewed the data and information for internal consistency and reasonableness, but did not audit it. In our opinion, it is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report may need to be revised accordingly.

Mercer certifies that the May 2012 to April 2013 rate ranges in Attachment A were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medicaid covered populations and services under the managed care contract. The undersigned actuary is a member of the American Academy of Actuaries and meets its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of the District to demonstrate compliance with CMS requirements under 42 CFR 438.6(c) and

accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by MCOs for any purpose. Mercer recommends that any MCO considering contracting with the District should analyze its own projected medical expense, administrative expense and any other premium needs for comparison to these rate ranges before deciding whether to contract with the District.

This certification letter assumes the reader is familiar with DCHFP, Medicaid eligibility rules and actuarial rating techniques. It is intended for the District and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

If you have any questions on any of the information provided, please feel free to call me at 612 642 8940.

Sincerely,

Jonathan C. Marsden

Jonathan C. Marsden, FSA, MAAA
Principal

Copy:
Wayne Turnage; Gnayswaran Nathan — DHCF
Tom Steiner; Chris Vaughn-Uding, Amy Bui — Mercer

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Attachment A — DCHFP Rate Summary

Capitation Rates

Effective May 1, 2012 to April 30, 2013

Legacy Medicaid Population			
Age/Sex Cell	**Bottom of Rate Range**	**Contract Rate**	**Top of Rate Range**
< 1 Year, Male and Female	$327.89	$327.89	$366.07
1 - 12 Years, Male and Female	$162.87	$162.87	$180.17
13 - 18 Years, Female	$212.87	$212.87	$234.27
13 - 18 Years, Male	$179.91	$179.91	$198.14
19 - 36 Years, Female	$282.34	$282.34	$308.14
19 - 36 Years, Male	$194.02	$194.02	$213.87
37 - 49 Years, Female	$500.30	$500.30	$544.84
37 - 49 Years, Male	$374.98	$374.98	$412.58
50+ Years, Female	$667.31	$667.31	$726.78
50+ Years, Male	$539.18	$539.18	$592.61
Infant Month of Birth	$3,821.79	$3,821.79	$4,083.18
Mother's Month of Delivery	$8,788.28	$8,788.28	$9,416.53
Total Legacy Medicaid	**$306.04**	**$306.04**	**$335.21**
Overall Rate Increase		**7.2%**	

775 Population			
Age/Sex Cell	**Bottom of Rate Range**	**Contract Rate**	**Top of Rate Range**
19 - 36 Years, Female (775)	$288.77	$313.17	$313.17
19 - 36 Years, Male (775)	$294.29	$317.06	$317.06
37 - 49 Years, Female (775)	$491.16	$528.94	$528.94
37 - 49 Years, Male (775)	$615.82	$663.88	$663.88
50+ Years, Female (775)	$855.47	$923.00	$923.00
50+ Years, Male (775)	$804.17	$867.86	$867.86
Total 775 Population	**$610.52**	**$658.68**	**$658.68**
Overall Rate Increase		**48.8%**	

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Attachment B — Projection of Expenditures

Legacy Medicaid Population					
Age/Sex Cell	August 2010 to July 2011 MMs	2011-2012 Rates	2012-2013 Rates	2011-2012 Expenditures	2012-2013 Expenditures
< 1 Year, Male and Female	56,601	$ 298.32	$ 327.89	$ 16,885,093	$ 18,558,516
1 - 12 Years, Male and Female	530,822	$ 145.17	$ 162.87	$ 77,059,381	$ 86,453,664
13 - 18 Years, Female	111,652	$ 180.21	$ 212.87	$ 20,120,834	$ 23,767,265
13 - 18 Years, Male	99,920	$ 154.78	$ 179.91	$ 15,465,684	$ 17,976,480
19 - 36 Years, Female	292,347	$ 266.27	$ 282.34	$ 77,843,191	$ 82,541,800
19 - 36 Years, Male	151,320	$ 170.47	$ 194.02	$ 25,795,564	$ 29,359,517
37 - 49 Years, Female	126,673	$ 477.94	$ 500.30	$ 60,541,877	$ 63,373,718
37 - 49 Years, Male	94,351	$ 295.31	$ 374.98	$ 27,862,842	$ 35,379,595
50+ Years, Female	80,630	$ 716.84	$ 667.31	$ 57,798,619	$ 53,804,923
50+ Years, Male	83,632	$ 479.70	$ 539.18	$ 40,214,036	$ 45,200,290
Infant Month of Birth	3,427	$ 4,598.05	$ 3,821.79	$ 15,757,517	$ 13,097,285
Mother's Month of Delivery	3,393	$ 8,916.90	$ 8,788.28	$ 30,255,042	$ 29,818,624
Total Legacy Medicaid	**1,631,574**	**$ 285.37**	**$ 306.04**	**$ 465,599,679**	**$ 499,331,678**

775 Population					
Age/Sex Cell	Annualized MMs Dec 2010 to July 2011	2011-2012 Rates	2012-2013 Rates	2011-2012 Expenditures	2012-2013 Expenditures
19 - 36 Years, Female (775)	4,625	$ 266.27	$ 313.17	$ 1,231,366	$ 1,448,241
19 - 36 Years, Male (775)	4,368	$ 170.47	$ 317.06	$ 744,613	$ 1,384,897
37 - 49 Years, Female (775)	4,938	$ 477.94	$ 528.94	$ 2,360,068	$ 2,611,898
37 - 49 Years, Male (775)	5,511	$ 295.31	$ 663.88	$ 1,627,453	$ 3,658,655
50+ Years, Female (775)	8,727	$ 716.84	$ 923.00	$ 6,255,972	$ 8,055,196
50+ Years, Male (775)	6,671	$ 479.70	$ 867.86	$ 3,199,886	$ 5,789,171
Total 775 Population	**34,839**	**$ 442.59**	**$ 658.68**	**$ 15,419,358**	**$ 22,948,058**

The current rates have been in effect from August 1, 2011 to April 30, 2012. The new rates are effective May 1, 2012 to April 30, 2013.
Expenditures are based on annualized member months as listed above.

