SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

Civil Action No.: 2012-8227
Judge Melvin R. Wright

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent.

PARTY-IN-INTEREST D.C. HEALTHCARE SYSTEM, INC.'S MOTION FOR (1) A STAY PENDING APPEAL OF THE ORDER APPROVING THE ASSET PURCHASE AGREEMENT, PLAN OF REORGANIZATION AND RELATED MATTERS; AND (2) INJUNCTIVE RELIEF

Pursuant to District of Columbia Superior Court Rules of Civil Procedure 62(a) and 65(a), D.C. Healthcare Systems, Inc. ("DCHSI"), by and through its undersigned counsel of record, hereby moves this Court to: (1) stay its March 1 Order (Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters) pending appellate review (2) preliminarily enjoin the Rehabilitator from liquidating Chartered or otherwise exceeding the limits of his authority under the Insurers Rehabilitation and Liquidation Procedures Act, D.C. Code § 31-1301 *et seq*. and the October 19, 2012 Order of this Court placing Chartered into rehabilitation; (3) vacating or rendering void all of the Rehabilitator's liquidating actions, including any and all purported agreements with AmeriHealth; (4) requiring Petitioner District of Columbia to reopen the bidding process for the Department of Healthcare Finance ("DHCF") Medicaid contract (Solicitation No. Doc70947/DHCF-2013-R-0003 (MCO)) ("DHCF Contract") and to extend all deadlines for a reasonable period sufficient to allow Chartered to submit a bid on its own behalf or, in the alternative, to permit all current bidders at the "best and final offer

stage" to bid to acquire Chartered; and (5) requiring the Rehabilitator to comply with Chartered's Restated Articles of Incorporation by obtaining DCHSI's advance approval of any decision that would change the nature or operation of Chartered's business or have a material affect on DCHSI's interest in Chartered.

WHEREFORE, good cause having been shown, DCHSI respectfully requests that its Motion for (1) a Stay Pending Appeal of the Order Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters; and (2) Injunctive Relief be granted. A Proposed Order is submitted herewith.

ORAL HEARING REQUESTED

Dated: March 6, 2013

Respectfully submitted,

_____/s/_____

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MEMORANDUM OF POINTS AND AUTHORITIES

Party-in-Interest D.C. Healthcare Systems, Inc. ("DCHSI") is the sole shareholder of Respondent D.C. Chartered Health Plan, Inc. ("Chartered"), a District of Columbia HMO that has ably served the District's neediest citizens since 1987 as an incumbent to the Department of Health Care Finance ("DHCF") Medicaid and Alliance contract. Petitioner DISB, acting as Chartered's rehabilitator, petitioned this Court for an expedited order approving a purported Reorganization Plan for Chartered and an Asset Purchase Agreement in which AmeriHealth District of Columbia would purchase Chartered's key assets. DCHSI objected to the expedited proceedings and asked for a briefing schedule so that it could demonstrate that the proposed Agreement with AmeriHealth is not fair and equitable and that the Rehabilitator's plan did not comport with the law. Rather than set a briefing schedule, on March 1, this Court granted all relief Petitioner had requested and denied DCHSI's request to file a brief on the merits. Recognizing that DCHSI intended to appeal, the Court granted DCHSI leave to file this motion for stay.[1]

DCHSI requests that the Court stay its March 1 order pending an expedited appeal (and concurrent petition for writ of mandamus) because the Rehabilitator's actions violate the order placing Chartered into rehabilitation and the governing rehabilitation statute. The Rehabilitator is taking steps to *liquidate* Chartered under the guise of a *rehabilitation* plan. Such liquidation would irreparably harm DCHSI and violate its rights as Chartered's sole shareholder and a creditor. In addition to staying its March 1 order, DCHSI requests that the Court grant DCHSI injunctive relief to: order the Rehabilitator to re-open the bidding process for Chartered's sale;

[1] Although the docket mistakenly lists the undersigned counsel as having appeared for Chartered and grants Chartered leave to file a stay motion, it is clear this was meant to refer to DCHSI. As shareholder and creditor of Chartered, DCHSI qualifies as a party in interest. *See Capital Linoleum Co. v. Savage*, 91 A.2d 564, 565 (D.C. 1952) (party in interest is one "who under substantive law has the legal right to enforce the claim"); Black's Law Dictionary 1232 (9th ed. 2009) (party in interest is a party "entitled under the substantive law to enforce the right sued upon and who generally, but not necessarily, benefits from the action's final outcome").

order the District to re-open the bidding process for the DHCF Contract; and to enjoin the Rehabilitator from taking further actions in excess of his authority.

PRELIMINARY STATEMENT

From the outset, Chartered's "Rehabilitator"[2] disregarded his fundamental obligation to *rehabilitate* Chartered in favor of an unauthorized *liquidation*. The proposed AmeriHealth transaction — whether or not properly recognized as a move toward liquidation, rather than reorganization — is not "fair and equitable" as required by the rehabilitation statute. The government has admitted that Chartered continues to meet the needs of enrollees and providers under the DHCF Contract, as it has through annual contract renewals for 25 years. Chartered's DHCF Contract is its sole revenue source. The government correctly alleged in its initial pleading that DCHSI is a party in interest in this proceeding; in fact, Chartered is DCHSI's sole revenue source, and if Chartered fails, DCHSI fails. DCHSI also is interested as a creditor — it is the lessor of Chartered's office lease, which the Rehabilitator seeks to breach without compensating DCHSI.

This proceeding was commenced for the express purpose of rehabilitating Chartered. The Rehabilitator's mandate is to reform and revitalize Chartered. *See* D.C. Code § 31-1312(c); Emergency Consent Order of Rehabilitation ("Rehabilitation Order") at 2, 3 (Rehabilitator has "authority to take such action as deemed necessary or appropriate to reform and revitalize Chartered"; "the Rehabilitator [is to] submit a plan of rehabilitation of Chartered for Court approval if one is feasible" or, "[i]f the Rehabilitator determines that a rehabilitation plan is not feasible," he "shall submit a report to the Court which states the basis for such determination"). If the Rehabilitator determines that a reorganization or other transformation of an insurer is

[2] By law, the DISB Commissioner is the Rehabilitator. He appointed Daniel L. Watkins to carry out the Rehabilitator's powers as Special Deputy to the Rehabilitator; DCHSI uses "the Rehabilitator" to refer to both the Commissioner and his deputy unless context requires otherwise. The Commissioner appointed Mr. Watkins over Chartered's objection that he was conflicted because his brother was Chartered's Chief Operating Officer for almost four years until September 2011, and was involved in conduct directly subject to the Rehabilitator's review.

appropriate, he must first prepare a plan to effect the changes and seek Court approval, and the Court may prescribe notice and hearings and then approve, disapprove, or modify the plan. *See* D.C. Code § 31-1312(e). The plan must be "fair and equitable to all parties concerned" and should not be carried out until it is approved by the Court. *Id.*

The goal of rehabilitating Chartered was to cure a deficiency in "risk-based capital" — even though Chartered meets its statutory minimum net worth requirement and the District owes Chartered a multiple of the amount of the alleged capital deficiency. Petitioner, however, never attempted to rehabilitate Chartered. To the contrary, every action has been directed toward effectuating an unauthorized liquidation, without the Rehabilitator first having sought a liquidation order under the Rehabilitation Statute. *See* D.C. Code § 31-1314 *et seq.* (the Commissioner may petition for a liquidation order when he "believes *further* attempts to rehabilitate an insurer would *substantially* increase the risk of loss to creditors, policyholders, or the public, or would be *futile*") (emphasis added).

The Rehabilitator's first and most critical liquidating step, taken just six weeks into this proceeding (and without prior notice to the Court or DCHSI, as required by Chartered's Articles of Incorporation), was to prevent Chartered from bidding on renewal of the five-year DHCF Contract to provide healthcare services to Medicaid and Alliance beneficiaries. If permitted to stand, this decision would strip Chartered of its only business and source of income. Next, the Rehabilitator put Chartered's resources and experience behind competitor AmeriHealth's bid on the DHCF Contract. Then, the Rehabilitator spent three months negotiating a sale transaction with AmeriHealth that, now that its terms were revealed on February 22, 2013, demonstrates that he is dismantling what would remain of Chartered. The Rehabilitator's disregard for Chartered's fate is further shown by the fact that, by tying Chartered's fortunes to one bidder to the exclusion of all others, he has risked leaving Chartered with nothing if AmeriHealth does not win the contract. The Rehabilitator's actions are consistent with the very definition of a liquidation, the "process of converting assets into cash," and diametrically opposed to a rehabilitation, which is the "process of reorganizing a debtor's financial affairs … so that the debtor may continue to

exist as a financial entity." Black's Law Dictionary 1080, 1451 (9th ed. 2009); *see also* 43 AM. JUR. 2D INSURANCE § 99.

The Court should not accept the Rehabilitator's remarkably quick conclusion that Chartered should be liquidated. The Court also should either reverse its March 1 order to consider facts that will demonstrate that the terms of the proposed Agreement are not "fair and equitable to all parties concerned," or stay that order pending appeal. This is particularly important because the record, as it now stands, consists almost entirely of *assertions of fact by the Rehabilitator*, but essentially no evidence. Although the government portrayed its Petition as a plan of "rehabilitation," the plan approved by this Court will strip Chartered of continued operations, surrendering any chance it has to maintain its existing DHCF Contract, enrollee and provider agreements, and giving away its desks, office supplies, phone numbers, and even its name. Even the Rehabilitator describes this plan as a "wind down" of operations.

Liquidation would be a strange and, to DCHSI's understanding, unprecedented fate for a company that (1) for over 25 years has fulfilled its responsibility to ensure Medicaid and Alliance enrollees receive proper coverage and to pay the complex network of providers it has developed; (2) is and has been in compliance with its statutory minimum net worth requirement; (3) suffered a diminution of capital surplus in 2011 because, as the Rehabilitator himself contends, DHCF unilaterally imposed $60 million in new costs on Chartered but then failed to meet its obligation to pay Chartered for those costs; (4) would have more capital than is required if only the District would pay what DHCF owes to Chartered; and (5) increased its capital and surplus by 50% in the first nine months of 2012. Simply put, if the District would pay what it owes, Chartered would not be subject to rehabilitation.

The Rehabilitator's decision not to allow Chartered to bid on the new DHCF Contract, by itself, was an act of liquidation. But liquidation is to be a last resort; the Rehabilitator should not have been permitted to take any steps toward liquidation until after exhausting all reasonable rehabilitation efforts. Even if the Rehabilitator had quickly determined that rehabilitation was somehow futile notwithstanding Chartered's strong track record and the District's $60 million

debt to Chartered, by order and statute he was required *first* to justify his conclusion to the Court and propose a plan of action before taking steps toward liquidation. This Court then would have had the full benefit of the adversary process in determining what is in the parties' (and interested parties') best interests, *before* the Rehabilitator abandoned Chartered's only business. The Rehabilitator usurped this Court's authority and ignored his statutory obligations. This Court's order has rewarded the Rehabilitator's improper conduct and accepted the Rehabilitator's plan without adequate justification and without even hearing from DCHSI, a truly aggrieved party that is not fairly and equitably treated under the Rehabilitator's plan.

Selling Chartered's key assets also violates its governing corporate documents, which the Rehabilitation Order did not supplant. The Rehabilitation Order gives the Rehabilitator the power of Chartered's board; it does not give him powers *greater* than those held by the board. Chartered's articles of incorporation provide that no board action is effective unless approved by DCHSI. Nevertheless, the Rehabilitator's liquidating actions all have been set into motion, and are now approved, without DCHSI even being consulted. The Rehabilitator thus also is usurping DCHSI's corporate authority.

The Rehabilitator's claim of exigency is disingenuous. The Rehabilitator himself has caused much of the perceived exigency by not allowing Chartered to bid on the DHCF Contract; by failing to work with DHCF to seek an extension of the bidding process if necessary to allow Chartered time to pursue a buyer and to bid; and by then pursuing a sale transaction that was so one-sided in favor of the buyer (and against Chartered's interests) that it prevents Chartered from considering any better offers and gives the buyer the option to walk away if it does not win the contract that the Rehabilitator so magnanimously gave up on Chartered's behalf. The Rehabilitator's having casting his lot with one bidder, to the exclusion of all others and at the risk of leaving Chartered with nothing if AmeriHealth does not win the DHCF Contract, underscores the irrationality of his course of action. Further, the process for awarding the new Medicaid contracts was, under D.C. procurement law, subject to an automatic stay as a result of DCHSI's bid protest from December 17, 2012 until February 27, 2013, when the bid protest was denied on

procedural grounds. The Rehabilitator represented in Court that the stay in fact was not honored, but that only shows further abuse of process and the need for relief.

DCHSI seeks a further injunction of the contracting process to permit a fair and open process untainted by collusion between the Rehabilitator and a bidder. This Court should exercise its power to require Petitioner District of Columbia to reopen the bidding process for the DHCF Contract and to extend all deadlines for a reasonable period sufficient to allow Chartered to submit a bid on its own behalf or, in the alternative, to permit all current bidders at the "best and final offer stage" to bid to acquire Chartered. This Court has jurisdiction to set an appropriate bidding schedule. Moreover, as a practical matter, it is common for the District to extend contracts and contract schedules generally, and it has extended the subject contract and bid dates repeatedly without any interruption in service.

The Court should stay its March 1 order so that it may give the Rehabilitator's Petition the careful scrutiny it requires, rather than expedited approval without consideration of the irreparable harm that will befall DCHSI. A stay would not cause any disruption to the provision of services to beneficiaries and would not result in any harm to the parties or to the public. If AmeriHealth were to lose the bid on the DHCF contract, it would walk away from the deal anyway (the Asset Purchase Agreement is conditioned on AmeriHealth winning the contract). If AmeriHealth were to win the DHCF Contract, it would have continued to rely substantially on the processes Chartered set up, including its provider agreements and its employees. No disruption in the provision of services would result from allowing Chartered to continue providing services as Chartered rather than as an arm of AmeriHealth for the relatively short time that it would take to allow for an expedited appeal or writ review of the issues.

Procedural History. DCHSI diligently has sought information from the Rehabilitator in the hopes of reaching a fair and equitable result. DCHSI has been requesting information from the Rehabilitator since Chartered was placed in rehabilitation and on at least eight separate occasions since then. *See* Ex. 1 (Affidavit of Stephen Glover), ¶ 3. It was not until the day that responses to the DHCF Contract were due that DCHSI learned that the Rehabilitator had caused

Chartered not to bid on the contract and, instead, had entered into a Letter of Intent with AmeriHealth. *See id.* ¶4. The Rehabilitator filed his First Status Report in this proceeding on January 11, 2013. DCHSI's counsel entered a notice of appearance in this proceeding the next business day, in advance of the first status hearing in this proceeding. DCHSI's counsel requested documents from the District immediately following the court conference on Thursday, January 15. DCHSI then worked with the District to enter into a confidentiality agreement so that documents could be provided, and agreement was reached on February 21. On February 22, the same day that the District provided documents to DCHSI, the Rehabilitator filed the Special Deputy to the Rehabilitator's Second Status Report ("Second Status Report"), revealing that it already had entered into an Asset Purchase Agreement with AmeriHealth on terms highly unfavorable to Chartered, and requesting expedited approval of the Agreement. DCHSI immediately requested time to file a brief and for a status conference. Petitioner opposed the Request but asked that, if DCHSI did file a brief, it do so by March 6. On March 1, however, even before the date on which the District would have had DCHSI file its brief, the Court approved the Asset Purchase Agreement, without a factual record and without affording DCHSI the opportunity to submit briefing opposing the Rehabilitator's plan on the merits.