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Attachment C-1 — August 2010 through July 2011 Financial Data Reported by DCHFP MCOs

STATEMENT FOR THE TIME PERIOD OF 08/01/2010 - 07/31/2011 FOR DC MCO FINANCIAL DATA

Legacy Medicaid	<1 M&F	1-12 M&F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37-49 FEMALE	37-49 MALE	50+ FEMALE	50+ MALE	Month of Birth	Month of Delivery	TOTAL	Non-Delivery	Delivery
MEMBER MONTHS OR DELIVERIES	56,601	530,822	111,652	99,920	292,347	151,320	126,673	94,351	80,630	83,832	3,427	3,393	1,631,574	1,628,147	6,820
PMPM MEDICAL EXPENSES															
Inpatient Hospital - Physical Health	$ 122.83	$ 25.76	$ 24.66	$ 35.14	$ 36.40	$ 50.10	$ 98.23	$ 108.16	$ 164.87	$ 171.72	$ 3,037.81	$ 6,209.54	$ 77.79	$ 58.61	$ 4,615.77
Inpatient Hospital - Mental Health	$ 0.00	$ 3.50	$ 12.98	$ 20.85	$ 4.64	$ 4.24	$ 5.88	$ 8.44	$ 4.96	$ 4.34	$ -	$ 1.36	$ 5.94	$ 5.95	$ 0.88
Outpatient Hospital - Physical Health	$ 19.46	$ 14.99	$ 21.74	$ 14.84	$ 25.55	$ 11.06	$ 60.43	$ 24.27	$ 85.40	$ 47.91	$ 26.52	$ 843.91	$ 28.13	$ 26.37	$ 433.18
Outpatient Hospital - Mental Health	$ 0.00	$ 0.00	$ 0.03	$ 0.02	$ 0.01	$ 0.02	$ 0.03	$ 0.14	$ 0.03	$ 0.22	$ -	$ -	$ 0.03	$ 0.03	$ -
Emergency Room	$ 59.52	$ 33.74	$ 36.49	$ 23.09	$ 52.42	$ 29.95	$ 51.54	$ 39.69	$ 43.83	$ 37.24	$ 52.66	$ 472.28	$ 40.59	$ 39.58	$ 261.42
Physician - Physical Health	$ 45.74	$ 22.57	$ 25.98	$ 15.94	$ 50.02	$ 19.42	$ 72.85	$ 42.45	$ 98.90	$ 75.21	$ 128.50	$ 695.27	$ 41.07	$ 39.44	$ 410.47
Physician - Mental Health	$ 0.11	$ 1.03	$ 0.76	$ 1.46	$ 0.51	$ 0.55	$ 1.04	$ 1.32	$ 1.06	$ 1.47	$ -	$ 0.39	$ 0.91	$ 0.91	$ 0.19
Pharmacy	$ 12.30	$ 11.00	$ 11.58	$ 12.76	$ 28.87	$ 30.35	$ 83.63	$ 67.92	$ 100.87	$ 84.56	$ 7.12	$ 0.31	$ 33.33	$ 33.39	$ 3.73
Transportation	$ 3.04	$ 1.48	$ 2.17	$ 1.39	$ 3.40	$ 1.84	$ 3.55	$ 2.02	$ 3.23	$ 2.67	$ 2.89	$ 1.07	$ 2.30	$ 2.29	$ 1.98
Dental	$ 0.14	$ 19.11	$ 32.33	$ 24.90	$ 16.08	$ 11.87	$ 17.34	$ 14.76	$ 18.84	$ 18.79	$ -	$ 1.85	$ 18.04	$ 18.08	$ 0.82
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 11.43	$ 6.87	$ 12.58	$ 7.40	$ 17.09	$ 7.54	$ 21.64	$ 13.40	$ 27.59	$ 22.69	$ 30.27	$ 143.52	$ 13.05	$ 12.72	$ 86.61
TOTAL MEDICAL EXPENSES	$ 274.67	$ 140.06	$ 181.28	$ 157.60	$ 235.00	$ 166.87	$ 416.15	$ 322.67	$ 550.37	$ 466.61	$ 3,285.77	$ 8,369.29	$ 261.19	$ 237.39	$ 6,814.86

775 Population	19 - 36 FEMALE	19 - 36 MALE	37-49 FEMALE	37-49 MALE	50+ FEMALE	50+ MALE	TOTAL
MEMBER MONTHS OR DELIVERIES	3,083	2,812	3,292	3,674	5,818	4,447	23,226
PMPM MEDICAL EXPENSES							
Inpatient Hospital - Physical Health	$ 64.14	$ 29.93	$ 83.20	$ 136.60	$ 239.57	$ 261.61	$ 155.77
Inpatient Hospital - Mental Health	$ 1.00	$ 3.15	$ 1.96	$ 17.79	$ 2.79	$ 3.69	$ 5.03
Outpatient Hospital - Physical Health	$ 18.69	$ 15.63	$ 78.66	$ 48.06	$ 115.95	$ 70.23	$ 65.88
Outpatient Hospital - Mental Health	$ -	$ 0.06	$ 0.16	$ 0.01	$ 0.20	$ 0.10	$ 0.10
Emergency Room	$ 46.88	$ 37.78	$ 46.71	$ 38.79	$ 44.21	$ 33.83	$ 41.27
Physician - Physical Health	$ 46.78	$ 27.41	$ 84.56	$ 55.57	$ 121.09	$ 83.94	$ 76.83
Physician - Mental Health	$ 1.09	$ 1.19	$ 2.12	$ 1.13	$ 1.02	$ 0.69	$ 1.16
Pharmacy	$ 25.84	$ 111.46	$ 101.63	$ 170.23	$ 151.76	$ 179.39	$ 131.10
Transportation	$ 1.63	$ 0.43	$ 1.80	$ 0.63	$ 1.48	$ 1.14	$ 1.22
Dental	$ 22.10	$ 15.53	$ 18.03	$ 19.04	$ 22.47	$ 19.87	$ 19.88
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 13.06	$ 3.19	$ 16.71	$ 11.84	$ 36.49	$ 29.74	$ 21.21
TOTAL MEDICAL EXPENSES	$ 241.22	$ 246.77	$ 435.63	$ 499.70	$ 737.04	$ 684.26	$ 519.25

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Attachment C-2 — August 2010 through July 2011 Encounter Data Reported by DCHFP MCOs

STATEMENT FOR THE TIME PERIOD OF 08/01/2010 - 07/31/2011 FOR DC MCO ENCOUNTER DATA

Legacy Medicaid	<1 M&F	1-12 M&F	13 - 18 FEMALE	13 - 18 MALE	19 - 36 FEMALE	19 - 36 MALE	37-49 FEMALE	37-49 MALE	50+ FEMALE	50+ MALE	Month of Birth	Month of Delivery	TOTAL	Non-Delivery	Delivery
MEMBER MONTHS OR DELIVERIES	57,393	529,258	112,089	99,948	292,311	161,022	127,079	94,706	80,626	83,664	3,275	3,069	1,631,272	1,627,996	6,345
PMPM MEDICAL EXPENSES															
Inpatient Hospital - Physical Health	$ 104.86	$ 19.37	$ 17.66	$ 22.46	$ 27.57	$ 37.92	$ 67.26	$ 79.81	$ 114.18	$ 126.64	$ 1,321.80	$ 4,118.32	$ 53.42	$ 43.11	$ 2,674.45
Inpatient Hospital - Mental Health	$ -	$ 1.16	$ 8.78	$ 11.80	$ 2.99	$ 3.23	$ 4.02	$ 10.39	$ 3.11	$ 5.12	$ -	$ 0.10	$ 3.87	$ 3.66	$ 0.05
Outpatient Hospital - Physical Health	$ 36.85	$ 19.42	$ 37.67	$ 19.08	$ 56.68	$ 17.27	$ 78.88	$ 32.68	$ 102.90	$ 57.47	$ 29.54	$ 318.40	$ 39.67	$ 39.09	$ 169.26
Outpatient Hospital - Mental Health	$ 0.23	$ 0.35	$ 0.53	$ 0.30	$ 0.37	$ 0.86	$ 0.43	$ 1.04	$ 0.40	$ 0.84	$ -	$ -	$ 0.48	$ 0.48	$ -
Emergency Room	$ 58.93	$ 28.41	$ 24.11	$ 18.96	$ 32.21	$ 22.78	$ 32.30	$ 29.64	$ 29.28	$ 27.66	$ 27.75	$ 40.55	$ 29.22	$ 29.15	$ 33.94
Physician - Physical Health	$ 49.21	$ 15.75	$ 18.91	$ 11.92	$ 33.17	$ 14.22	$ 56.82	$ 37.05	$ 82.41	$ 67.66	$ 402.55	$ 1,525.77	$ 33.93	$ 30.31	$ 945.84
Physician - Mental Health	$ 1.17	$ 4.58	$ 3.89	$ 4.99	$ 1.69	$ 0.96	$ 2.73	$ 1.80	$ 2.60	$ 1.89	$ 0.15	$ 8.48	$ 3.05	$ 3.04	$ 4.18
Pharmacy	$ 15.04	$ 11.13	$ 12.33	$ 12.16	$ 28.83	$ 30.08	$ 84.19	$ 65.79	$ 100.53	$ 79.87	$ 0.11	$ 30.87	$ 33.18	$ 33.19	$ 14.98
Transportation	$ 5.64	$ 2.62	$ 3.98	$ 2.59	$ 6.47	$ 3.79	$ 6.76	$ 4.17	$ 6.20	$ 5.38	$ 1.63	$ 82.88	$ 4.50	$ 4.35	$ 40.93
Dental	$ 0.28	$ 18.50	$ 29.80	$ 23.33	$ 14.79	$ 10.74	$ 15.97	$ 13.83	$ 17.31	$ 17.29	$ -	$ 4.96	$ 16.93	$ 16.96	$ 2.40
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 5.08	$ 4.15	$ 12.47	$ 9.11	$ 26.84	$ 7.22	$ 29.77	$ 14.89	$ 34.16	$ 22.86	$ 7.04	$ 124.02	$ 14.71	$ 14.49	$ 63.62
TOTAL MEDICAL EXPENSES	$ 277.30	$ 126.46	$ 170.33	$ 136.70	$ 230.60	$ 149.08	$ 379.13	$ 291.06	$ 483.08	$ 412.70	$ 1,790.67	$ 6,264.36	$ 232.97	$ 218.04	$ 3,949.66

775 Population	19 - 36 FEMALE	19 - 36 MALE	37-49 FEMALE	37-49 MALE	50+ FEMALE	50+ MALE	TOTAL
MEMBER MONTHS OR DELIVERIES	2,738	2,447	2,700	3,264	5,022	3,867	20,028
PMPM MEDICAL EXPENSES							
Inpatient Hospital - Physical Health	$ 78.87	$ 35.56	$ 20.49	$ 163.30	$ 175.98	$ 194.65	$ 126.12
Inpatient Hospital - Mental Health	$ 4.12	$ 1.91	$ 0.32	$ 18.80	$ 3.79	$ 14.12	$ 7.58
Outpatient Hospital - Physical Health	$ 30.61	$ 21.72	$ 65.34	$ 52.17	$ 121.48	$ 50.59	$ 64.36
Outpatient Hospital - Mental Health	$ 0.17	$ 0.64	$ 0.44	$ 1.07	$ 0.17	$ 1.55	$ 0.68
Emergency Room	$ 28.05	$ 27.43	$ 24.30	$ 26.32	$ 25.12	$ 18.84	$ 24.58
Physician - Physical Health	$ 34.25	$ 22.06	$ 64.75	$ 60.74	$ 106.89	$ 83.45	$ 68.83
Physician - Mental Health	$ 2.12	$ 1.09	$ 2.53	$ 1.85	$ 1.55	$ 1.41	$ 1.73
Pharmacy	$ 25.49	$ 98.11	$ 97.80	$ 162.01	$ 113.73	$ 165.16	$ 115.15
Transportation	$ 1.28	$ 1.50	$ 3.20	$ 3.24	$ 3.68	$ 4.23	$ 3.05
Dental	$ 19.76	$ 13.40	$ 14.48	$ 13.30	$ 20.34	$ 18.14	$ 17.05
Other (DME, Home Health, Vision, Lab, & X-Ray)	$ 23.05	$ 9.36	$ 30.56	$ 18.26	$ 41.84	$ 34.09	$ 28.45
TOTAL MEDICAL EXPENSES	$ 247.77	$ 230.78	$ 324.20	$ 521.07	$ 614.38	$ 586.24	$ 457.57