To ensure that Chartered's rehabilitation is conducted within the terms of the Rehabilitation order, the law governing rehabilitations, and Chartered's articles of incorporation, and to remedy the ongoing and irreparable harm to DCHSI, this Court should stay its March 1 Order and grant DCHSI's requested injunctive relief.[3]

[3] This Court denied the District's motion to strike DCHSI's motion for a status conference and briefing schedule because DCHSI, as a creditor and as Chartered's sole shareholder, is a party in interest having a right to be heard. In any event, DCHSI meets the standards for formal intervention. Mandatory intervention is appropriate because DCHSI's legally-protectable ownership interests in Chartered are at risk due to the Rehabilitator's conduct; no other party can represent DCHSI's interests; and the motion is timely. *See* D.C. Super. Ct. R. Civ. P. 24(a)(2). Permissive intervention is appropriate because DCHSI's claims arise from the Rehabilitator's actions. *See id.* 24(b)(2).

I. FACTS

A. Chartered, an HMO dependent on a DHCF Contract, is taken over by Petitioner for rehabilitation

Chartered is a District of Columbia HMO that since 1987 has been an incumbent to the DHCF Contract, which is Chartered's only business and source of income. *See* Emergency Consent Petition for an Expedited Order of Rehabilitation ("Rehabilitation Petition") at ¶¶ 2-3 (Oct. 19, 2012); the First Status Report at 3, ¶ 4A. DCHSI is the sole shareholder of Chartered, and Chartered is DCHSI's sole source of revenue. *See* Ex. 2 (Affidavit of Richard Evans), ¶¶ 2-3. Chartered leases its business space, located at 1025 15th Street, N.W., Washington, DC, from DCHSI. Chartered is a party in interest in this proceeding. *See* Rehabilitation Petition at ¶ 4.

Chartered's governance is controlled by its Restated Articles of Incorporation, Article VIII of which provides that "[n]o action of the Board of Directors shall take effect unless it has been approved by the unanimous vote of the outstanding shares entitled to vote." Ex. 3 (Chartered's Restated Articles of Incorporation). Thus, no action by Chartered's board is effective unless approved by DCHSI.

DCHSI bought Chartered with the District of Columbia government's approval in May 2000, after Chartered's prior owner filed for bankruptcy. Rehabilitation Petition at ¶ 3. Throughout the bankruptcy and sale process, Chartered's provision of healthcare services under the DHCF Contract continued undisturbed. *Id.*

The DHCF Contract is DHCF's largest contract, serving over 100,000 members a month. *See* Ex. 4 (Testimony of Wayne Turnage before the D.C. Council Comm. on Health and Comm. on Public Services and Consumer Affairs), at 2. Chartered has developed "a significant provider network incorporating primary, urgent and emergency care health services," giving "both Medicaid and Alliance beneficiaries ... access to the full range of health care services they may need to address their medical needs." *Id.*

By 2011, DHCF and DISB increased their financial oversight of Chartered due to concerns over the adequacy of Chartered's risk-based capital reserves. As reflected in

Chartered's audited financial statements, Chartered had the following total stockholder's equity in the years from 2004 to 2011 (the 2011 financial report, finalized under the Rehabilitator's supervision, changed the terminology from "stockholder's equity" to "total capital and surplus"):

2004: $11,843,556
2005: $15,945,518
2006: $20,717,538
2007: $21,312,995
2008: $21,059,187
2009: $13,656,951
2010: $17,444,611
2011: $5,949,445

See Ex. 5 (Chartered's Financial Statements Relating to 2004-2010); First Status Report Ex. 3, at 5.

The decrease in 2011, an obvious aberration, is hardly surprising, given that — as the Rehabilitator has concluded — the District owes Chartered over $60 million, plus interest, for retrospective rate adjustments due under the DHCF Contract.[4] Based on DCHSI's reading of Chartered's financial statement as of September 30, 2012, which counted only $32 million of the now $60 million claim and showed approximately $9 million in surplus capital, Chartered's current capital and surplus, or stockholder's equity, now is over $37 million when the full claim is taken into account. *See* Second Status Report at 2, Ex. 1. This is substantially above Chartered's historical capitalization in years when its DHCF Contract was continually renewed.

In the spring of 2012, the DISB Commissioner and the DHCF Director began to apply substantial political pressure on Chartered and DCHSI. First, they insisted that DCHSI's sole shareholder, Jeffrey Thompson, step down as chairman of Chartered's board of directors.

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4 *See* Ex. 16 (Ltr. from Mercer to DHCF, June 22, 2010), at 1 (developing capitation rates for July 1, 2010–April 30, 2011 and noting that "[t]he projections are [] 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)"); Ex. 17 (Mercer's DCHFP Data Book for Rates Effective May 1, 2012) at 3 (noting that "childless adults were added to the DCHFP program effective July 2010 for individuals up to 133% the federal poverty level" and those with "incomes between 134% and 200% of the FPL [] were enrolled in the MCOs effective December 2010).

Second, they insisted that DCHSI agree to sell Chartered. Bowing to that pressure, Mr. Thompson agreed to and did step down as chairman of Chartered's board and DCHSI agreed to pursue the sale of Chartered.

DISB retained, at Chartered's expense, Daniel Watkins, who became the Special Deputy to the Rehabilitator, and Faegre Baker Daniels, the law firm that now represents him. DISB did this over Chartered's objections based on Mr. Watkins' conflict of interest and those of his chosen law firm: The Deputy Rehabilitator's brother, Robert Watkins, served as Chartered's Chief Operating Officer from December 2007 to September 2011 and, in that role, was actively involved on Chartered's behalf in rate-setting, contract negotiations, and pharmacy management. As a result, the Deputy Rehabilitator is directly involved in reviewing the practices and decisions of his own brother. *See* Ex. 11 (Under Request for Proposals No. DHCF-2013-R-0003, Protest of D.C. Healthcare Systems, Inc. (CAB No. P-0930) (Dep't of Health Care Finance Dec. 17, 2012) ("Bid Protest"), at 2. Furthermore, the Deputy Rehabilitator's chosen counsel, Faegre Baker Daniels, serves as counsel and advisor to entities owned by or directly affiliated with AmeriHealth Mercy, *see id.* at 3, 10 (citing June 9, 2012 E-mail from T. Glassic to A. Bolden; sources *available at* http://online.wsj.com/article/SB10001424052970203914304576627071487867628.html; http://www.ibx.com/companyJnfo/news/press_releases/2011/08_09_IBC_and_BCBS_oCMichigan.html; www.in.govlilrc/files/2012_employer.pdf), and United Health Care.

In early October 2012, the DISB Commissioner and the DHCF Director approached Chartered's board to obtain its consent to submit Chartered to rehabilitation. The regulators "met with Chartered's board and laid out what [they] proposed to do and how it would benefit everyone if the company did not contest [their] petition for receivership," including the effort to sell Chartered to one of several entities interested in continuing Chartered's business. *See* Ex. 10 (Testimony of William P. White before the D.C. Council Comm. on Health and Comm. on Public Services and Consumer Affairs), at 4. Chartered's board consented. That consent would have been ineffective under Chartered's articles of incorporation without DCHSI's consent. The

regulators represented to DCHSI that the Rehabilitator would provide information to and consult and cooperate with DCHSI. *See* Ex. 1, ¶¶ 5-6. DCHSI consented — that is, both Chartered and DCHSI consented to a *rehabilitation*, not to a *liquidation*.

In the context of discussing Chartered's potential sale, the Rehabilitator recognized that "Chartered required a new Medicaid contract with the District to be a viable acquisition candidate." First Status Report at 3, ¶ 4A. Shortly after this proceeding started, the Rehabilitator testified that "a sale and change of ownership, if feasible, is the best and safest outcome for everyone," pointedly stating:

> I do believe that Chartered is a far more attractive prospect in rehabilitation *as it now has a far better chance to get its all-important city Medicaid contract renewed.*

Ex. 10, at 4 (emphasis added). This indication that Chartered would seek the award of the new DHCF Contract is consistent with the Rehabilitation Order (at 2), which gives the Rehabilitator the "[a]uthority to accept new or renewal business or extension of Chartered's contracts." The Rehabilitator expressed that it was important for him to "conduct an orderly, fair and open process of evaluating the many well capitalized companies and people who appear to see value in Chartered as an ongoing concern." Ex. 10, at 5.

The current DHCF Contract was scheduled to expire on April 30, 2013 and the bidding process on the new five-year DHCF Contract (the "Medicaid RFP") was to begin in early November 2012, with initial bids due in early December 2012. It is routine in District contracting to extend such deadlines generally, and such extensions have occurred repeatedly with the DHCF Contract in particular. Knowing, as he testified, that there were "many well capitalized companies" with an interest in purchasing Chartered outright and given the importance of the services that Chartered was providing to over 100,000 District residents, the Rehabilitator could have taken a number of steps to delay the bidding schedule so that he could "conduct an orderly, fair and open process" to evaluate those companies. For example, there is no apparent reason why the Rehabilitator could not have asked the Director of DHCF, another District agency,

simply to extend the bid date for the new contract, particularly since they worked hand in hand to have Mr. Thompson resign, to have DCHSI agree to sell, and to bring about the consensual rehabilitation. That failing, Chartered could have submitted the response to the Medicaid RFP that it had been preparing for some time, *see* Ex. 11, at 10; *see also* Ex. 6 (Form Letter from J. Sheehy)("Chartered RFP"), at 2 and Ex. 10, at 4, by the early December deadline and could have continued to identify and negotiate with prospective bidders from a position of strength. If the Rehabilitator felt that he needed more time to respond to the RFP, he could have asked DHCF for an extension or sought relief from this Court if necessary. Instead, he accepted the schedule and conducted a two-day bidding process after which he determined to liquidate Chartered.

B. Rather than rehabilitate Chartered, the Rehabilitator begins to liquidate it

In October 2012, the Court entered the Rehabilitation Order and appointed DISB Commissioner White as the Rehabilitator. *See* Rehabilitation Order at 1. The Rehabilitation Order vests the Rehabilitator with "all appropriate and necessary powers provided under the Insurers Rehabilitation and Liquidation Procedures Act, D.C. Code § 31-1301 *et seq*. (the "Rehabilitation Act")," and specifically gives the Rehabilitator, among other things, "all powers of the directors, officers and managers of Chartered"; control of Chartered's assets and the power to "administer them *under the general supervision of the Court*"; the "[a]uthority to take such action as deemed necessary or appropriate *to reform and revitalize Chartered*"; and the "[a]uthority to *accept new or renewal business or extension of Chartered's contracts*." Rehabilitation Order at 2 (emphases added). The Court also ordered that "the Rehabilitator submit a plan of rehabilitation of Chartered for Court approval, if one is feasible," and if he determines it is not, to "submit a report to the Court which states the basis for such determination." *Id.* at 3.

The Rehabilitator appointed Daniel Watkins as Special Deputy to the Rehabilitator, with all the powers of the Rehabilitator. *See* Order Appointing Daniel L. Watkins Special Deputy to the Rehabilitator, Nov. 2, 2012. The Rehabilitator appointed Faegre Baker Daniels as its counsel.

See First Status Report at 1, ¶ 2. Although the Rehabilitation Act requires that the "compensation of the special deputy [and] counsel ... shall be fixed by the Commissioner, *with the approval of the court,*" D.C. Code § 31-1312(a) (emphasis added), the record does not reflect that the Rehabilitator obtained Court approval for the compensation of the Deputy Rehabilitator or his counsel, despite the conflicts issues described herein.

Neither the Rehabilitation Act nor the Rehabilitation Order negates Chartered's governing corporate documents. To the contrary, the Rehabilitation Act recognizes the importance of an insurer's governing documents, providing that an insurer's disregard for its own governing documents is a ground for ordering the insurer into rehabilitation. *See* D.C. Code § 31-1310(9) (insurer's willful violation of its articles of incorporation or bylaws constitutes grounds for a rehabilitation order). Accordingly, although the Rehabilitator has the board's powers, any exercise of those powers is ineffective unless and until approved by DCHSI.

In November 2012, the Rehabilitator's retained investment banker solicited interested parties "to respond to a preliminary request for information in connection with ... a potential acquisition and recapitalization of [Chartered]." *See* Ex. 6, at 1 . The Chartered RFP directed that all responses were due by 5 p.m. Eastern Standard Time on November 14, 2012, just two business days after the letter was sent, and it further stated that "a limited number" of responders then would be selected to continue in the process and submit a binding letter of intent by December 1, 2012. *Id*. at 2.

The Chartered RFP required bidders to submit "a detailed response" providing a variety of information, including: (1) indicating the bidder's ability to fund an estimated $30 million in capitalization with the expectation that "any Transaction will be effected via the sale of 100% of the issued share capital of [Chartered]"; (2) "clearly outlin[ing] your proposed sources of financing," including a "summary financing plan" and "the names and contact information of proposed third-party funding sources or partners and the steps and timing required to secure the necessary funds"; and (3) because Chartered "has received the [Medicaid RFP]," executing "a binding letter of intent prior to [Chartered] submitting a response to the RFP" and indicating all

due diligence required "prior to executing a binding letter of intent" on December 1. *Id.* at 2 (also requiring bidders to agree to Chartered's response to the Medicaid RFP).

On February 22, 2013, DCHSI saw for the first time a non-binding letter agreement dated November 30, 2012, reflecting that Chartered agreed to provide its "resources, assets, and know-how in support of" AmeriHealth's own RFP bid in exchange for $5 million, to be paid if AmeriHealth "or one of its affiliates is chosen as a Service Provider under the [Medicaid] RFP and commences operations thereunder." *See* Ex. 7 (Chartered/AmeriHealth Letter Agreement) (Nov. 30, 2012). The sole condition of AmeriHealth's obligation to pay $5 million is AmeriHealth winning the Medicaid RFP; subject to that condition, the money is to be paid on the sooner of the closing of the Agreement or within five days after AmeriHealth begins performing the DHCF Contract. *See id.*

Just after responses to the Medicaid RFP were due, the Rehabilitator revealed that — without first submitting to this Court either a plan of rehabilitation or the basis for a determination that rehabilitation was futile — he had caused Chartered *not* to respond to the Medicaid RFP but, instead, had entered into a letter of intent for a transaction with AmeriHealth, and that AmeriHealth had responded to the Medicaid RFP. *See* Ex. 8 (Receiver's Status Report on Chartered) (Dec. 3, 2012).[5] In fact, as DCHSI later learned, by the week of November 26, 2012, the Rehabilitator had decided to enter into a *non-binding* letter of intent with AmeriHealth and to work with AmeriHealth "to complete a response to the DHCF RFP in [AmeriHealth's] name (utilizing key Chartered personnel and experience in the response) and to negotiate a definitive agreement with [AmeriHealth]." First Status Report at 5, ¶ 6.

The Rehabilitator selected AmeriHealth even though, contrary to the requirements of the Chartered RFP, it did not submit a *binding* letter of intent, did not agree to recapitalize Chartered, and did not approve a response by Chartered to the Medicaid RFP. Moreover,

[5] The initial status report that appeared on the DISB website and is attached hereto incorrectly dated the report December 3, 2002. The date has since been updated on the DISB website in a new version of the status report (which does not differ in substance).

AmeriHealth avoided altogether the stated requirement of providing in excess of $30 million in financing to Chartered. There is no indication that other bidders were extended the same opportunity to bid on terms *contrary to those announced in the* Chartered RFP.

Thus, less than six weeks after this rehabilitation proceeding was commenced, the Rehabilitator had abandoned any effort to continue Chartered's business and had taken steps to sell off its parts — setting into motion an unauthorized *liquidation* plan — without the approval of DCHSI and without the required advance approval of this Court.

C. DCHSI's unsuccessfully protests the DHCF bidding process

In December 2012, DCHSI filed a bid protest before the District of Columbia Contract Appeals Board ("CAB") challenging the DHCF bidding process regarding RFP DHCF-2013-R-0003, renewal of a five-year contract to provide healthcare services to the District's Medicaid-eligible population enrolled in the District of Columbia Healthy Families Program and to its D.C. Health Care Alliance members beginning May 1, 2013. *See* Ex. 11. Chartered, an incumbent under the current contract, had failed to submit a bid by the December 3, 2012 proposal deadline as DCHSI was led to believe that Chartered would when it consented to place Chartered under rehabilitation in October 2012. *See* Ex. 1, ¶4.

DCHSI's bid protest explained that the RFP should be canceled and resolicited because conflicts of interest existed regarding the Deputy Rehabilitator and his outside counsel; and the RFP was tainted by an illegal restraint of trade and collusive bidding. *See* Ex. 11, at 11, 13. The conflict issues included the fact that the Deputy Rehabilitator's brother, Robert Watkins, served as Chartered's Chief Operating Officer from December 2007 through September 2011 and, while in that position, was actively involved in rate-setting, contract negotiations, and pharmacy management; which necessarily meant that the Deputy Rehabilitator, in analyzing and examining Chartered, reviewed practices engaged in and decisions made by his brother. *Id*. at 12. In addition, Faegre Baker Daniels, a consultant retained by DISB to examine and analyze Chartered (and, the law firm ultimately hired to serve as the Rehabilitator's counsel) represented or advised

direct competitors of Chartered, or their corporate parents or affiliates, that had expressed interest in acquiring Chartered and could gain an advantage if Chartered no longer could service the D.C. market. *Id*. These conflicts of interest violated both the D.C. Code and the D.C. Rules of Professional Conduct, and may have improperly influenced the Deputy Rehabilitator and Faegre's decision to "no bid" the contract on Chartered's behalf. *Id.* By allowing the same individuals who controlled or advised three potential bidders (Chartered, United Healthcare, and AmeriHealth) on the District Medicaid contract to cause one of the three (Chartered) to "no bid," the District allowed collusive bidding. *Id* at 13-14.

The District moved to dismiss the bid protest, arguing that the issues were under the exclusive jurisdiction of the Superior Court, not the CAB. *See* Ex. 12 (D.C.'s Mot. to Dismiss for Lack of Subject Matter Jurisdiction and Standing in Resp. to Protest of D.C. Healthcare Systems, Inc. ("Motion to Dismiss") at 1, Protest of D.C. Healthcare Systems, Inc. (Jan. 10, 2013) (CAB No. P-0930)). The District also claimed that DCHSI lacked standing to protest because DCHSI was not an "aggrieved party" or an actual or prospective bidder or offeror. *Id*. at 12. DCHSI responded by demonstrating its "aggrieved party" status (*i.e.*, due to the improper behavior of the District's agents or officials, DCHSI was denied the opportunity to compete under the RFP.) *See* Ex. 13 (Opp. of Protestor D.C. Healthcare Systems, Inc. to the D.C.'s Mot. to Dismiss ("Opp. to Motion to Dismiss") at 11-13, Protest of D.C. Healthcare Systems, Inc. (Jan. 25, 2013) (CAB No. P-0930)). DCHSI also is a prospective bidder or offeror under the District contract because an agency may properly attribute the experience or past performance of an affiliated company (here, Chartered) to an offeror where the firm's proposal demonstrates that resources of the affiliate will affect the performance of the offeror. *Id.* at 14. DCHSI also had the capacity to submit a stand-alone proposal based on its experience in the managed healthcare business and the fact that it had independent resources it could have organized and marshaled to submit its own bid under the RFP, and would have done so had it known Chartered would not be allowed to bid. *Id*. at 14-15. DCHSI's allegations concerning collusive bidding, anti-competitive

behavior, and conflicts of interest all are alleged violations of the District's procurement laws and regulations.

On February 27, 2013, the CAB dismissed DCHSI's bid protest, finding that it lacked subject matter jurisdiction and that DCHSI lacked standing. *See* Ex. 14 (Order Dismissing Protest, Protest of D.C. Healthcare Systems, Inc. (Feb. 27, 2013) (CAB No. P-0930)).

While DCHSI reserves its right to appeal the CAB decision, it notes that this Court has the power — either through an appeal or through injunctive relief in this proceeding — to provide a remedy to DCHSI, as an aggrieved party, by extending the current contract and re-opening the bidding process on the DHCF Contract.

D. The Rehabilitator's First Status Report to the Court

In January 2013 the Rehabilitator filed his First Status Report, which claimed that one of his "overarching goals" has been to "preserve any residual value for Chartered's shareholder." *See* First Status Report at 2, ¶2; *see also id.* at 3, ¶4A (acknowledging "Chartered required a new Medicaid contract with the District to be a viable acquisition candidate"). He also attempted to justify his previous actions in preventing Chartered from bidding on the renewal of the DHCF Contract; assigning Chartered employees to help AmeriHealth prepare its own bid for the DHCF Contract; and, contrary to the requirements for bidders set forth in the Chartered RFP, accepting AmeriHealth's *non-binding* letter of intent to buy Chartered's assets when other bidders were required to submit *binding* letters of intent to capitalize Chartered.

The Rehabilitator argued that DHCF was unwilling to award the DHCF contract to Chartered unless Chartered had a new owner and was out of rehabilitation by mid-January 2013, which conditions he believed could not be satisfied. *See id.* at 3, ¶ 4B. The DHCF Director thus not only was involved in pressuring Chartered to consent to rehabilitation, he then purported to impose new bid "requirements" that are not found in the Medicaid RFP that would disqualify

Chartered.[6] No authority supports these requirements. And the DHCF Director ignored that the rehabilitation was intended to cure Chartered's alleged undercapitalization, which primarily is caused by DHCF's $60 million debt to Chartered and could be corrected swiftly if DHCF simply would pay Chartered what it owes.

The First Status Report also addressed Chartered's recently-completed audited financial statement as of December 31, 2011. *See* First Status Report at 3. As described above, the audit report reflects Chartered's reported reduction in capital and surplus, but also notes that Chartered met or exceeded the minimum net worth requirement as of December 31, 2011. *See id.* at Ex. 3, at 14, Note 7.

E. The Rehabilitator's Second Status Report and Petition for Order Approving the Asset Purchase Agreement

On February 22, 2013 the Rehabilitator filed both a Second Status Report and a Petition seeking approval for the AmeriHealth acquisition of Chartered.

The Second Status Report discusses Chartered's financial results as of September 30, 2012, and shows that Chartered's stockholder's equity, which the Rehabilitator calls capital and surplus, was $9 million, up 50% from $5.9 million at year-end 2011. *See* Second Status Report at 2, ¶ 1(a). The Rehabilitator also explains that he determined that the District in fact owes Chartered $60 million, plus interest, rather than the $32 million booked as of September 30, 2012. The Rehabilitator has not explained his basis for booking only $32 million of the $60 million.[7] The claim arises from unpaid retrospective rate adjustments primarily due under the DHCF Contract because in mid-2010 DHCF unilaterally transferred certain high-risk populations to Chartered's rolls with no rate adjustment. This resulted in a dramatic increase in Chartered's

[6] The voluminous RFP can be found on CAB's website *available at* http://app.cab.dc.gov/WorkSite/Docket_Case_Number.asp by entering case number P-0930 and selecting "AR Exhibit 1, Solicitation No. Doc70947-DHCF-2013-R-0003," filed Jan. 10, 2013.

[7] Nor has the Rehabilitator explained why the 2011 Audited Financial Statements reflect a "$10,000,000 allowance," which would appear to contemplate a dramatic reduction of the claim resulting in a discount to the D.C. government.

benefit costs, which the District is obligated to pay under the DHCF Contract but to date has not paid. *See* Second Status Report at 3, ¶ 1(d).

If the Rehabilitator is correct, then Chartered's current stockholders' equity based on the $60 million claim (without regard to interest) would increase by $28 million from the $32 million accounted for in September, and thus from $9 million to over $37 million. This is substantially in excess of Chartered's stockholder's equity at any prior year, when its DHCF Contract was continually renewed.

If, as it appears, Chartered has shareholder equity of $37 million (indeed, even if Chartered were to recover substantially less than the amount the Rehabilitator concedes is due), Chartered's capitalization is at least equal to what it has been throughout its continuous renewals of the DHCF Contract.

The Rehabilitator also entered into an asset purchase agreement with an AmeriHealth affiliate. Chartered represents in the proposed Agreement that it "has all necessary and corporate power and authority to enter into this Agreement" and that the delivery, performance and consummation of the agreement by Chartered" have been duly authorized by all requisite corporate action." *See* Agreement §4.02. But this is false, because the Rehabilitator never obtained DCHSI's consent, as required by Chartered's Restated Articles of Incorporation. This representation is, however, consistent with the Rehabilitator's refusal to provide DCHSI with any meaningful information regarding the terms of this proposed transaction before filing the Second Status Report with the Court, despite DCHSI's willingness to enter into a non-disclosure agreement. *See* Ex. 1 ¶¶ 3, 7. As the Rehabilitator stated in an affidavit in the Bid Protest, he believes he "was under no obligation under D.C. law or the Rehabilitation Order to consult with or inform [DCHSI] … prior to taking action." *See* Ex. 9 (Affidavit of Daniel L. Watkins) at 1, ¶ 3, filed in support of D.C's Mot. for Leave to File Reply to Protester's Opp. to Motion to Dismiss, CAB No. P-0930.

The Proposed Agreement would consummate the Rehabilitator's decimation of Chartered and, in turn, DCHSI. *See* Evans Aff. ¶ 4. In effect, the Proposed Agreement contemplates the

transfer of substantial Chartered assets to AmeriHealth for the sum of $5 million.[8] These assets include not only the DHCF Contract and provider contracts (subject to opt-out), but also Chartered's telephone numbers and trade name, certain intellectual property rights, all furniture, equipment, supplies, machinery, tools, vehicles and office equipment, enroller records, claims data, price lists, supplies and sales records, financial and accounting records and more. *See* Agreement § 2.01.

The Proposed Agreement is subject to numerous closing conditions, including that AmeriHealth be awarded the next DHCF contract. *Id.* § 7.02(i); *see* Questions and Answers About the Status and Petition to Approve the Sale of Certain Assets of DC Chartered Health Plan Inc. to Amerihealth (Feb. 22, 2013), available at http://disb.dc.gov/node/433812; Ex. 16 (Statement by Special Deputy Rehabilitator Daniel L. Watkins). Thus, if the Rehabilitator's gamble is not successful — and despite collusion, AmeriHealth fails to win the contract — Chartered not only will have lost its own chance to win the DHCF contract and its only opportunity to continue as a going concern, but also will be left without its would-be buyer and without any real value to attract another buyer. *See* First Status Report at 3, ¶ 4A ("Chartered required a new Medicaid contract with the District to be a viable acquisition candidate").[9]

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[8] The Proposed Agreement's stated purchase price is $5 million, all of which is subject to an indemnification provision. *See* Proposed Agreement §§ 2.05, 8.02. Beyond that, it is unclear whether the $5 million to be paid under the Proposed Agreement is new consideration, or the same $5 million to be paid under the November 30, 2012 letter agreement. *See* § I.B., above. If the latter, then if AmeriHealth wins the Medicaid RFP and the Proposed Agreement closes, AmeriHealth would receive Chartered's assets *for no additional payment*. Even if there is a total payment of $10 million, Chartered still is left as a shell, and there is no basis on which to determine fair value.

[9] The Proposed Agreement also is subject to the conditions that (1) the broad Representations and Warranties of Chartered are true in all material respects and all Covenants of Chartered are complied with in all material respects; (2) AmeriHealth obtain an HMO license that it finds acceptable in its sole discretion; (3) Chartered make arrangements paying pre-closing provider claims that AmeriHealth in its sole discretion finds to be appropriate; and (4) AmeriHealth enter into employment contracts with ten named officers and employees of Chartered that AmeriHealth in its sole discretion finds acceptable. *See* Agreement §§7.02 (b), (c), (j), (o), (p).

The Rehabilitator admits, perhaps unwittingly, that he is liquidating Chartered, when he states that his next step would be to "wind down Chartered's remaining operations," marshal the remaining assets, and apply those assets to the outstanding liabilities. *See* Second Status Report at 8. *See also* Ex. 15, at 1 (also noting that, if the AmeriHealth transaction does *not* close, the Rehabilitator "would continue to marshal Chartered's assets, resolve Chartered's liabilities and wind down Chartered's affairs after the expiration of its current Medicaid contract"). This seems to be precisely what D.C. Council member David Catania, who formerly chaired the Council's Health Committee, wanted when he stated less than a week after this proceeding was filed: "It's finished, as far as I'm concerned. There just is simply no way it [Chartered] resurrects itself from receivership." *See* Tom Howell Jr., *Chartered Health Plan's finances draw scrutiny*, Washington Times, Oct. 25, 2012, *available at* http://m.washingtontimes.com/news/2012/oct/25/chartered-health-plans-finances-draw-scrutiny/?page=all; *see also* Mike Debonis, *Health Plan Takeover in DC Eases Concerns but Doesn't Erase Them,* Washington Post, Oct. 22, 2012, *available at* http://www.washingtonpost.com/local/dc-politics/health-plan-takeover-in-dc-eases-concerns-but-doesnt-erase-them/2012/10/22/333d15c4-1c8d-11e2-9cd5-b55c38388962_story.html ("This receivership is the epitaph for Chartered.").

The Rehabilitator also claims that his plan is "fair and equitable for all parties concerned" and that it is the "best way to [] preserve residual value, if any, for Chartered's sole shareholder." *See* Second Status Report at 10. The Court in its March 1 Order agreed that the plan is fair and equitable but did so without having permitted DCHSI to file any substantive opposition. However, the notion that the plan is fair and equitable is belied by the terms of the deal with AmeriHealth. The transaction would leave Chartered with no ability to conduct business, with no ability to satisfy its obligations to DCHSI under its lease, with liabilities to providers, and perhaps whatever furniture or supplies AmeriHealth, in its sole discretion, may decide to leave behind. *See* Agreement §7.02. DCHSI would be left owning a shell company that holds liabilities, a lease with no ability to collect rent from Chartered, and the right to attempt to collect amounts owed by the District after the relevant records have been transferred to AmeriHealth

and after the contract also is transferred, such that DHCF will have even less incentive to pay Chartered the amounts owed.

The Rehabilitator claims that the Agreement was "negotiated in good faith and at arm's length by professionals and advisors who vigorously advocated the interests of their respective clients," but neglects to mention that potential conflict issues have not been resolved and that no one represented the interests of DCHSI as Chartered's sole shareholder and a creditor. *Id.* at 4.

II. ARGUMENT

The Court should reconsider its March 1 Order now that it has facts and substantive argument. Alternatively, the Court should stay its March 1 Order to allow DCHSI to seek appellate review (by appeal or writ) of that order because the Rehabilitator exceeded his powers by taking steps toward liquidation before securing this Court's approval; the proposed deal is not fair or equitable to the concerned parties but, rather, violates DCHSI's rights as sole shareholder of Chartered and decimates Chartered's ability to continue its business and sells off key assets without ensuring fair value is obtained; and DCHSI is threatened with irreparable harm if the sale is consummated.

Issuance of stay or injunctive relief turns on the balancing of four factors (1) likelihood of success on the merits; (2) irreparable injury without a stay (the most significant factor); (3) lack of harm to the other side from a stay; and (4) public interest factors favoring a stay. *Akassy v. William Penn Apartments, Ltd. P'ship*, 891 A.2d 291, 309 (D.C. 2006); *Dist. of Columbia v. E. Trans-Waste of Maryland, Inc.*, 758 A.2d 1, 14 (D.C. 2000).

A. There is a substantial likelihood that DCHSI will prevail on the merits

DCHSI seeks to enjoin two related, but distinct, improper actions by the Rehabilitator: (1) his steps to liquidate Chartered without exhausting all reasonable rehabilitation efforts, including re-opening the bidding on the Chartered RFP and submitting a response to the DHCF RFP, and (2) his violation of DCHSI's rights under the Restated Articles of Incorporation. The merits of both claims are framed by the Rehabilitation Act, D.C. Code § 31-1301 *et seq*., which

adopted the National Association of Insurance Commissioners ("NAIC") Insurer Receivership Model Act (the "NAIC Model Act," *available at* http://www.naic.org/store/free/MDL-555.pdf).