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Attachment D-1 — Rate Development Overview
Legacy Medicaid Population

	Base Year	Target Rate Development Data Adjustments						12-13 Resulting Rate Range		
	A	B	C	D	F	G	H			
New Rate Cell Description	Base Year PMPM*	Trend **	Program Changes	Managed Care Adjustment	Administration ***	Profit ***	MCO Tax ****	Target Rate *****	Lower bound Rate	Upper bound Rate
< 1 Year, Male and Female	$ 273.44	5.3%	0.9%	0.0%	10.0%	2.0%	2.0%	$ 350.01	$ 327.89	$ 366.07
1 - 12 Years, Male and Female	$ 135.92	5.4%	-0.5%	0.0%	10.0%	2.0%	2.0%	$ 171.91	$ 162.87	$ 180.17
13 - 18 Years, Female	$ 177.68	5.2%	-0.8%	0.0%	10.0%	2.0%	2.0%	$ 223.50	$ 212.87	$ 234.27
13 - 18 Years, Male	$ 150.37	4.9%	-0.4%	0.0%	10.0%	2.0%	2.0%	$ 188.99	$ 179.91	$ 198.14
19 - 36 Years, Female	$ 234.38	5.4%	-0.8%	0.0%	10.0%	2.0%	2.0%	$ 295.27	$ 282.34	$ 308.14
19 - 36 Years, Male	$ 159.46	6.3%	-0.2%	0.0%	10.0%	2.0%	2.0%	$ 205.40	$ 194.02	$ 213.87
37 - 49 Years, Female	$ 407.33	6.0%	-0.1%	0.0%	10.0%	2.0%	2.0%	$ 523.17	$ 500.30	$ 544.84
37 - 49 Years, Male	$ 305.85	6.5%	0.2%	0.0%	10.0%	2.0%	2.0%	$ 396.64	$ 374.98	$ 412.58
50+ Years, Female	$ 542.16	6.1%	0.2%	0.0%	10.0%	2.0%	2.0%	$ 698.40	$ 667.31	$ 726.78
50+ Years, Male	$ 440.74	6.2%	0.3%	0.0%	10.0%	2.0%	2.0%	$ 569.93	$ 539.18	$ 592.61
Infant Month of Birth	$ 3,388.43	2.2%	2.7%	0.0%	6.0%	2.0%	2.0%	$ 4,006.06	$ 3,821.79	$ 4,083.18
Mother's Month of Delivery	$ 7,768.86	2.5%	1.9%	0.0%	6.0%	2.0%	2.0%	$ 9,182.68	$ 8,788.28	$ 9,416.53
Overall	$ 253.92	5.4%	0.0%	0.0%	9.7%	2.0%	2.0%	$ 321.76	$ 306.04	$ 335.21
							Rate Change	12.8%	7.2%	17.5%

*Blend of 75% Financial Data and 25% Encounter Data
** The trend shown is annualized from the 21 month period May 1, 2012 to April 30, 2013
*** Shown as a % of the total rate before loading for premium tax.
**** Shown as a % of the gross premium.
***** Rate Development Formula: Lower Bound Rate = ((A*(1+B)^(21/12)*(1+C)*(1+D)*(1+E))/(1-F-G))/(1-H)

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Attachment D-2 — Rate Development Overview
775 Population

	Base Year	Target Rate Development Data Adjustments						12-13 Resulting Rate Range		
	A	B	C	D	F	G	H			
New Rate Cell Description	Base Year PMPM*	Trend **	Program Changes	Managed Care Adjustment	Administration ***	Profit ***	MCO Tax ****	Target Rate *****	Lower bound Rate	Upper bound Rate
19 - 36 Years, Female	$ 242.86	4.8%	-0.7%	0.0%	10.0%	2.0%	2.0%	$ 301.03	$ 288.77	$ 313.17
19 - 36 Years, Male	$ 242.02	5.7%	-0.2%	0.0%	10.0%	2.0%	2.0%	$ 305.69	$ 294.29	$ 317.06
37 - 49 Years, Female	$ 407.70	5.0%	-0.3%	0.0%	10.0%	2.0%	2.0%	$ 509.01	$ 491.16	$ 528.94
37 - 49 Years, Male	$ 505.04	5.4%	0.5%	0.0%	10.0%	2.0%	2.0%	$ 639.97	$ 615.82	$ 663.88
50+ Years, Female	$ 708.37	5.0%	0.3%	0.0%	10.0%	2.0%	2.0%	$ 888.41	$ 855.47	$ 923.00
50+ Years, Male	$ 659.74	5.3%	0.7%	0.0%	10.0%	2.0%	2.0%	$ 836.29	$ 804.17	$ 867.86
Overall	**$ 503.52**	**5.2%**	**0.3%**	**0.0%**	**10.0%**	**2.0%**	**2.0%**	**$ 634.33**	**$ 610.52**	**$ 658.68**
							Rate Change	43.3%	37.9%	48.8%

*Blend of 75% Financial Data and 25% Encounter Data
** The trend shown is annualized from the 19 month period May 1, 2012 to April 30, 2013
*** Shown as a % of the total rate before loading for premium tax.
**** Shown as a % of the gross premium.
***** Rate Development Formula: Lower Bound Rate = ((A*(1+B)^(19/12)*(1+C)*(1+D)*(1+E))/(1-F-G))/(1-H)

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Attachment E — Family Planning Rate Development
Legacy Medicaid Population only