1. DCHSI will prevail in showing that the Rehabilitator improperly has taken steps to liquidate Chartered

All aspects of a rehabilitation proceeding are subject to court supervision. The Rehabilitation Act (like the Rehabilitation Order) vests title to Chartered's assets in the Rehabilitator, but he is constrained to "administer [the assets] under the general supervision of the court." D.C. Code § 31-1311(a). Significantly, the Rehabilitation Act requires that "[i]f the rehabilitator determines" that any "transformation of the insurer is appropriate," he must "prepare a plan to effect the changes" and apply to the court "for approval of the plan." *Id.* § 31-1312(e). Then, "after any notice and hearings the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified," as necessary for the court to find the plan "fair and equitable to all parties concerned." *Id.* Before a rehabilitator may take steps to liquidate an insurer, he first must obtain an order of liquidation upon a showing that "further attempts to rehabilitate [the] insurer would substantially increase the risk of loss to creditors, policyholders, or the public, or would be futile." *Id.* § 31-1314(a).

Here, the Rehabilitator's mandate is to rehabilitate and revitalize Chartered if possible. *See* Rehabilitation Order at 2; *see* D.C. Code § 31-1312(c). The Rehabilitator, however, has ignored his mandate and exceeded the limits of his authority.

The Rehabilitator effected a "transformation" of Chartered before obtaining Court approval and without demonstrating that it would be fair and equitable by (1) causing Chartered not to bid on, and thus not to engage in, its only business, and (2) entering into an agreement to sell Chartered's assets. The Rehabilitation Act could not be clearer that "[i]f the rehabilitator determines" that any "transformation of the insurer is appropriate," he must "prepare a plan to effect the changes" and apply to the court "for approval of the plan." *Id.* § 31-1312(e). The law contemplates that the plan will not be carried out until after it is approved. *See id.* ("If the plan is approved, the rehabilitator shall carry out the plan."). At a minimum, the Rehabilitator must

receive Court approval *before* effecting a transformation. Here, as the Second Status Report makes clear, the Rehabilitator took it on himself to make and implement transformative decisions amounting to an unauthorized liquidation beginning with his November 2012 agreement with AmeriHealth and his failure to have Chartered bid on the DHCF Contract.

Even if there had been no practical alternative, as the Rehabilitator claims, he had no authority to take these actions before he received Court approval. But the Rehabilitator did have other options he could and should have exhausted before engaging in a fire sale. Indeed, the Rehabilitator represented to the D.C. Council on October 25, 2012, that there were "many well capitalized, experienced companies and people who appear to see value in Chartered as a going concern." *See* Ex. 10, at 5. To allow time for that interest from buyers to play out, the Rehabilitator could have asked his counterpart from DHCF, with whom he had worked hand-in-hand for six months leading to obtaining Chartered's and DCHSI's consents to rehabilitation, to defer the bidding process. Cooperation failing, had he properly caused Chartered to respond to the Medicaid RFP, he could have filed a bid protest and obtained an automatic stay of the process, or he could have asked this Court to intervene in aid of its own jurisdiction over this proceeding. *See, e.g., Dist. of Columbia v. Group Ins. Admin.*, 633 A.2d 2, 15 (D.C. 1993).

In either event, there is no reason why he could not have had Chartered file its own response to the Medicaid RFP and at the same time pursued negotiations with AmeriHealth and other interested parties from a position of strength — as a company that not only had tremendous goodwill in the community and experienced and capable employees, but also had the prospect, with a good purchaser, of once again securing the DHCF Contract. *See* Debonis, *supra* (quoting Sharon Baskerville, Executive Director of D.C. Primary Care Association, a non-profit health action and advocacy organization, stating that notwithstanding the concerns about Mr. Thompson, "People in the community … don't know or care who Jeff Thompson is; they just know that when they go to get their health care, it's there.").

Instead, the Rehabilitator conducted a two-day bidding process, at the end of which he took a company that arguably does not even have a capital deficit and abandoned its entire

business by not bidding on the DHCF Contract. He then put Chartered's resources and expertise to work for competitor AmeriHealth, and agreed to sell off Chartered's assets. The Rehabilitator has not offered evidence sufficient to support his conclusion that the deal struck with AmeriHealth was the best option or that the assets would be sold for fair value. DCHSI understands that the Rehabilitator is under tremendous political pressure, as reflected in Council member Catania's statement when the rehabilitation was filed that Chartered is "finished," and there "just is simply no way [Chartered] resurrects itself." *See* Howell Jr., *supra.* The Rehabilitator's duty and obligation is to honor the requirements of the Rehabilitation Order and the Rehabilitation Act, and to work to reform and revitalize Chartered, not to bow to political pressure.

A recent decision from Pennsylvania, which like the District of Columbia has adopted the NAIC Model Act, demonstrates that a rehabilitator's legal duty is to exhaust all reasonable possibilities of rehabilitation before seeking permission to pursue liquidation, and that the Rehabilitator's actions here fall well short of what is required. *See Consedine v. Penn Treaty Network Am. Ins. Co.*, 2012 WL 6721078, *68 (Pa. Commw. Ct. May 3, 2012).

In *Consedine*, the court denied the rehabilitator's motion to convert a consented-to rehabilitation into a liquidation proceeding. The rehabilitator had submitted a preliminary rehabilitation plan that called for an effort to obtain from certain states actuarially-justified premium rate increases that were necessary to fund anticipated future claims. *See id.*, 2012 WL 6721078, at *18. Absent such rate increases, the insurers would be able to satisfy their obligations to insureds for some time, but would be unable to fund all anticipated future claims, rendering them technically insolvent. *See id.* at *3-4. The rehabilitator committed to submit a formal rehabilitation plan, but two days before it was due he filed motions to liquidate the two insurers. *Id.* at *4-*5. The court permitted the insurers' shareholder to take discovery and contest the liquidation petition. *Id.* at *5.

After trial, the court ruled in favor of the shareholders, finding that the rehabilitator had failed to meet his burden under the Pennsylvania statute (which is materially identical to the

Rehabilitation Act) to prove "'that continued rehabilitation would "substantially increase the risk of loss to creditors, [policyholders], or the public, or would be futile."'" *Id.* at *63 (*quoting Koken v. Legion Ins. Co.*, 831 A.2d 1196, 1230 (Pa. Commw. Ct. 2003) (*quoting* 40 PA. STAT. ANN. § 221.18(a) (West))*; see also* D.C. Code § 31-1314(a). This standard sets a high barrier between rehabilitation and liquidation, because liquidation "is a remedy of last resort" and the rehabilitator may not petition for liquidation unless he has reasonable cause to believe that one of the two elements of the liquidation standard is satisfied. *See Consedine*, 2012 WL 6721078, at *63 (*quoting Koken*, 831 A.2d at 1230).

The court held that the rehabilitator failed to satisfy the liquidation standard for reasons that apply here: The rehabilitator had "not undertaken a meaningful effort to rehabilitate the Companies and, to the contrary, ha[d] acted to frustrate rehabilitation" and had "abandoned [rehabilitation] in its nascency." 2012 WL 6721078 at *4, *8. The rehabilitator had terminated his efforts to obtain rate increases just four months into the proceeding "without the knowledge or approval of the Court." *Id.* at *20. The rehabilitator also had refused to appeal adverse "decisions of state regulators to disapprove actuarially justified premium rate increase filings." *Id.*[10] The rehabilitator concluded that rehabilitation was futile without finally developing a rehabilitation plan, instead "look[ing] for reasons to be excused from that duty." *Id.* at *81. The rehabilitator failed to give due regard to the fact that "[d]uring a rehabilitation, the impaired insurer operates under the protection and direction of the Court" and focused on the wrong facts by having his decisions turn on the insurers' capitalization levels, despite the fact that satisfying the insurer's obligations to policyholders, "not surplus, is paramount." *Id.* The court ordered that

[10] No deference is owed to a rehabilitator's decision when, as here, the court "'must apply specific statutory standards to the evidence presented.'" 2012 WL 6721078 at *63 (*quoting Koken*, 831 A.2d at 1232); *see also Atl. Seaboard Corp. v. Fed. Power Comm'n*, 131 U.S. App. D.C. 291, 297, 404 F.2d 1268, 1274 (D.C. Cir. 1968) (courts defer to agency's decisions only "insofar as they are supported by substantial evidence and are not inconsistent with the statute"); *Robinson v. Bradshaw*, 92 U.S. App. D.C. 216, 220, 206 F.2d 435, 439 (D.C. Cir. 1953) (although deference is the norm, "nevertheless, when convinced that the evidence, with the statute, requires a different result we must not refuse a remedy").

the rehabilitator "shall develop a plan of rehabilitation of the Companies, in consultation with the [shareholder]." *Id.* at *83.

So too here, the Rehabilitator terminated efforts to rehabilitate before informing or seeking the approval of the Court, and began to liquidate without ever making a meaningful effort to rehabilitate. The Rehabilitator impeded rehabilitation by blocking Chartered from bidding on the new DHCF Contract and collusively devoting Chartered's resources to supporting competitor AmeriHealth's bid based only on a *non-binding* letter of intent. The Rehabilitator then entered into the Agreement with AmeriHealth conditioned on AmeriHealth winning the contract, giving AmeriHealth what amounts to a free option on Chartered's key assets. If AmeriHealth does not prevail, Chartered is left with no buyer, no contract, no business, no income stream, and no hopes of finding a new buyer. And, if AmeriHealth wins the contract and the sale goes through, Chartered would lose not only its business, but also its desks, chairs or office supplies, phone numbers, and even its name.

The Rehabilitator's duty was to devote his full attention to preparing a robust bid on the Medicaid RFP *for Chartered* while negotiating with AmeriHealth *and others*; if necessary, to seek an extension of the deadlines for the Medicaid RFP from his fellow regulators at DHCF or from the CAB or this Court, *see Consedine*, 2012 WL 6721078, at *20 (rehabilitator should have appealed adverse decisions denying rate increases); and to extend the Chartered RFP deadlines to permit a fair, reasonable, and competitive bidding process. Indeed, the Rehabilitator should have challenged the Medicaid RFP outright, given inherent flaws that were raised in the Bid Protest.[11] The DISB and DHCF regulators here, as in *Consedine*, have focused on the alleged inadequacy of Chartered's surplus, when it is the service of the Medicaid population that "is paramount" — and it is uncontested that Chartered continues to serve its enrollees and pay its providers. *See id.* at *81. Moreover, all these facts must be considered in view of the fact that Chartered's reported

[11] For example, there was an amendment on November 29, 2012, requiring bids two business days later (December 3), including a special clause applying a prevailing wage and fringe benefit law even though that law is not applicable to Medicaid contracts. *See* Ex. 14, at 5-6 n.3.

risk-based capital shortfall arises almost entirely from DHCF's underpayments and can be corrected by DHCF taking appropriate action to pay its debt to Chartered.

In short, the Rehabilitator had no authority unilaterally to abandon rehabilitation in its nascency and to begin to liquidate without exhausting good-faith efforts to rehabilitate Chartered. Even then, the Rehabilitator lacked authority to take any steps to transform or liquidate Chartered without first affording this Court a meaningful opportunity to assess the Rehabilitator's written plan on adequate notice to interested parties such as DCHSI. *See* D.C. Code § 31-1312(e). Instead, the Rehabilitator improperly treated liquidation as a first resort and began to implement a liquidation plan on his own.

The Rehabilitator's sale process and the Proposed Agreement also violate principles of corporate law and are contrary to the Rehabilitator's duty to reform and revitalize an insurer in rehabilitation, if possible. *See*, D.C. Code § 31-1312. And that is what DCHSI consented to. *See* Emergency Consent Petition for An Expedited Order of Rehabilitation Pursuant to D.C. Official Code §§ 31-1310, 31-1311, 31-1312 and 31-3420(a) On or Before October 23, 2012 ("Consent Petition") at 3, ¶ 6. When the Rehabilitator exercises the powers of directors, which he is given under D.C. Code § 31-1312, he should exercise them in a manner consistent with the duties of directors of the insurer which, under established corporate law, include an obligation to act in the best interests of the Company. *See*, *e.g.*, *Aronson v. Lewis*, 473 A.2d 805, 812 (Del. 1984).

Under Delaware corporate law[12], directors effecting a sale or transformation under circumstances comparable to those presented here have fiduciary obligations to terminate a deal and accept a new proposal that offers better terms for stockholders. *See, e.g., Omnicare, Inc. v. NCS Healthcare, Inc*., 818 A.2d 914, 939 (Del. 2003). In addition, when a company is to be sold, the directors' primary objective must be to secure the transaction offering the best value reasonably available for the stockholders — and they must exercise their fiduciary duties to

[12] Delaware corporate law is commonly followed and relied on by the D.C. Court of Appeals on issues such as directors' fiduciary duties. *See, e.g., Daley v. Alpha Kappa Alpha Sorority, Inc*., 26 A.3d 723 (D.C. 2011); *Behradrezaee v. Dashtara*, 910 A.2d 349 (D.C. 2006).

further that end. *See*, *Revlon, Inc. v. MacAndrews & Forbes Holdings*, 506 A.2d 173, 182, 66 A.L.R. 4th 157, 166 (Del. 1986). The Rehabilitator exercised the powers of Chartered's board of directors in negotiating the Proposed Agreement, though he failed to obtain the consent of Chartered's sole shareholder as required for such board actions by the Articles of Incorporation. The Rehabilitator's failure to negotiate a "fiduciary out" provision and his failure to seek better offers were not in the best interests of the company and, if taken by a director, would violate the director's fiduciary duties in this context. Although the Rehabilitator also must meet his statutory duties to policyholders and the public, there is nothing inherent in his obligation to act in the best interests of the company that would have presented a conflict. To the contrary, had the Rehabilitator acted in the best interests of the company and in accordance with the duties owed to the company by a director in this context, it would have maximized the value of the transaction, thereby assuring maximum benefiting creditors and teh shareholder, without any harm to the public.

Based on the undisputed facts regarding the proposed Agreement, DCHSI is likely to prevail in establishing, as a matter of law, that the Rehabilitator has acted improperly in its sale of Chartered.

2. The Rehabilitator has violated DCHSI's rights to information and to approve or reject board-level decisions

Under the Rehabilitation Act, an order of rehabilitation does not nullify the rights of shareholders. To the contrary, the Rehabilitation Act recognizes that shareholders have protectable rights. *See, e.g.,* D.C. Code § 31-1304 (court may prevent any action that might lessen the value of the insurer's assets or prejudice shareholder rights); *id.* § 31-1305(c) (owners obligated to cooperate in rehabilitation, but that "shall not be construed to abridge otherwise existing legal rights"); *id*. § 31-1316(b) ("the *rights of* [the insurer's] *shareholders*" are fixed when liquidation order entered) (emphasis added).

Although the Rehabilitator has authority over Chartered, he does not have the power to amend or abrogate Chartered's governing corporate documents. When another rehabilitator,

purportedly exercising the authority of the board of directors to amend the bylaws of two insurers in rehabilitation, gave herself the power to consent to liquidation, the court found that the rehabilitator exceeded her authority. *See Koken*, 831 A.2d at 1226-27. Although a rehabilitator assumes the board's "'full power to direct and manage' and to 'deal with the property and business of the insurer,'" the rehabilitator must direct those powers "but to one end; to achieve a successful rehabilitation." *Id*. at 1227 (quoting Pennsylvania statute).[13]

The Rehabilitator has ignored Chartered's governing documents altogether under the erroneous assumption that DCHSI no longer has rights. But the Rehabilitation Act recognizes that DCHSI retains its rights under Chartered's articles of incorporation. The Rehabilitator's actions taken on behalf of the board — such as his decisions to abandon Chartered's business, commit Chartered's resources to preparing a competitor's bid, sell Chartered's assets, and reduce Chartered's claim for reimbursement from DHCF — all required approval by DCHSI. Chartered and DCHSI consented to a rehabilitation, not to liquidation. Because it is undisputed that the Rehabilitator has done all this without DCHSI's approval, DCHSI has established a probability of success of the merits.

3. Actions taken by Petitioner DISB in concert with DHCF have impermissibly interfered with a fair process for bidding on the DHCF Contract

As DCHSI explained argued in its bid protest, the RFP for the DHCF Contract should be canceled and re-solicited because conflicts of interest exist (regarding the Deputy Rehabilitator and his outside counsel) and the RFP was tainted by an illegal restraint of trade and collusive bidding. The District took the position, and the Contract Appeals Board found, that the issues raised by DCHSI could not be addressed by the CAB and, therefore, are under this Court's jurisdiction, as well as that DCHSI lacked standing. DCHSI intends to appeal that decision, and this Court also will have jurisdiction over the appeal; DCHSI will request that the actions be consolidated.

[13] The *Koken* court nevertheless ordered liquidation because, unlike here and in *Consedine*, the insurers were unable to satisfy their obligations to policyholders. *See Koken, 831 A.2d.* at 1245.

Any party "aggrieved" by a decision of a District of Columbia agency may initiate an action for equitable relief in Superior Court. *Capitol Hill Restoration Soc., Inc. v. Moore*, 410 A.2d 184, 188 (D.C. 1979); *Group Ins. Admin*., 633 A.2d at 14. Agency decisions falling under Superior Court jurisdiction include CAB bid protest decisions. *Jones & Artis Const. Co. v. Dist. of Columbia Contract Appeals Bd*., 549 A.2d 315, 318 (D.C. 1988). The Superior Court has authority to issue the relief requested by DHCSI including enjoining and reopening the bidding process. *See Group Ins. Admin.*, 633 A.2d at 19 (recognizing the Superior Court's authority to enjoin the award of a contract, thereby requiring the government to repeat the bidding process, where the original bid process was allegedly tainted); *see also MORI Associates, Inc. v. United States*, 102 Fed. Cl. 503 (Fed. Cl. 2011) (court enjoined a federal agency from suspending a bid solicitation process and enjoined the award of a contract where the bid process was allegedly tainted).[14]

DCHSI is an aggrieved party with standing to challenge the bid process. "'In order to seek review of an administrative agency's decision, (1) the petitioner must allege that the challenged action has caused him injury in fact; (2) the interest sought to be protected by the petitioner must be arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question; and (3) there must be no clear legislative intent to withhold judicial review either from the class of persons or in the type of case involved.'" *Group Ins. Admin.*, 633 A.2d at 17 (quoting *Lee v. Dist. of Columbia Bd. of Appeals & Review*, 423 A.2d 210, 216 (D.C. 1980)). DCHSI meets the standing requirements to challenge the bid process. Since the DHCF Contract is Chartered's sole source of income and Chartered is DCHSI's sole holding, the challenged bid process has undoubtedly injured DCHSI.

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[14] "With few exceptions, District contracting practice parallels federal government contract law." *Dano Res. Recovery, Inc. v. Dist. of Columbia*, 620 A.2d 1346, 1351 (D.C. 1993) ("Thus, as in the past, we avail ourselves here of decisions of the former United States Court of Claims and present United States Claims Court and United States Court of Appeals for the Federal Circuit, as well as the federal boards of contract appeals, all of which have particular expertise in this area.").

In addition, the District of Columbia Procurement Act is meant "to ensure the fair and equitable treatment of all persons who deal with the procurement system of the District government." D.C. Code §2-351.01(b)(4). DCHSI's allegations that the bid process was tainted by conflicts of interest, collusion, and illegal restraint of trade fall within the zone of interests to be protected by the statute. 633 A.2d at 19. Finally, there does not seem to be any "clear legislative intent" to withhold judicial review of the bid process from a party who is the owner of a potential contract bidders, and a potential bidder in its own right, that is negatively affected by a CAB decision. Accordingly, DHCSI has standing to bring the instant claim in Superior Court.[15]

With respect to the bidding process, DCHSI requests that the Court enter an Order requiring Petitioner District of Columbia to reopen the bidding process for the DHCF contract and to extend all deadlines for a reasonable period sufficient to allow Chartered to submit a bid on its own behalf. In the alternative, DCHSI requests that the Court permit all bidders on the DHCF Contract at the "best and final offer stage" to bid to acquire Chartered. These options could produce better results with little disruption and are the type of options the Rehabilitator should have evaluated and preserved.

B. DCHSI will suffer irreparable harm if the Rehabilitator is allowed to proceed unchecked

If the Rehabilitator is allowed to continue on his current course and his destructive actions are allowed to stand, the very existence of Chartered's business — and therefore the very existence of DCHSI's business — will be threatened and DCHSI's rights as shareholder and creditor will continue to be violated. *See* Ex. 2, ¶ 4.

Irreparable harm is established on a showing of an "'economic loss [that] threatens the very existence of the movant's business.'" *E. Trans-Waste*, 758 A.2d at 15 (quoting *Group Ins.*

[15] DCHSI is also an "aggrieved person" under the Contract Appeals Board standard. *See* D.C. Mun. Regs. tit. 27, § 100.2(a) (2006) (defining an "aggrieved person" as an actual or prospective bidder or offeror whose direct economic interest would be affected by the award of a contract or by the failure to award a contract, or who is aggrieved in connection with the solicitation of a contract).

Admin., 633 A.2d at 23 (quoting *Wisconsin Gas Co. v. FERC*, 244 U.S. App. D.C. 349, 354, 758 F.2d 669, 674 (D.C. Cir. 1985))).

Irreparable harm also may be premised on the infringement of shareholders' rights. *See Walker v. Johnson*, 17 App. D.C. 144, 168 (D.C. Cir. 1900) (the deprivation of shareholders voting rights constitutes "an injury for which there is no relief at law — certainly none that is... adequate"); *Telecom-SNI Investors, L.L.C. v. Sorrento Networks, Inc.,* CIV.A. 19038-NC, 2001 WL 1117505 (Del. Ch. Sept. 7, 2001) (""Courts have consistently found that corporate management subjects shareholders to irreparable harm by denying them the right to vote their shares..."" (quoting *Int'l Banknote Co., Inc. v. Muller*, 713 F. Supp. 612, 623 (S.D.N.Y. 1989)); *Treco, Inc. v. Land of Lincoln Sav. & Loan*, 572 F. Supp. 1447, 1450 (N.D. Ill. 1983) (plaintiff shareholders would suffer "irreparable harm" absent an injunction requiring a vote to allow cumulative voting at the company's annual meeting, because, without the injunction, "plaintiffs would be unnecessarily frustrated in their attempt to obtain representation on [the] Board of Directors"); *cf. In re Antioch Univ.*, 418 A.2d 105, 110 (D.C. 1980) (finding irreparable harm and granting a preliminary injunction where a university on the brink of bankruptcy was denied the right to manage and marshal the assets of its law school and noting that "[e]ach day that the University was denied this right, the right was irretrievably lost").

The DHCF Contract is Chartered's raison d'être and sole source of revenue. Chartered, in turn, is the raison d'être of DCHSI's business. *See* Ex. 1, ¶ 3. The Rehabilitator's refusal to permit Chartered to bid on the DHCF Contract necessarily means the contract would be awarded to entities other than Chartered, threatening Chartered's very existence and, by extension, DCHSI. It would be truly remarkable if, during a *rehabilitation* proceeding, the government – DISB in conjunction with DHCF – could gut Chartered's business by preventing it from bidding on the DHCF Contract and then sell Chartered's parts without even consulting its owner.

The terms of the proposed AmeriHealth deal demonstrate not only that it is not "fair and equitable to all parties concerned" as required by the Rehabilitation Statute, *see* DC Code § 31-1312(e), but also that it would result in irreparable harm to Chartered's shareholder and creditor,

DCHSI. If the Rehabilitator were permitted to enter into the Agreement on behalf of Chartered, Chartered would be decimated without adequate compensation.

The closing conditions included in the Asset Purchase Agreement give AmeriHealth the ability to walk away from the deal for various reasons, including if AmeriHealth is not awarded the new DHCF Contract. But if AmeriHealth abandons the deal, it will leave Chartered with no business and no practical ability to attract a new buyer.

Even if the deal does go through, the terms unreasonably favor AmeriHealth, to Chartered's detriment. The Rehabilitator has proffered no information to show the value of the transferred assets. At a minimum, he should be required to present, and the parties should be able to test, a fair and independent valuation of Chartered as it was before the Rehabilitator eliminated Chartered's business. There can be no question, in view of the assets being sold to AmeriHealth, that Chartered would be left with no ability to conduct any business or generate revenues in the future.[16]

To avoid the irreparable harm facing DCHSI, this Court should enjoin the Rehabilitator's *sub rosa* liquidation plan; require the Rehabilitator to reopen the bidding for a sale of Chartered on notice to all potentially interested parties and with the same Court-approved rules applied to all bidders; and require Chartered, in consultation with DCHSI, to submit a response to the Medicaid RFP if it is reopened.

That the Rehabilitator is improperly engaged in a liquidation is all the more improper given that he failed to supply this Court with any factual record: The Rehabilitator never supplied this Court with testimony, affidavits or evidence to justify a liquidation. Nor have any opposing parties been given the opportunity (until now) to oppose the Rehabilitator's actions and supply opposing evidence.

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[16] It is not surprising that the proposed Agreement so heavily favors the buyer, since AmeriHealth had all the leverage once the Rehabilitator decided to forgo Chartered's bid on the new DHCF Contract and permitted AmeriHealth to rely on Chartered's experience and expertise in formulating its own bid.

C. Preventing the Rehabilitator from essentially liquidating Chartered and requiring him to recognize DCHSI's rights will not harm the parties or the public

Requiring the Rehabilitator to exhaust all reasonable efforts to rehabilitate Chartered and to recognize the rights of Chartered's shareholder would not harm any party, since *these are requirements of the Rehabilitation Act and Chartered's governing documents*. Requiring the Rehabilitator to act within his mandate also *serves* the public interest.

Requiring that the bidding on both the DHCF Contract and the sale of Chartered be reopened would also serve the interests of the public and not result in any harm to the parties or the public. As the Rehabilitator and the DHCF Director have acknowledged, Chartered has developed a significant provider network, provided ongoing full-service healthcare to needy District residents and met its obligations to pay providers since 1987. *See* Ex. 10, at 2; Ex. 4, at 2. Indeed, even if Chartered's reserves are too few, it is uncontested that Chartered meets or exceeds the District's statutory minimum net worth requirement as of December 31, 2011, and that the Rehabilitator has asserted a $60 million underpayment claim against the District. *See* First Status Report Ex. 3 at 14, Note 7; Second Status Report at 3. Thus, the interests of the public, policyholders and creditors would best be served by permitting Chartered to bid on the DHCF Contract, and the Court should order that the bidding on the DHCF Contract be re-opened.

In any event, this Court should require that the Chartered RFP be reopened and conducted with a reasonable timeframe, so that Chartered in fact has a legitimate chance to realize fair value and can compete to continue bringing its more than 25 years of developed expertise to bear for the benefit of the District's neediest residents. Other insurers may see greater value in Chartered's assets — a current bidder on the DHCF Contract that purchases Chartered could rely on the acquisition to improve its position and pay more than AmeriHealth is offering. Re-opening the Chartered RFP would foster competition and afford Chartered the chance to survive and prosper, which is the purpose of the Rehabilitation Act. There is no

conceivable harm to the government in allowing a longstanding service provider to continue to perform under the contract as it successfully has for over 25 years.

In contrast to the lack of harm to the parties and the public, DCHSI would face irreparable harm if its request for a preliminary injunction is not granted. DCHSI therefore is entitled to a stay and injunctive relief. *See Eastern Trans-Waste*, 758 A.2d at 14.

III. CONCLUSION

DCHSI respectfully requests that the Court enter an order (1) staying its March 1 Order (Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters) pending appellate review and (2) preliminarily enjoining the Rehabilitator from liquidating Chartered or otherwise exceeding the limits of his authority under the Rehabilitation Act and Rehabilitation Order; (3) vacating or rendering void all of the Rehabilitator's liquidating actions, including any and all purported agreements with AmeriHealth; (4) requiring Petitioner District of Columbia to reopen the bidding process for the DHCF Contract and to extend all deadlines for a reasonable period sufficient to allow Chartered to submit a bid on its own behalf or, in the alternative, to permit all current bidders at the "best and final offer stage" to bid to acquire Chartered; and

[continued on next page]

(5) requiring the Rehabilitator to comply with Chartered's Restated Articles of Incorporation by obtaining DCHSI's advance approval of any decision that would change the nature or operation of Chartered's business or have a material affect on DCHSI's interest in Chartered.

Dated: March 6, 2013 Respectfully submitted,

_____/s/_____

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Counsel for DCHSI

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of March, 2013, a copy of the foregoing was filed and served by email upon:

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Courtesy Copy to:

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_____/s/_____
Jennifer A. Sincavage

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CIVIL DIVISION

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

Civil Action No.: 2012-8227
Judge Melvin R. Wright

v.

DC CHARTERED HEALTH PLAN, INC.,

Respondent.

ORDER GRANTING PARTY-IN-INTEREST D.C. HEALTHCARE SYSTEM, INC.'S MOTION FOR (1) A STAY PENDING APPEAL OF THE ORDER APPROVING THE ASSET PURCHASE AGREEMENT, PLAN OF REORGANIZATION AND RELATED MATTERS; AND (2) INJUNCTIVE RELIEF

Before this Court is Party-in-Interest D.C. Healthcare Systems, Inc.'s ("DCHSI") Motion for (1) a Stay Pending Appeal of the Order Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters; and (2) Injunctive Relief ("Motion"). The Court having considered the arguments of the parties hereby orders that:

1. The Court's March 1, 2013 Order Approving Asset Purchase Agreement, Plan of Rehabilitation and Related Matters is stayed pending appellate review;
2. The Rehabilitator is preliminarily enjoined from liquidating Chartered or otherwise exceeding the limits of his authority under the Insurers Rehabilitation and Liquidation Procedures Act, D.C. Code § 31-1301 *et seq*. (the "Rehabilitation Act") and the October 19, 2012 Order of this Court placing Chartered into rehabilitation;
3. All of the Rehabilitator's liquidating actions are vacated and rendered void, including any and all purported agreements with AmeriHealth;

4. Petitioner District of Columbia is required to reopen the bidding process for the Department of Healthcare Finance ("DHCF") Medicaid contract (Solicitation No. Doc70947/DHCF-2013-R-0003 (MCO)) ("DHCF Contract") and to extend all deadlines for a reasonable period sufficient to allow Chartered to submit a bid on its own behalf or, in the alternative, to permit all current bidders at the "best and final offer stage" to bid to acquire Chartered; and

5. The Rehabilitator is required to comply with Article VIII of Chartered's Restated Articles of Incorporation by obtaining DCHSI's advance approval of any decision that would change the nature or operation of Chartered's business or have a material affect on DCHSI's interest in Chartered.

SO ORDERED.

_____
Judge Melvin R. Wright

Entered on: _____

Copies to be Served:

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SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

Civil Action No. 2012-8227
Judge Melvin R. Wright

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent.