	Databook			Family Planning		Service Rate Range		Family Planning Rate Range		
Rate Cell Description	Base Year PMPM*	Base Year Rx	Base Year Medical	Family Planning Percentage	Base Year Family Planning PMPM	Lower Bound Service Rate	Upper Bound Service Rate	FP lower Bound	FP Contract Rate	FP Upper Bound
< 1 Year, Male and Female	$ 273.44	$ 12.95	$ 260.49	0.0%	$ -	$ 282.77	$ 315.70	$ -	$ -	$ -
1 - 12 Years, Male and Female	$ 135.92	$ 11.20	$ 124.72	0.0%	$ 0.01	$ 140.46	$ 155.38	$ 0.01	$ 0.01	$ 0.01
13 - 18 Years, Female	$ 177.68	$ 12.08	$ 165.60	2.1%	$ 3.44	$ 183.58	$ 202.04	$ 3.82	$ 3.82	$ 4.20
13 - 18 Years, Male	$ 150.37	$ 13.36	$ 137.00	0.0%	$ 0.01	$ 155.15	$ 170.68	$ 0.01	$ 0.01	$ 0.01
19 - 36 Years, Female	$ 234.38	$ 28.81	$ 205.56	2.4%	$ 4.95	$ 243.49	$ 265.74	$ 5.86	$ 5.86	$ 6.40
19 - 36 Years, Male	$ 159.46	$ 28.45	$ 131.00	0.0%	$ 0.03	$ 167.32	$ 184.44	$ 0.04	$ 0.04	$ 0.04
37 - 49 Years, Female	$ 407.33	$ 83.57	$ 323.76	0.4%	$ 1.39	$ 431.45	$ 469.87	$ 1.86	$ 1.86	$ 2.02
37 - 49 Years, Male	$ 305.65	$ 63.23	$ 242.62	0.0%	$ 0.02	$ 323.38	$ 355.81	$ 0.03	$ 0.03	$ 0.03
50+ Years, Female	$ 542.16	$ 102.26	$ 439.90	0.0%	$ 0.04	$ 575.49	$ 626.78	$ 0.06	$ 0.06	$ 0.06
50+ Years, Male	$ 440.74	$ 82.17	$ 358.58	0.0%	$ -	$ 464.99	$ 511.07	$ -	$ -	$ -
Infant Month of Birth	$ 3,388.43	$ 6.98	$ 3,381.45	0.0%	$ -	$ 3,445.73	$ 3,681.39	$ -	$ -	$ -
Mother's Month of Delivery	$ 7,788.86	$ 7.89	$ 7,780.98	0.4%	$ 34.19	$ 7,923.51	$ 8,489.94	$ 34.82	$ 34.82	$ 37.30
Overall	**$ 253.92**	**$ 32.99**	**$ 220.93**	**0.6%**	**$ 1.31**	**$ 264.96**	**$ 290.19**	**$ 1.57**	**$ 1.57**	**$ 1.72**

Family Planning percentage was developed based on the FY11 encounter data.
The family planning rate is strictly a service rate. The District is not claiming for any administrative costs associated with family planning.

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **All Medicaid Rate Cohorts Combined**

		Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	919,051		384,610		311,014		Summation of 10 attached worksheets
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$170.87	$65,719,540	$170.81	$53,123,544	Summation of 10 attached worksheets
	Pharmacy Costs:	N/A	N/A	$27.81	$10,695,019	$30.52	$9,490,992	Summation of 10 attached worksheets
	Subotal Costs:	N/A	N/A	$198.68	$76,414,559	$201.32	$62,614,536	
	Gross Cap Revenue:	$217.15	$199,573,324	$221.95	$85,364,186	$222.13	$69,085,612	Summation of 10 attached worksheets
Subgroup 774:	Member Months:	212,576		97,109		80,349		Summation of 10 attached worksheets
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$294.85	$28,632,783	$314.76	$25,290,844	Summation of 10 attached worksheets
	Pharmacy Costs:	N/A	N/A	$85.06	$8,260,574	$93.33	$7,498,836	Summation of 10 attached worksheets
	Subotal Costs:	N/A	N/A	$379.92	$36,893,357	$408.09	$32,789,680	
	Gross Cap Revenue	$388.90	$82,671,699	$379.47	$36,849,692	$379.98	$30,530,727	Summation of 10 attached worksheets
Subgroup 775:	Member Months:	12,923		8,529		7,473		Summation of 10 attached worksheets
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$354.67	$3,025,017	$431.22	$3,222,521	Summation of 10 attached worksheets
	Pharmacy Costs:	N/A	N/A	$185.28	$1,580,259	$167.00	$1,247,999	Summation of 10 attached worksheets
	Subotal Costs:	N/A	N/A	$539.95	$4,605,276	$598.22	$4,470,520	
	Gross Cap Revenue:	$463.83	$5,994,084	$463.61	$3,954,135	$467.36	$3,492,590	Summation of 10 attached worksheets
Medicaid Sum (Grand Total Of All 3 Subgroups):	Member Months:	1,144,550		490,248		398,836		Summation from data above
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$198.63	$97,377,340	$204.69	$81,636,909	Summation from data above
	Pharmacy Costs:	N/A	N/A	$41.89	$20,535,852	$45.73	$18,237,827	Summation from data above
	Subotal Costs:	N/A	N/A	$240.52	$117,913,192	$250.42	$99,874,736	
	Capitated PCP Costs:	N/A	N/A	$6.67	$3,268,698	$6.70	$2,672,342	"Cap Pmts PCP 11.15.12 CAP WITH PHYSICIAN . . . "
	Other Capitated Costs:	N/A	N/A	$5.93	$2,906,153	$5.77	$2,302,165	"Capitation Rates 11.15.12 Legal NON-PCP PMPM"
	Less: Reinsurance Recoveries:	N/A	N/A	($0.83)	($408,335)	($1.07)	($425,193)	"Reinsurance premiums and recoveries . . . "
	Dental Costs:	N/A	N/A	$16.27	$7,976,335	$16.27	$6,489,062	PMPM extrapolated from annual "DCHFP Final Reports Template" reports filed 12.05.12
	Mental Health Costs:	N/A	N/A	$6.97	$3,417,029	$6.97	$2,779,887	PMPM extrapolated from annual "DCHFP Final Reports Template" reports filed 12.05.12
	Total Costs:	$256.33	$293,382,780	$275.52	$135,073,072	$285.06	$113,692,999	1st period taken from annual "DCHFP Final Reports Template" reports filed 12.06.12; 2nd & 3rd periods are summations of data above
	Gross Cap Revenue:	$251.84	$288,239,107	$257.36	$126,168,013	$258.52	$103,108,930	Summation from data above
	Birth (Kick) Revenue	$27.53	$31,507,188	$29.85	$14,632,520	$27.82	$11,094,806	"Birth Receipts 7.1.10 - 12.31.11 Edget 11.15.12"
	Total Revenue:	$279.36	$319,746,295	$287.20	$140,800,533	$286.34	$114,203,736	
	* Net Adjusted Revenue:	*$241.93*	*$276,900,292*	*$248.72*	*$121,933,261*	*$247.97*	*$99,900,435*	
Medical Component Gain (Loss)		($14.40)	($16,482,488)	($26.80)	($13,139,810)	($37.09)	($14,792,563)	($44,414,862)
Grossed Up Gain (Loss)		($16.63)	($19,032,896)	($30.95)	($15,172,991)	($42.83)	($17,081,482)	($51,287,369)

* = Per Mercer, revenue is assumed to include a load factor of 13.4% to cover G&A, premium taxes & profit

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Male & Female < 1 Year of Age**

		Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	41,353		17,767		14,090		"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$587.09	$10,430,824	$429.14	$6,046,593	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$17.61	$312,884	$26.87	$378,612	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$604.70	$10,743,708	$456.01	$6,425,205	
	Gross Cap Revenue:	$305.43	$12,630,447	$298.32	$5,300,251	$298.32	$4,203,329	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months:	0		4		3		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$0.00	$0	$18.67	$56	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$0.00	$0	$18.67	$56	
	Gross Cap Revenue:	$305.43	$0	$298.32	$1,193	$298.32	$895	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	0		0		0		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$0.00	$0	$0.00	$0	
	Gross Cap Revenue:	$305.43	$0	$298.32	$0	$298.32	$0	"Premium Capitation Rates 10.10.12 . . ."
Rate Cohort Grand Totals:	Member Months:	41,353		17,771		14,093		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$586.96	$10,430,824	$429.05	$6,046,593	
	Pharmacy Costs:	N/A	N/A	$17.61	$312,884	$26.87	$378,668	
	Subotal Costs:	N/A	N/A	$604.56	$10,743,708	$455.92	$6,425,261	
	Gross Cap Revenue	$305.43	$12,630,447	$298.32	$5,301,445	$298.32	$4,204,224	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Male & Female 1 - 12**

		Period 1		Period 2		Period 3		
		8/1/10 - 7/31/11		8/1/11 - 12/31/11		1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	391,671		165,507		133,865		"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$94.66	$15,666,157	$96.44	$12,910,251	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$15.14	$2,505,985	$18.17	$2,432,070	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$109.80	$18,172,142	$114.61	$15,342,321	
	Gross Cap Revenue:	$135.43	$53,044,004	$145.17	$24,026,651	$145.17	$19,433,182	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months:	0		0		0		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$0.00	$0	$0.00	$0	
	Gross Cap Revenue:	$135.43	$0	$145.17	$0	$145.17	$0	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	0		0		0		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$0.00	$0	$0.00	$0	
	Gross Cap Revenue:	$135.43	$0	$145.17	$0	$145.17	$0	"Premium Capitation Rates 10.10.12 . . ."
Rate Cohort Grand Totals:	Member Months:	391,671		165,507		133,865		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$94.66	$15,666,157	$96.44	$12,910,251	
	Pharmacy Costs:	N/A	N/A	$15.14	$2,505,985	$18.17	$2,432,070	
	Subotal Costs:	N/A	N/A	$109.80	$18,172,142	$114.61	$15,342,321	
	Gross Cap Revenue:	$135.43	$53,044,004	$145.17	$24,026,651	$145.17	$19,433,182	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Female 13 - 18**

	Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	83,328		34,148		27,562	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$127.84	$4,365,342	$137.78	$3,797,451	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$14.39	$491,543	$13.62	$375,372	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$142.23	$4,856,885	$151.40	$4,172,823	
	Gross Cap Revenue:	$165.58	$13,797,450	$180.21	$6,153,811	$180.21	$4,966,948	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months:	20		10		6		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$47.80	$478	$41.83	$251	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$186.30	$1,863	$0.00	$0	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$234.10	$2,341	$41.83	$251	
	Gross Cap Revenue:	$165.58	$3,312	$180.21	$1,802	$180.21	$1,081	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	0		0		0		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$0.00	$0	$0.00	$0	
	Gross Cap Revenue:	$165.58	$0	$180.21	$0	$180.21	$0	"Premium Capitation Rates 10.10.12 . . ."
Rate Cohort Grand Totals:	Member Months:	83,348		34,158		27,568		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$127.81	$4,365,820	$137.76	$3,797,702	
	Pharmacy Costs:	N/A	N/A	$14.44	$493,406	$13.62	$375,372	
	Subotal Costs:	N/A	N/A	$142.26	$4,859,226	$151.37	$4,173,074	
	Gross Cap Revenue:	$165.58	$13,800,762	$180.21	$6,155,613	$180.21	$4,968,029	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Male 13 - 18**

	Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	73,232		29,891		23,935	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$92.18	$2,755,432	$81.57	$1,952,406	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$14.13	$422,228	$14.75	$353,027	"Phcy Claim 11.12.12 Doug DCMC RX cost . . "
Subotal Costs:	N/A	N/A	$106.31	$3,177,660	$96.32	$2,305,433	
Gross Cap Revenue:	$146.87	$10,755,584	$154.78	$4,626,529	$154.78	$3,704,659	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months:	22		14		12	
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$785.71	$11,000	$367.42	$4,409	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$29.93	$419	$56.58	$679	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
Subotal Costs:	N/A	N/A	$815.64	$11,419	$424.00	$5,088	
Gross Cap Revenue:	$146.87	$3,231	$154.78	$2,167	$154.78	$1,857	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	0		0		0	
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.16.12 Doug DCMC MED-Surg
Pharmacy Costs:	N/A	N/A	$0.00	$0	$0.00	$0	"Phcy Claim 11.12.12 Doug DCMC RX cost . "
Subotal Costs:	N/A	N/A	$0.00	$0	$0.00	$0	
Gross Cap Revenue:	$146.87	$0	$154.78	$0	$154.78	$0	"Premium Capitation Rates 10.10.12 . . "
Rate Cohort Grand Totals:	Member Months:	73,254		29,905		23,947	
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$92.51	$2,766,432	$81.71	$1,956,815	
Pharmacy Costs:	N/A	N/A	$14.13	$422,647	$14.77	$353,706	
Subotal Costs:	N/A	N/A	$106.64	$3,189,079	$96.48	$2,310,521	
Gross Cap Revenue:	$146.87	$10,758,815	$154.78	$4,628,696	$154.78	$3,706,517	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Female 19 - 36**

	Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	182,389		76,872		62,233	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$252.92	$19,442,620	$261.57	$16,278,447	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$31.33	$2,408,493	$32.07	$1,996,114	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
Subotal Costs:	N/A	N/A	$284.25	$21,851,113	$293.65	$18,274,561	
Gross Cap Revenue:	$281.04	$51,258,605	$266.27	$20,468,707	$266.27	$16,570,781	"Premium Capitation Rates 10 10 12 . . ."
Subgroup 774:	Member Months:	28,641		13,419		11,387	
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$203.74	$2,734,009	$165.36	$1,883,005	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$41.42	$555,772	$44.44	$506,023	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
Subotal Costs:	N/A	N/A	$245.16	$3,289,781	$209.80	$2,389,028	
Gross Cap Revenue:	$281.04	$8,049,267	$266.27	$3,573,077	$266.27	$3,032,016	"Premium Capitation Rates 10 10 12 . . ."
Subgroup 775:	Member Months:	1,614		1,015		891	
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$126.31	$128,205	$207.22	$184,633	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$25.35	$25,729	$29.71	$26,469	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
Subotal Costs:	N/A	N/A	$151.66	$153,934	$236.93	$211,102	
Gross Cap Revenue:	$281.04	$453,599	$266.27	$270,264	$266.27	$237,247	"Premium Capitation Rates 10 10 12 . . ."
Rate Cohort Grand Totals:	Member Months:	212,644		91,306		74,511	
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$244.29	$22,304,834	$246.22	$18,346,085	
Pharmacy Costs:	N/A	N/A	$32.75	$2,989,994	$33.94	$2,528,606	
Subotal Costs:	N/A	N/A	$277.03	$25,294,828	$280.16	$20,874,691	
Gross Cap Revenue:	$281.04	$59,761,470	$266.27	$24,312,049	$266.27	$19,840,044	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Male 19 - 36**

		Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	39,419		16,477		13,536		"Phcy Claim 11 16 12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$67.36	$1,109,873	$140.68	$1,904,291	"Phcy Claim 11 16 12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$17.35	$285,834	$21.35	$288,949	"Phcy Claim 11 12 12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$84.71	$1,395,707	$162.03	$2,193,240	
	Gross Cap Revenue:	$161.38	$6,361,438	$170.47	$2,808,834	$170.47	$2,307,482	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months	1,546		23,618		19,300		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$147.47	$3,482,940	$133.42	$2,575,032	"Phcy Claim 11 16 12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$43.18	$1,019,794	$47.81	$922,763	"Phcy Claim 11 12 12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$190.65	$4,502,734	$181.23	$3,497,795	
	Gross Cap Revenue	$161.38	$8,318,493	$170.47	$4,026,160	$170.47	$3,290,071	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	1,545		957		878		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$624.39	$597,540	$53.88	$47,311	"Phcy Claim 11 16 12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$171.98	$164,581	$183.65	$161,243	"Phcy Claim 11 12 12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$796.36	$762,121	$237.53	$208,554	
	Gross Cap Revenue:	$161.38	$249,332	$170.47	$163,140	$170.47	$149,673	"Premium Capitation Rates 10.10.12 . . ."
Rate Cohort Grand Totals:	Member Months:	92,510		41,052		33,714		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$126.43	$5,190,353	$134.27	$4,526,634	
	Pharmacy Costs:	N/A	N/A	$35.81	$1,470,209	$40.72	$1,372,955	
	Subotal Costs:	N/A	N/A	$162.25	$6,660,562	$174.99	$5,899,589	
	Gross Cap Revenue:	$161.38	$14,929,264	$170.47	$6,998,134	$170.47	$5,747,226	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Female 37 - 49**

	Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):							
Member Months:	67,630		27,478		22,141		"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$269.27	$7,399,010	$275.74	$6,105,107	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$91.76	$2,521,316	$90.77	$2,009,701	"Phcy Claim 11.12.12 Doug DCMC Rx cost . . ."
Subotal Costs:	N/A	N/A	$361.03	$9,920,326	$366.51	$8,114,808	
Gross Cap Revenue:	$436.77	$29,538,755	$477.94	$13,132,835	$477.94	$10,582,070	"Premium Capitation Rates 10.10.12 . . "
Subgroup 774:							
Member Months:	20,649		9,495		7,697		
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$424.96	$4,035,007	$394.11	$3,033,454	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
Pharmacy Costs:	N/A	N/A	$118.75	$1,127,563	$121.81	$937,600	"Phcy Claim 11.12.12 Doug DCMC RX cost . . "
Subotal Costs:	N/A	N/A	$543.71	$5,162,570	$515.92	$3,971,054	
Gross Cap Revenue:	$436.77	$9,018,864	$477.94	$4,538,040	$477.94	$3,678,704	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:							
Member Months	1,934		1,114		942		
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$301.40	$335,763	$302.62	$285,072	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . "
Pharmacy Costs:	N/A	N/A	$152.91	$170,338	$142.91	$134,625	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
Subotal Costs:	N/A	N/A	$454.31	$506,101	$445.54	$419,697	
Gross Cap Revenue:	$436.77	$844,713	$477.94	$532,425	$477.94	$450,219	"Premium Capitation Rates 10.10.12 . . "
Rate Cohort Grand Totals:							
Member Months:	90,213		38,087		30,780		
	PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
FFS Costs:	N/A	N/A	$309.02	$11,769,780	$306.16	$9,423,633	
Pharmacy Costs:	N/A	N/A	$100.28	$3,819,217	$100.13	$3,081,926	
Subotal Costs:	N/A	N/A	$409.30	$15,588,997	$406.29	$12,505,559	
Gross Cap Revenue:	$436.77	$39,402,332	$477.94	$18,203,301	$477.94	$14,710,993	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Male 37 - 49**