STATE OF NEW YORK)
:ss:.
COUNTY OF NEW YORK)

AFFIDAVIT OF LORIE E. LUPKIN IN SUPPORT OF PARTY-IN-INTEREST D.C. HEALTHCARE SYSTEM, INC.'S MOTION FOR (1) A STAY PENDING APPEAL OF THE ORDER APPROVING THE ASSET PURCHASE AGREEMENT, PLAN OF REORGANIZATION AND RELATED MATTERS; AND (2) INJUNCTIVE RELIEF

LORIE E. LUPKIN declares under penalty of perjury that:

1. I am an attorney with Manatt, Phelps & Phillips, LLP, attorneys for D.C. Healthcare Systems, Inc. ("DCHSI"). I submit this affidavit in support of DCHSI's Motion for (1) a Stay Pending Appeal of the Order Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters; and, (2) Injunctive Relief.
2. Annexed as Exhibit 1 is a true and correct copy of the Affidavit of Stephen I. Glover, dated March 15, 2013.
3. Annexed as Exhibit 2 is a true and correct copy of the Affidavit of Richard Evans, dated February 27, 2013.
4. Annexed as Exhibit 3 is a true and correct copy of the Restated Articles of Incorporation with Amendments of D.C. Chartered Health Plan, Inc.

5. Annexed as Exhibit 4 is a true and correct copy of the Testimony of Wayne Turnage, Director, Department of Health Care Finance, before the Council of the District of Columbia Committee on Health and Committee on Public Services and Consumer Affairs, dated October 25, 2012, obtained from the Contract Appeals Board's website, *available at* http://app.cab.dc.gov/WorkSite/Docket_Case_Number.asp.
6. Annexed as Exhibit 5 is a true and correct copy of D.C. Chartered Health Plan, Inc.'s Financial Statements with Independent Auditors' Report Thereon Relating to 2004-2010.
7. Annexed as Exhibit 6 is a true and correct copy of a Form Letter from James M. Sheehy, Keefe, Bruyette & Woods, dated November 9, 2012.
8. Annexed as Exhibit 7 is a true and correct copy of a Letter Agreement, dated November 30, 2012, entered into among D.C. Chartered Health Plan, Inc. and AmeriHealth Mercy Health Plan.
9. Annexed as Exhibit 8 is a true and correct copy of a document entitled "Receiver's Status Report on Chartered Health Plan, Inc." dated Dec. 3, 2012, obtained from the Contract Appeals Board's website, *available at* http://app.cab.dc.gov/WorkSite/Docket_Case_Number.asp.
10. Annexed as Exhibit 9 is a true and correct copy of the Declaration of Daniel L. Watkins, filed as Exhibit A to the District of Columbia's Motion for Leave to Reply to Protestor's Opposition to the District of Columbia's Motion to Dismiss (CAB No. P-0930), dated February 5, 2013.

11. Annexed as Exhibit 10 is a true and correct copy of the Testimony of William P. White, Commissioner of the Department of Insurance, Securities and Banking, at the Joint Oversight Roundtable on the D.C. Chartered Health Plan, Inc. Receivership of the Committee on Public Services and Consumer Affairs, Yvette Alexander, Chairperson, and the Committee on Health, David Catania, Chairperson, dated Oct. 25, 2012, obtained from Contract Appeals Board's website, *available at* http://app.cab.dc.gov/WorkSite/Docket_Case_Number.asp.
12. Annexed as Exhibit 11 is a true and correct copy of Protest of D.C. Healthcare Systems, Inc. Under Request for Proposals No. DHCF-2013-R-0003 (CAB No. P-0930), dated Dec. 17, 2012 (without exhibits).
13. Annexed as Exhibit 12 is a true and correct copy of the District of Columbia's Motion to Dismiss for Lack of Subject Matter Jurisdiction and Standing in Response to Protest of D.C. Healthcare Systems, Inc. (CAB No. P-0930), dated January 10, 2013 (without exhibits).
14. Annexed as Exhibit 13 is a true and correct copy of the Opposition of Protestor D.C. Healthcare Systems, Inc. to the District of Columbia's Motion to Dismiss (CAB No. P-0930), dated January 25, 2013 (without exhibits).
15. Annexed as Exhibit 14 is a true and correct copy of the District of Columbia Contract Appeals Board Order Dismissing Protest (CAB No. P-0930), dated February 27, 2013.
16. Annexed as Exhibit 15 is a true and correct copy of a document entitled "Questions and Answers about D.C. Chartered Health Plan Inc.", dated Feb. 22, 2013, obtained from D.C. Chartered Health Plan, Inc. Rehabilitation's website, *available at* http://disb.dc.gov/node/344592.

17. Annexed as Exhibit 16 is a true and correct copy of a Letter dated June 22, 2010 from Jonathan C. Marsden, Mercer, to Tanya Ehrmann, District of Columbia Department of Health Care Finance, regarding District of Columbia Healthy Families Program Rate Development and Actuarial Certification for the Contract Period July 1, 2010 through April 30, 2011. We have highlighted select portions of the letter for the convenience of the Court.

18. Annexed as Exhibit 17 is a true and correct copy of a document dated January 6, 2012 entitled "DCHFP Book for Rates Effective May 1, 2012: District of Columbia Department of Health Care Finance."

Lorie E. Lupkin

Sworn to before me this
6th day of March, 2013

Notary Public

9/8/13

EXHIBIT 1

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CIVIL DIVISION

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

v.

DC CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No.: 2012-8227

Judge Melvin R. Wright

AFFIDAVIT OF STEPHEN I. GLOVER

The undersigned, STEPHEN I. GLOVER, having been duly sworn, hereby deposes and states as follows:

1. My name is Stephen I. Glover and the facts set forth below are true based upon my personal knowledge.

2. I am a partner at the law firm Gibson, Dunn & Crutcher LLP, attorneys for D.C. Healthcare Systems, Inc. ("DCHSI") and its owner on certain corporate matters, including in connection with the rehabilitation of D.C. Chartered Health Plan, Inc. ("Chartered").

3. From October 19, 2012 until recently, during the meetings and telephone conferences with the Special Deputy to the Rehabilitator and the Rehabilitator's outside counsel, including those on November 2, 2012, November 9, 2012, November 16, 2012, November 23, 2012, November 30, 2012, December 5, 2012, December 14, 2012 and January 11, 2013, on behalf of DCHSI, I repeatedly requested information from the Special Deputy to the Rehabilitator and the Rehabilitator's outside counsel with respect to the status of the proposed rehabilitation plan for Chartered, including structure, value and other key terms of a potential transaction, details regarding the status of negotiations with buyers and the District government, and details regarding timing. I did not receive any meaningful information in respect of these requests from the Special Deputy to the Rehabilitator and the Rehabilitator's outside counsel. In particular, for example, they did not provide: (a) any information regarding the offers made by AmeriHealth District of Columbia, Inc. ("AmeriHealth") or other prospective buyers who were

contacted by the Special Deputy to the Rehabilitator or its advisers; (b) a copy or description of the terms of the non-binding letter of intent entered into by AmeriHealth and Chartered; (c) the purchase price proposed to be paid by AmeriHealth; (d) a description of the other key terms of the proposed agreement between AmeriHealth and Chartered, including the structure of the transaction, the allocation of assets and liabilities between buyer and seller, conditions to completion and indemnification arrangements between buyer and seller; (e) drafts of the proposed definitive agreement between AmeriHealth and Chartered; (f) the status of any discussions among Chartered, AmeriHealth and/or the District government regarding the current Medicaid contract or the request for proposals relating to the new five-year Medicaid contract, including but not limited to any discussions regarding pricing and preparation of a response to the RFP; (g) the status of any discussions between Chartered, AmeriHealth and/or the District government regarding the settlement of Chartered's retrospective rate adjustment claim.

4. The Special Deputy to the Rehabilitator indicated to us that Chartered would respond in its own right to the RFP for a new five year Medicaid contract. It was not until December 3, 2012, when the deadline for such response had expired, that I learned that Chartered had not responded to the RFP.

5. In the days leading to DCHSI's consent to rehabilitation, the Special Deputy to the Rehabilitator and his agents told us that during the rehabilitation they would provide information to and cooperate and consult with DCHSI. As stated, once DCHSI gave its consent and the rehabilitation proceeding began, the Special Deputy to the Rehabilitator and his counsel did not cooperate with DCHSI's repeated requests for information that was important to DCHSI's financial and business interests.

6. Before DCHSI consented to the commencement of rehabilitation proceedings and the filing of a Consent Petition for an Order of Rehabilitation, I asked the Special Deputy to the Rehabilitator to provide a letter confirming that he would consult with DCHSI during the rehabilitation process. The Special Deputy to the Rehabilitator said that he would provide such a letter, but that he would not be able to do so until after the Consent Petition was filed. On several occasions after DCHSI signed its consent. I asked the Special Deputy to the Rehabilitator to provide the letter, but he refused.

7. During the meeting on December 14, 2012, I told the Special Deputy to the Rehabilitator and the Rehabilitator's outside counsel that DCHSI would be willing to sign a confidentiality agreement before any confidential information relating to the rehabilitation of Chartered was shared with DCHSI by the Special Deputy to the Rehabilitator. The Special Deputy to the Rehabilitator said he would think about this proposal. [I did not receive a follow-up response from the Special Deputy to the Rehabilitator on this proposal after the meeting.]

I solemnly affirm that the contents of the foregoing are true to the best of my knowledge, information and belief.

3/5/13
Date

Stephen I. Glover

Sworn to before me this 5th day of March, 2013

OLA RENEE CHATMAN NOTARY PUBLIC DISTRICT OF COLUMBIA

Notary Public

Ola Renee Chatman
Notary Public, District of Columbia
My Commission Expires 6/30/2015

My commission expires: 6/30/2015

EXHIBIT 2

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA
CIVIL DIVISION

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

v.

DC CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No.: 2012-8227

Judge Melvin R. Wright

AFFIDAVIT OF RICHARD EVANS

The undersigned, RICHARD EVANS, having been duly sworn, hereby deposes and states as follows:

1. My name is Richard Evans and the facts set forth below are true based upon my personal knowledge. I am a Director of D.C. Healthcare Systems, Inc. ("DCHSI").

2. DCHSI is the sole shareholder of D.C. Chartered Health Plan, Inc. ("Chartered").

3. Chartered is DCHSI's sole source of revenue.

4. Without revenue from Chartered, DCHSI's existence would be threatened.

I solemnly affirm that the contents of the foregoing are true to the best of my knowledge, information and belief.

2-27-2013
Date

Richard Evans

Sworn to before me this 27th day of February, 2013

Janice K. Buzard
Notary Public

My commission expires: 2/28/13

JANICE K. BUZARD
NOTARY PUBLIC
District of Columbia
My Commission Expires
February 28, 2013

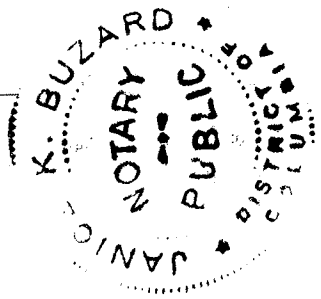

EXHIBIT 3

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that the attached is a true and correct copy of the documents for this entity as shown by the records of this office.

D.C. CHARTERED HEALTH PLAN, INC.

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of **04/12/2012**

Business and Professional Licensing Administration

Patricia E. Grays

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: GH0MBWBCAW

870913

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
BUSINESS REGULATION ADMINISTRATION

C E R T I F I C A T E

THIS IS TO CERTIFY that all applicable provisions of the DISTRICT OF COLUMBIA BUSINESS CORPORATION ACT have been complied with and ACCORDINGLY, this CERTIFICATE of Incorporation is hereby issued to D.C. CHARTERED HEALTH PLAN, INC.

as of January 20, 19 87.

Donald G. Murray
Acting Director

R. Benjamin Johnson
Administrator
Business Regulation Administration

Miriam Hellen Jones
Superintendent of Corporations
Corporations Division

Marion Barry, Jr.
Mayor

***

ARTICLES OF INCORPORATION
of
D.C. CHARTERED HEALTH PLAN, INC.

TO: RECORDER OF DEEDS
WASHINGTON, D.C.

The undersigned natural persons, of the age of 21 years or more, do, under and by virtue of the District of Columbia Corporation Act authorizing the formation of Corporations, with the intention of forming a Corporation, hereby adopts the following Articles of Incorporation for such Corporation:

FIRST: The name of the corporation is D.C. CHARTERED HEALTH PLAN, INC.

SECOND: The period of its duration is perpetual.

THIRD: The purpose or purposes for which the Corporation is organized are: to provide management and administration services to providers of health care; to engage in and to do any lawful act concerning any or all lawful business for which corporations may be incorporated under the District of Columbia Corporation Act, including but not limited to, the power to engage in the business of manufacturing, processing, research and development and to invest its funds in real estate, mortgages, stocks, bonds and other types of investment assets and to own, and to deal with or dispose of such real and personal property as may be necessary or appropriate for the conduct of its business.

FOURTH: The aggregate number of shares which the Corporation is authorized to issue is one hundred thousand shares of common stock having a par value of $1.00 per share.

FIFTH: The Corporation will not commence business until at

JAN 20 1987

By

least One Thousand Dollars ($1,000) has been received by it as consideration for the issuance of shares.

SIXTH: The address, including street and number of the initial registered office of the Corporation is 665 E. Street, S.W., Washington, D.C. 20024, and the name of the initial registered agent at that address is Lewis W. Marshall.

SEVENTH: The following persons shall constitute the initial Board of Directors and shall serve as the Directors until the first annual meeting of the Shareholders or until their successors are elected and shall qualify:

Name	Address
Jerry H. Dolchin	Suite 2000, 1234 Market St., Phila., PA 19107
Mark I. Slotkin	Suite 2000, 1234 Market St., Phila., PA 19107
Lewis W. Marshall	2758 Unicorn Lane, Washington, DC 20015

EIGHTH: The name and address of each Incorporator is as follows:

Name	Address
Jerry H. Dolchin	Suite 2000, 1234 Market St., Phila., PA 19107
Mark I. Slotkin	Suite 2000, 1234 Market St., Phila., PA 19107
Lewis W. Marshall	2758 Unicorn Lane, Washington, DC 20015

Dated: December 1, 1986

Jerry H. Dolchin, Incorporator

Mark I. Slotkin, Incorporator

Lewis W. Marshall, Incorporator

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that the attached is a true and correct copy of the documents for this entity as shown by the records of this office.

D.C. CHARTERED HEALTH PLAN, INC.

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of **04/13/2012**

Business and Professional Licensing Administration

Patricia E. Grays

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: SI3W45GE3B

~~9-D-86~~
8209B

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
BUSINESS REGULATION ADMINISTRATION

CERTIFICATE

THIS IS TO CERTIFY that all applicable provisions of the DISTRICT OF COLUMBIA BUSINESS CORPORATION ACT have been complied with and accordingly, this CERTIFICATE of AMENDMENT is hereby issued to

D.C. CHARTERED HEALTH PLAN, INC.

as of JANUARY 10th, 1989 .

Donald G. Murray
Director

Henry C. Lee, III
Administrator
Business Regulation Administration

Vandy L. Jamison, Jr
Assistant Superintendent of Corporations
Corporations Division

Marion Barry, Jr.
Mayor

005722
9-12-86

CERTIFICATE OF AMENDMENT
TO THE
ARTICLES OF INCORPORATION
OF
D.C. CHARTERED HEALTH PLAN, INC.

The undersigned, for the purpose of amending Articles of Incorporation pursuant to Sections 29-356 and 29-357 of the District of Columbia Business Corporation Act, do hereby certify that:

FIRST: The name of the corporation is D.C. Chartered Health Plan, Inc. (the "Corporation").

SECOND: Current Article Fourth is deleted in its entirety and the following substituted in lieu thereof:

> FOURTH: The total number of shares of all classes of capital stock which the Corporation shall have the authority to issue is 350,000 shares, consisting of 300,000 shares of common stock with a par value of $.10 per share (the "Common Stock") and 50,000 shares of preferred stock with a par value of $1.00 per share ("Preferred Stock"). The 300,000 shares of Common Stock which the Corporation is authorized to issue are hereby divided into three classes

FILED
JAN 10 1989
BY: [illegible]

as follows: 100,000 shares of Class A Common Stock, 100,000 shares of Class B Common Stock, and 100,000 shares of Class C Common Stock.