		Period 1 8/1/10 - 7/31/11		Period 2 8/1/11 - 12/31/11		Period 3 1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	12,373		5,214		4,351		"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$153.26	$799,121	$167.64	$729,383	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$62.95	$328,217	$68.81	$299,402	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$216.21	$1,127,338	$236.45	$1,028,785	
	Gross Cap Revenue	$281.44	$3,482,257	$295.31	$1,539,746	$295.31	$1,284,894	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months:	40,433		17,232		14,189		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$277.97	$4,789,961	$273.89	$3,886,178	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$87.69	$1,511,006	$103.09	$1,462,724	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$365.66	$6,300,967	$376.98	$5,348,902	
	Gross Cap Revenue:	$281.44	$11,379,464	$295.31	$5,088,782	$295.31	$4,190,154	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	1,919		1,178		935		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$254.90	$300,272	$561.18	$524,707	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$211.05	$248,615	$212.76	$198,933	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$465.95	$548,887	$773.95	$723,640	
	Gross Cap Revenue:	$281.44	$540,083	$295.31	$347,875	$295.31	$276,115	"Premium Capitation Rates 10.10.12 . . ."
Rate Cohort Grand Totals:	Member Months:	54,725		23,624		19,475		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$249.30	$5,889,354	$263.94	$5,140,268	
	Pharmacy Costs:	N/A	N/A	$88.38	$2,087,838	$100.70	$1,961,059	
	Subotal Costs:	N/A	N/A	$337.67	$7,977,192	$364.64	$7,101,327	
	Gross Cap Revenue:	$281.44	$15,401,804	$295.31	$6,976,403	$295.31	$5,751,162	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Female 50+**

	Period 1		Period 2		Period 3		
	8/1/10 - 7/31/11		8/1/11 - 12/31/11		1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	19,992		8,043		6,623	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$354.68	$2,852,657	$375.39	$2,486,188	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$134.25	$1,079,782	$161.36	$1,068,678	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ."
	Subotal Costs:	N/A	N/A	$488.93	$3,932,439	$536.75	$3,554,866	
	Gross Cap Revenue:	$709.09	$14,176,127	$716.84	$5,765,544	$716.84	$4,747,631	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 774:	Member Months:	32,055		15,334		12,743		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$432.86	$6,637,545	$531.37	$6,771,219	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . "
	Pharmacy Costs	N/A	N/A	$129.10	$1,979,641	$131.17	$1,671,563	"Phcy Claim 11.12.12 Doug DCMC RX cost . . "
	Subotal Costs:	N/A	N/A	$561.97	$8,617,186	$662.54	$8,442,782	
	Gross Cap Revenue:	$709.09	$22,729,880	$716.84	$10,992,025	$716.84	$9,134,692	"Premium Capitation Rates 10.10.12 . . . "
Subgroup 775:	Member Months	3,499		2,507		2,292		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$387.94	$972,556	$510.24	$1,169,480	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . "
	Pharmacy Costs:	N/A	N/A	$222.52	$557,846	$202.81	$464,842	"Phcy Claim 11.12.12 Doug DCMC RX cost . . ,"
	Subotal Costs:	N/A	N/A	$610.45	$1,530,402	$713.05	$1,634,322	
	Gross Cap Revenue:	$709.09	$2,481,106	$716.84	$1,797,118	$716.84	$1,642,997	"Premium Capitation Rates 10.10.12 . . ,"
Rate Cohort Grand Totals:	Member Months:	55,546		25,884		21,658		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$404.22	$10,462,758	$481.43	$10,426,887	
	Pharmacy Costs:	N/A	N/A	$139.75	$3,617,269	$147.99	$3,205,083	
	Subotal Costs:	N/A	N/A	$543.97	$14,080,027	$629.42	$13,631,970	
	Gross Cap Revenue:	$709.09	$39,387,113	$716.84	$18,554,687	$716.84	$15,525,321	

DC Chartered Health Plan
Retrospective Premium Claim
"Pharmacy Claim for Medicaid Subgroups 774 & 775"

Updated: 12/11/12

Rate Cohort: **Male 50+**

		Period 1		Period 2		Period 3		
		8/1/10 - 7/31/11		8/1/11 - 12/31/11		1/1/12 - 4/30/12		Data Sources:
Legacy Subgroup (all but 774 & 775):	Member Months:	7,664		3,213		2,678		"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$279.65	$898,504	$341.09	$913,427	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$105.43	$338,737	$107.94	$289,067	"Phcy Claim 11.12.12 Doug DCMC RX cost . . "
	Subotal Costs:	N/A	N/A	$385.07	$1,237,241	$449.03	$1,202,494	
	Gross Cap Revenue:	$590.90	$4,528,658	$479.70	$1,541,276	$479.70	$1,284,637	"Premium Capitation Rates 10.10.12 . . "
Subgroup 774:	Member Months:	39,210		17,983		15,012		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$386.02	$6,941,843	$475.44	$7,137,296	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . ."
	Pharmacy Costs:	N/A	N/A	$114.80	$2,064,516	$133.06	$1,997,428	"Phcy Claim 11.12.12 Doug DCMC RX cost . . "
	Subotal Costs:	N/A	N/A	$500.83	$9,006,359	$608.49	$9,134,724	
	Gross Cap Revenue:	$590.90	$23,169,189	$479.70	$8,626,445	$479.70	$7,201,256	"Premium Capitation Rates 10.10.12 . . ."
Subgroup 775:	Member Months:	2,412		1,758		1,535		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$392.88	$690,681	$658.84	$1,011,318	"Phcy Claim 11.16.12 Doug DCMC MED-Surg . . "
	Pharmacy Costs:	N/A	N/A	$235.01	$413,150	$170.61	$261,887	"Phcy Claim 11.12.12 Doug DCMC RX cost . . "
	Subotal Costs:	N/A	N/A	$627.89	$1,103,831	$829.45	$1,273,205	
	Gross Cap Revenue:	$590.90	$1,425,251	$479.70	$843,313	$479.70	$736,340	"Premium Capitation Rates 10.10.12 . . ."
Rate Cohort Grand Totals:	Member Months:	49,286		22,954		19,225		
		PMPM $	Gross $	PMPM $	Gross $	PMPM $	Gross $	
	FFS Costs:	N/A	N/A	$371.66	$8,531,028	$471.37	$9,062,041	
	Pharmacy Costs:	N/A	N/A	$122.70	$2,816,403	$132.56	$2,548,382	
	Subotal Costs:	N/A	N/A	$494.36	$11,347,431	$603.92	$11,610,423	
	Gross Cap Revenue:	$590.90	$29,123,097	$479.70	$11,011,034	$479.70	$9,222,233	