The Corporation's Board of Directors shall be comprised of twelve members. The holders of the Class A Common Stock shall have the right to elect six members of the Board of Directors, designated as the Class A Directors, and the holders of the Class B Common Stock shall have the right to elect six members of the Board of Directors, designated as the Class B Directors. No later than July 31, 1989, the holders of both Class A Common Stock and Class B Common Stock shall each select two of their six members of the Board Directors from the subscribers of the Corporation, based upon the Corporation's subscriber board membership selection procedure. Until the subscribers are chosen, the Board of Directors shall consist of eight

members of which four members shall be designated Class A Directors and four members shall be designated as Class B Directors.

The holders of Class C Common Stock shall have no right to elect members of the Board of Directors. The holders of Preferred Stock shall have no right to elect members of the Board of Directors. The holders of the Preferred Stock shall be entitled to receive, when and as declared by the Board of Directors, yearly dividends from the surplus or net profits of the Corporation at a rate of 5.5 percent per annum. Such dividends shall be payable before any dividends shall be paid upon, or set apart for, the Common Stock of the Corporation and shall be cumulative. Such dividends shall be paid during the first quarter of Corporation's 1991 fiscal year unless there is an affirmative vote of no less than seventy-five percent (75%) of the

entire Board of Directors that such dividends should not be paid at that time.

Except as otherwise provided for herein, a description of the respective classes of Common Stock and a statement of the designations, preferences, voting powers (or no voting powers), relative, participating, optional, or other special rights and privileges and the qualifications, limitations, and restrictions of the Common Stock and Preferred Stock shall be established by resolution of the Corporation's Board of Directors; provided, however, that no share of the Corporation's capital stock shall be convertible into Class A or Class B Common Stock.

THIRD: A new Article Eighth is added to read as follows:

> The affirmative vote of no less than seventy-five percent (75%) of the entire Board of Directors shall be required to approve any merger, consolidation, dissolution, reduction of stated capital, sale, lease, exchange, mortgage, pledge or other disposition of all or substantially all of the property and assets of the Corporation, amendment of the Articles of Incorporation or Bylaws, issuance of any securities, change in nature of Corporation's business, establishment of reserves or any contract or other financial relationship to which a member of the Board of Directors or five percent (5%) or more stockholder of the Corporation is a party or in which a member of the Board of Directors or five percent (5%) or more stockholder of the Corporation has a direct or indirect material interest.

FOURTH: A new Article Ninth is added to read as follows:

If in any of the years in which Consumers United Capital Corporation, a Delaware corporation, owns shares of the Corporation's Class B Common Stock, the pre-tax annual income of the Corporation is less than seventy-five percent (75%) of the amount projected in the Corporation's Joint Venture Proposal Of February 1988 at page 2 and any subsequent annual projections as adopted by the Board of Directors, not including projections for the Corporation's commercial marketing, then the president of the Corporation shall call a special meeting of the Board of Directors for the purpose of determining whether the Corporation should continue its business activities. In the event three-fourths (3/4) of the Corporation's entire Board of Directors does not affirmatively vote to continue the Corporation's business activities,

the Board of Directors shall cause all steps to be taken necessary to wind-up the Corporation's business activities and to dissolve the Corporation pursuant to the District of Columbia Business Corporation Act.

FIFTH: These amendments to the Corporation's Articles of Incorporation were adopted by the shareholders entitled to vote thereon effective December 30, 1988.

SIXTH: Seventy-six shares of the Corporation's Common Stock were outstanding prior to the adoption of these amendments and each share was entitled to one vote.

SEVENTH: These amendments were adopted by the shareholders of the Corporation at a meeting held for that purpose on 12/30, 1988. Seventy-six of the 76 outstanding shares of the Corporation's Common Stock were represented at the meeting. Of the 76 shares represented, 76 shares were voted in favor of the adoption of the amendment and 0 shares were voted against the adoption of the amendment.

EIGHTH: Each share of the Corporation's Common Stock issued and outstanding immediately prior to the filing of this

Certificate of Amendment shall, by virtue of the filing of this Certificate of Amendment and without any action on the part of the holder thereof, be converted into and exchangeable for 445 shares of Class A Common Stock of the Corporation. Each such share shall be deemed fully paid and non-assessable.

NINTH: These amendments shall cause a change in the amount of stated capital from $76.00 to $ 80,000 and a change in the paid-in surplus from $597,086 to $ 517,162. The Corporation shall effect such change by transferring paid-in surplus to stated capital on the books and records of the Corporation.

IN WITNESS WHEREOF, the undersigned has subscribed his name this 30 day of December, 1988.

D.C. Chartered Health Plan, Inc.

By: Robert Bowles Jr

Its: President

Received with all required signatures.

Sylvester C. Bowles

Secretary

December 30, 1988

Date

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that the attached is a true and correct copy of the documents for this entity as shown by the records of this office.

D.C. CHARTERED HEALTH PLAN, INC.

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of **04/13/2012**

Business and Professional Licensing Administration

Patricia E. Grays

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: SI3W45GE3B

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
BUSINESS REGULATION ADMINISTRATION

CERTIFICATE

THIS IS TO CERTIFY that all applicable provisions of the DISTRICT OF COLUMBIA BUSINESS CORPORATION ACT have been complied with and accordingly, this CERTIFICATE of AMENDMENT is hereby issued to

D.C. CHARTERED HEALTH PLAN, INC.

as of July 14th, 1992 .

Barbara E. Brown
Acting Director

James E. Kerr
Administrator
Business Regulation Administration

Miriam Hellen Jones
Superintendent of Corporations
Corporations Division

Sharon Pratt Kelly
Mayor

ARTICLES OF AMENDMENT
TO THE
ARTICLES OF INCORPORATION
OF
D.C. CHARTERED HEALTH PLAN, INC.

The undersigned corporation, for the purposes of amending its Articles of Incorporation pursuant to the District of Columbia Business Corporation Act, does hereby certify that:

FIRST: The name of the corporation is D.C. Chartered Health Plan, Inc. (the "**Corporation**").

SECOND: The Articles of Incorporation are amended as follows:

1. New Article Tenth is added to read as follows:

> TENTH: No shareholder of any class of stock of the Corporation shall have the preemptive right to subscribe for or acquire additional shares of the Corporation, whether now or hereafter authorized.

THIRD: These amendments to the Corporation's Articles of Incorporation were adopted by at least two-thirds of the shareholders entitled to vote thereon effective April 21, 1992.

FOURTH: Thirty three thousand eight hundred twenty six and eighty three tenths (33,826.83) shares of the Corporation's Class A Common Stock, zero (0) shares of the Corporation's Class B Common Stock, zero(0) shares of the Corporation's Class C Common Stock, and zero (0) shares of the Corporation's Preferred Stock, were outstanding prior to the adoption of these amendments and each such outstanding class shares were entitled to one vote.

FIFTH: These amendments were adopted by the shareholders of the Corporation at a meeting held for that purpose on April 21, 1992. 29,883.33 of the 33,826.83 outstanding shares of the Corporations's Class A Common Stock were represented in person or by proxy at the meeting. Of the 29,883.33 shares represented, 25,721.74 shares

were voted in favor of the adoption of the amendment and 4,161.59 shares were voted against the adoption of the amendment with 3,943.50 shares abstaining.

SIXTH: These amendments to the Corporation's Articles of Incorporation were adopted by an affirmative vote of at least seventy-five percent (75%) of the entire Board of Directors effective April 6, 1992.

SEVENTH: These amendments do not provide for an exchange, reclassification, or cancellation of the issued shares of the Corporation.

EIGHTH: These amendments shall not effect a change in the amount of stated capital of the Corporation.

IN WITNESS WHEREOF, the Corporation has caused these Articles of Amendment to the Articles of Incorporation to be signed in its name and on its behalf by its President and attested to by its Secretary on the 4th day of June, 1992, and its President acknowledges that these Articles of Amendment are the act and deed of the Corporation and, under the penalties of perjury, that the matters and facts set forth herein with respect to authorization and approval are true in all material respects to the best of his knowledge, information and belief.

D.C. CHARTERED HEALTH PLAN, INC.

By: Robert C. Bowles
President

Attested to:

Lewis Marshall
Secretary

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS
CORPORATIONS DIVISION

CERTIFICATE

THIS IS TO CERTIFY that the attached is a true and correct copy of the documents for this entity as shown by the records of this office.

D.C. CHARTERED HEALTH PLAN, INC.

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of **04/13/2012**

Business and Professional Licensing Administration

PATRICIA E. GRAYS
Superintendent of Corporations
Corporations Division

Vincent C. Gray
Mayor

Tracking #: SI3W45GE3B

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GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS

★ ★ ★

CERTIFICATE

THIS IS TO CERTIFY that all applicable provisions of the District of Columbia Business Corporation Act have been complied with and accordingly, this ***CERTIFICATE OF AMENDMENT*** is hereby issued to:

D.C. CHARTERED HEALTH PLAN, INC.

IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of this office to be affixed as of the **30th** day of **October, 2000.**

Carlynn M. Fuller
Acting Director

Patricia E. Grays
Acting Administrator
Business Regulation Administration

Patricia E. Grays

for Patricia E. Grays
Superintendent of Corporations
Corporations Division

Anthony A.
Williams Mayor

Q70913

RESTATED ARTICLES OF INCORPORATION WITH AMENDMENTS OF D.C. CHARTERED HEALTH PLAN, INC. A District of Columbia Corporation

TO: The Department of Consumer and Regulatory Affairs
Corporations Division, Government of the District of Columbia

I, the undersigned, a vice-president of D.C. Chartered Health Plan, Inc., adopt these Restates Articles of Incorporation with Amendments.

ARTICLE I
CORPORATE NAME

The present name of the corporation is D.C. CHARTERED HEALTH PLAN, INC. The original corporate name was D.C. CHARTERED HEALTH PLAN, INC. and the original Articles of Incorporation were filed on January 20, 1987.

ARTICLE II
DURATION

The period of duration of the corporation is perpetual. The original period of duration was perpetual.

ARTICLE III
ADOPTION OF RESTATED ARTICLES WITH AMENDMENTS

These Restated Articles both restate and amend the Articles of Incorporation. The Board of Directors adopted a resolution setting for the proposed amendments and directing that the amendments be submitted to the shareholder for approval. The shareholder approved the amendments by a unanimous vote of the shares outstanding and entitled to vote on October 28, 2000.

ARTICLE IV
AMENDMENT OF FOURTH ARTICLE

The Articles of Incorporation are amended by striking out the Fourth Article in its entirety and inserting in its place the following new Article IV:

FILE
OCT 30 2000

"ARTICLE IV
CORPORATE STOCK AND CLASSES OF STOCK

The corporation is authorized to issue 1,000 shares of common stock with a par value of $1.00 per share. The corporation is authorized to issue one class of common stock."

ARTICLE V
AMENDMENT OF EIGHTH ARTICLE

The Articles of Incorporation are amended by striking out the Eighth Article in its entirety and inserting in its place the following new Article VIII:

"ARTICLE VIII
SHAREHOLDER APPROVAL OF BOARD ACTIONS

No action of the Board of Directors shall take effect unless it has been approved by the unanimous vote of the outstanding shares entitled to vote."

ARTICLE VI
AMENDMENT OF NINTH ARTICLE

The Articles of Incorporation are amended by striking out the Ninth Article in its entirety and inserting in its place the following new Article IX:

"ARTICLE IX
PREEMPTIVE RIGHTS

The preemptive rights of the shareholders of the corporation shall not be limited in any way."

ARTICLE VII
AMENDMENT OF TENTH ARTICLE

The Articles of Incorporation are amended by striking out the Tenth Article in its entirety and inserting in its place the following new Article X:

XEROX COPY

"ARTICLE X
INTERNAL AFFAIRS

The internal affairs of the corporation shall be conducted according to the shareholder agreement of the corporation."

Nicholas G. Karambelas
Vice President

October 30, 2000
Date

(CORPORATE SEAL)

EXHIBIT 4

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Joint Oversight Roundtable

On

The Chartered Health Plan Receivership

Testimony of

Wayne Turnage

Director

Department of Health Care Finance

Before the

Council of the District of Columbia

Committee on Health

And

Committee on Public Services and Consumer Affairs

Thursday, October 25, 2012

John A. Wilson Building,
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Introduction

Good morning Chairperson Catania, Chairperson Alexander and members of the Committee on Health and the Committee on Public Services and Consumer Affairs. I am Wayne Turnage, Director of the Department of Health Care Finance (DHCF), and I appreciate the opportunity to provide testimony on the status of our activities with Chartered Health Plan (Chartered), in light of the recent decision to take the company into receivership.

The initial portion of my testimony will focus on the impact of the company's receivership on its Medicaid and Alliance beneficiaries as well as the Department's oversight and monitoring responsibilities specific to Chartered. The last part of my remarks outlines DHCF's upcoming plans to re-bid the entire managed care program.

Impact of Receivership on Beneficiary Access to Care and Provider Payments

As has been accurately stated in the past, the managed care agreement that DHCF has with CHP is our largest contract, covering approximately 110,000 members a month at an annual cost of more than $359 million ($334M DCHF and $25M Alliance). With this contract, CHP has established a significant provider network incorporating primary, urgent and emergency care health services. Specifically, CHP has contracts with a total of 5,387 health care providers including 10 acute and specialty hospitals, 35 community clinics, 484 primary care physicians and numerous dentists and other specialty care physicians. Through this network, both Medicaid and Alliance beneficiaries have access to the full range of health care services they may need to address their medical needs.

There are three important facts to be emphasized about the impact of the decision by the Department of Insurance Securities and Banking (DISB) to take CHP into receivership. First, this decision allows DHCF to extend a contract to CHP for the remainder of the original contract

period which extends to April 30, 2013. This contract is forthcoming to the Council for approval.

Second, this decision does not alter or diminish the existing health care provider network for Chartered's beneficiaries. Accordingly, each of the 110,000 members will continue to have access to the same network and hence the full range of health care services they enjoyed prior to the move that placed the company into receivership. This would obviously have not been possible had DHCF been forced to move Chartered's existing members to the District's remaining Medicaid and Alliance health plans in response to the company's problems.

The third noteworthy fact is that the contractual arrangements governing provider payments from Chartered to the many providers in the network are unchanged. In most cases these are straightforward fee-for-service payments made by Chartered to providers for the care delivered to beneficiaries. In some other cases, Chartered has established more complex capitated risk-based payment systems with its providers for the members they carry in their networks. Unwinding these arrangements in the middle of the fiscal year without creating significant problems for both plan members and providers would be a daunting task. The receivership solution allowed DHCF to avoid this problem as well.

Monitoring of Chartered Health Plan During Receivership Status

Chartered's receivership status will not restrict DHCF's monitoring activities which we routinely implement to govern our health plans. Currently, the Division of Managed Care is responsible for oversight and monitoring of the agency's managed care program. Contract Administrators (CAs) are assigned to each Managed Care Organization (MCO) for the purpose of monitoring MCO compliance with the contract while also providing guidance as needed by the plans.

To carry out this function, each CA routinely meets with key MCO staff to review and address policy questions, health plan changes or updates, and any plan deficiencies that could adversely impact beneficiaries. In addition, contract staff must review performance reports that health plans are required to submit to DHCF. These reports enable staff to trend MCO performance in several areas including the level of case management provided, beneficiary grievance rates, and service use patterns that point to a disproportionate use of costly and potentially unnecessary treatment trends (e.g. use of emergency room for non-emergency care). CAs also regularly employ a check list based on provisions from the health plan contracts to ensure that all components of oversight are monitored and completed.

While Chartered is in receivership, each of these monitoring and oversight activities will continue unabated. For the remaining six months of the contract, DHCF staff will meet with Chartered to continually assess the company's implementation activities. A coordinated schedule of weekly and monthly meetings will occur to evaluate program activities, address critical concerns, and assess the status of any corrective actions imposed upon the company.

The following outlines several of the primary activities that will be implemented to assess the performance of Chartered for the remaining months of the contract.

1. DHCF staff will review claims payment activities with Chartered's Provider Relations and Claims Department. This will be conducted to determine the timeliness of payments for clean claims submitted to the MCO while also identifying outstanding payments.

2. DHCF staff will work with Chartered's Provider Relations team to ensure adherence to provider agreements. The goal here will be to confirm that there is no change in payment practices or any diminution of beneficiary access to care.

3. DHCF staff will attend all meetings convened by Chartered with their network providers. These meetings are typically held quarterly and

should be used to highlight program changes, updates, and any residual provider issues.

4. The Department will conduct a 360 evaluation of randomly selected providers within Chartered's network including specialists, primary care doctors, pediatricians, dentists and early intervention providers. This will assist DHCF in identifying issues not openly discussed during Chartered's provider meetings.

5. The Department will conduct monthly site visits to Chartered, focusing on key areas of concern and assessing current staff levels. Chartered will be required to notify DHCF of all staff departures, replacing the requirement to only notify us of key personnel departures.

Finally, it should also be noted that, at time of receivership, DHCF was in the process of establishing a corrective action plan for Chartered to address problems with inadequate staff. Company officials were notified of DHCF's plans to cap enrollment of new beneficiaries until these staff deficiencies are addressed. We anticipate modifying the contract that the Council is about to receive to impose this enrollment cap beginning in the month of November. The restriction will remain in place until Chartered successfully implements the necessary corrective action.

Status of Process to Rebid the Entire Managed Care Program

Notwithstanding the current or future status of Chartered, the Department has begun the process to rebid its managed care program. The current contract for all health plans in the program expires April 30, 2013. Hence, the Department is pursuing a schedule that permits an orderly transition to the new five year contracts. The following indicates the schedule DHCF will pursue with the Office of Contracts and Procurement to successfully rebid the program.

- October 30, 2012 - Release Request For Proposals (RFP) to solicit new bidders.

- November 30, 2012 - All responses to the RFP from prospective bidders are due

- December 31, 2012 - Select three health plans and award five-year contracts
- February 01, 2013 – Initiate necessary transition activities for any new plans selected to be a part of the program
- May 1, 2013 - New contract year begins

DHCF is cognizant of the challenge this timelines poses for Chartered, especially since we will not award a contract to any company while it is in receivership. Thus, if Chartered is to compete for the next bid, this timeline essentially means that the company will either need to be sold or successfully exit receivership before the contract award date.

This concludes my remarks Chairpersons Catania and Alexander and I welcome your questions and those of other members as well.

EXHIBIT 5

KPMG

D.C. CHARTERED HEALTH PLAN, INC.

(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Financial Statements

December 31, 2005 and 2004

(With Independent Auditors' Report Thereon)

D.C. CHARTERED HEALTH PLAN, INC
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

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KPMG LLP
1660 International Drive
McLean, VA 22102

Independent Auditors' Report

The Board of Directors
D.C. Chartered Health Plan, Inc.:

We have audited the accompanying balance sheets of D.C. Chartered Health Plan, Inc. (the Company), a wholly owned subsidiary of DC Healthcare Systems, Inc., as of December 31, 2005 and 2004, and the related statements of operations, stockholder's equity, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of D.C. Chartered Health Plan, Inc. as of December 31, 2005 and 2004, and the results of its operations and its cash flows for the years then ended, in conformity with U.S. generally accepted accounting principles.

KPMG LLP

May 19, 2006

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Balance Sheets

December 31, 2005 and 2004

Assets		2005	2004
Current assets:			
Cash and cash equivalents	$	20,803,904	16,034,306
Premiums receivable – Medicaid, net (note 1(d))		1,930,172	1,908,923
Reinsurance receivable (note 6)		82,624	229,438
Income tax receivable		—	115,507
Due from affiliates (note 5)		1,965,425	456,149
Prepaid expenses and other current assets		987,846	714,237
Deferred income taxes (note 7)		83,493	70,964
Total current assets		25,853,464	19,529,524
Certificates of deposit-long term		5,741,811	5,541,276
Certificates of deposit – pledged (notes 3 and 9)		2,828,007	2,828,007
Property and equipment, net (note 2)		2,278,179	2,478,290
Goodwill, net (note 1(i))		1,460,583	1,460,583
Noncurrent deferred income taxes (note 7)		611,770	546,150
Other assets		144,734	132,836
Total assets	$	38,918,548	32,516,666
Liabilities and Stockholder's Equity			
Current liabilities:			
Accrued salaries and benefits	$	735,560	588,144
Accounts payable and accrued expenses		1,041,668	904,662
Current portion, capital lease obligation (note 4)		113,936	104,105
Healthcare costs payable (note 8)		13,646,918	13,091,300
Claims payable – uninsured (note 2)		2,037,653	199,442
Unpaid claims adjustment expenses (note 1(g))		422,070	392,739
Total current liabilities		17,997,805	15,280,392
Noncurrent capital lease obligation (note 4)		112,565	226,847
Deferred rent liability		137,178	49,128
Other noncurrent liabilities		24,198	115,315
		18,271,746	15,671,682
Stockholder's equity:			
Class A common stock; $0.10 par value. Authorized, issued, and outstanding 1,000 shares in 2005 and 2004		100	100
Additional paid-in capital		4,690,419	4,690,419
Retained earnings		15,956,283	12,154,465
Total stockholder's equity		20,646,802	16,844,984
Commitments and contingencies (notes 3, 4, 5, 8 and 9)			
Total liabilities and stockholder's equity	$	38,918,548	32,516,666

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Operations

Years ended December 31, 2005 and 2004

	2005	2004
Revenues:		
Medicaid	$ 99,048,249	90,080,546
Commercial and other	—	119
Administrative services fees (note 1(a))	6,946,625	6,938,881
Total revenues	105,994,874	97,019,546
Expenses:		
Healthcare costs, net (notes 5, 6 and 8)	81,765,779	74,602,035
General and administrative costs (notes 1(a), 4, 5 and 10)	18,705,754	17,032,612
Total expenses	100,471,533	91,634,647
Operating income	5,523,341	5,384,899
Other income and expense, net	1,077,390	602,141
Income before income taxes	6,600,731	5,987,040
Provision for income taxes (note 7)	2,798,913	2,706,380
Net income	$ 3,801,818	3,280,660

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Stockholder's Equity

Years ended December 31, 2005 and 2004

	Class A common stock ($0.10 par value; 1,000 shares authorized, issued, and outstanding)	Additional paid-in capital	Retained earnings	Total stockholder's equity
Balance at December 31, 2003	$ 100	4,690,419	8,873,805	13,564,324
Net income	—	—	3,280,660	3,280,660
Balance at December 31, 2004	100	4,690,419	12,154,465	16,844,984
Net income			3,801,818	3,801,818
Balance at December 31, 2005	$ 100	4,690,419	15,956,283	20,646,802

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems. Inc.)

Statements of Cash Flows

Years ended December 31, 2005 and 2004

		2005	2004
Cash flows from operating activities:			
Net income	$	3,801,818	3,280,660
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization		647,678	571,056
Provision for doubtful accounts		—	(2,853)
Changes in operating assets and liabilities:			
Increase in premiums receivable – Medicaid		(21,249)	(187,329)
Decrease (increase) in reinsurance receivable		146,814	(181,126)
Decrease (increase) in income tax receivable		115,507	(115,507)
Decrease (increase) in due from (to) affiliate		(1,509,276)	468,775
Increase in prepaid expenses and other current assets		(273,609)	(140,276)
Increase in deferred income taxes		(78,149)	(35,292)
Increase in other assets		(11,898)	(119,336)
Increase in accrued salaries and benefits		147,416	11,052
Increase (decrease) in accounts payable and accrued expenses		137,006	(799,279)
Increase in healthcare costs payable		555,618	3,179,913
Increase (decrease) in uninsured claims payable		1,838,211	(24,460)
Decrease in deferred revenue		—	(1,895,000)
Increase in unpaid claims adjustment expenses		29,331	86,201
Decrease in other noncurrent liabilities		(91,117)	(82,672)
Increase in deferred rent liability		88,050	49,128
Decrease in income tax payable		—	(591,445)
Net cash provided by operating activities		5,522,151	3,472,210
Cash flows used in investing activities:			
Additions to property and equipment		(447,567)	(1,074,570)
Purchase of certificates of deposit		(200,535)	(157,039)
Net cash used in investing activities		(648,102)	(1,231,609)
Cash flows used in financing activities:			
Principal payments on capital lease obligation		(104,451)	(76,201)
Net increase in cash and cash equivalents		4,769,598	2,164,400
Cash and cash equivalents, beginning of year		16,034,306	13,869,906
Cash and cash equivalents, end of year	$	20,803,904	16,034,306
Supplemental disclosure of cash flow information:			
Income taxes paid	$	3,065,904	3,448,624
Interest paid		41,857	51,271
Supplemental noncash financing activities:			
Assets acquired under capital lease	$	—	188,500

See accompanying notes to financial statements.

(1) Summary of Significant Accounting Policies

(a) Corporate Information and Basis of Accounting

D.C. Chartered Health Plan, Inc. (Chartered) was established on December 31, 1986 under the laws of the District of Columbia. Chartered's primary purpose is to provide quality healthcare within a managed care framework. Chartered accomplishes this primarily through a contract with the District of Columbia Department of Health (DOH), which requires Chartered to provide healthcare services to the Medicaid and Temporary Aid to Needy Families (TANF) residents of the District of Columbia through a Health Maintenance Organization (HMO). Chartered currently provides healthcare services to approximately 38,000 beneficiaries receiving assistance under Medicaid and TANF. Approximately 93% of Chartered's revenue was earned from its Medicaid contract for the years ended December 31, 2005 and 2004. The contract with the DOH requires Chartered to provide transportation services to its Medicaid members through RapidTrans, Inc. (RapidTrans), a wholly owned subsidiary of Chartered's parent, DC Healthcare Systems, Inc. (DCHSI). Chartered also provides the services of a health center to both members and nonmembers through a contract with Chartered Family Health Center, P.C. (CFHC), a wholly owned subsidiary of DCHSI.

Chartered's business strategy lies in its fundamental commitment to promoting access and emphasizing prevention and health maintenance, as well as treatment. Each member enrolled in Chartered is assigned a primary care physician. Chartered has over 1,365 physicians under contract, including 314 primary care physicians. Chartered's members receive prescriptions, health education, nutrition counseling, and when necessary, referrals to specialists and hospital services. Chartered focuses on increasing access to its services by (i) improving knowledge and awareness of benefits; (ii) providing extensive wellness and preventative healthcare services; and (iii) directly providing transportation to and from healthcare appointments.

Medicaid beneficiaries in the District of Columbia are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with DOH commencing May 1, 1998, under which Chartered is designated as the default plan for one-fifth of the Medicaid beneficiaries who do not voluntarily select a plan. The terms of this contract extend through July 31, 2008 and the contract is renewable annually, subject to rate negotiations. The rates for the contract year ending July 31, 2006 have been negotiated and signed by Chartered and DOH. In addition, the rates for contract year ending July 31, 2007 are in the process of being negotiated and finalized between Chartered and DOH.

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As a result of the bankruptcy proceedings of Chartered's previous parent company, the stock of Chartered was held in a trust (the Collateral Trust), and Bank of America, N.A. (BOA) was designated and appointed as the Collateral Trustee, obtaining full legal title to the collateral and full legal power and authority to transfer, sell, assign, or dispose of the collateral, including the stock of Chartered. The Collateral Trust entered into a stock sale and transfer agreement pursuant to which the stock of Chartered was sold to DCHSI. DCHSI financed the purchase through a $3,500,000 bank loan at a floating prime rate of interest. Payments of interest on the loan commenced on June 12, 2000, and continued monthly through May 12, 2001. Payments of principal and interest on the loan commenced on June 12, 2001, and will continue monthly through May 12, 2011. The outstanding principal balance on the loan was $1,313,778 and $1,496,168 at December 31, 2005 and 2004, respectively. Chartered and the owner of DCHSI are guarantors on the loan. This loan is partially collateralized by a $1,000,000 certificate of deposit from DCHSI that will be held for the entire term of the loan. The balance of the certificate of deposit held by DCHSI, including accrued interest was $1,255,386 and $1,206,367 at December 31, 2005 and 2004, respectively. Additionally, Chartered granted the lender a first security interest in certain collateral held by Chartered, except for the $2,828,007 certificates of deposit discussed in notes 3 and 9; however, in the event the lender exercises its rights under the guaranty, the owner of DCHSI has agreed in writing to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered may be obligated to pay under the guaranty.

The accompanying financial statements are presented on the historical basis of accounting and do not reflect any allocation of the purchase price based on the fair value of the assets acquired and the liabilities assumed on May 17, 2000.

(b) Cash and Cash Equivalents

Cash and cash equivalents are generally comprised of highly liquid instruments with original maturities of three months or less.

(c) Property and Equipment

Property and equipment are stated at cost and are depreciated using the straight-line method over a period of three to seven years. Chartered capitalized external direct costs of materials and services and internal payroll costs related to the implementation of a claims management system. Leasehold improvements are also stated at cost and are amortized using the straight-line method over the term of the related lease or the estimated useful life of the improvement, whichever is shorter. Equipment under capital leases is stated at the present value of minimum lease payments and is amortized using the straight-line method over the term of the lease.

(d) Medicaid Revenue

Chartered recognizes premiums received from DOH for members as revenue in the period to which healthcare coverage relates. Member premiums are paid on a fixed monthly fee per capita basis. Medicaid premiums receivable are presented net of allowances for uncollectible amounts of $23,885 in the accompanying balance sheets at December 31, 2005 and 2004.

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(e) Administrative Services Revenue

Chartered has an administrative services agreement (the agreement) with DOH to provide administrative services supporting a program that provides comprehensive, integrated, and coordinated healthcare services for the uninsured population of the District of Columbia. Chartered provides administrative services to approximately 32,000 members. Under the terms of the agreement, Chartered is expected to maintain and administer a network of healthcare providers, provide for the enrollment of eligible individuals in the program, provide general administrative services including claims administration, and provide quality and utilization management services for the program. The effective date of the agreement was June 1, 2001, the agreement extends through May 31, 2006, and may be terminated at any time upon mutual consent of the parties. The agreement also allows for an automatic renewal of two additional two-year terms, unless the parties terminate the agreement in writing 180 days prior to the expiration of each renewal date. Revenue under the contract is due monthly and is recognized during the period in which Chartered is obligated to provide administrative services. Chartered's revenue for these services is negotiated with DOH annually, and was $6,946,625 and $6,938,881 in 2005 and 2004, respectively. Chartered incurred expenses of $7,751,682 and $7,808,397 in 2005 and 2004, respectively, to administer the contract.

Effective June 1, 2006 the DOH voluntarily terminated the administrative services agreement and entered into a new contract with Chartered. Under the new contract Chartered will provide healthcare services to a portion of the uninsured population of the District of Columbia and receive premiums based on a fixed monthly per capita basis of $212.21 per beneficiary per month. Chartered is expected to provide healthcare services to approximately 15,000 beneficiaries.

(f) Reinsurance

Reinsurance premiums and recoveries are reported net as a component of healthcare costs.

(g) Healthcare Costs and Unpaid Claims Adjustment Expenses

Chartered contracts with various healthcare providers for the provision of related medical care services to its members. The providers are compensated based on fixed fees per member per month (capitation), per diem rates, or fee-for-service rates as specified in the provider agreements. Healthcare costs are recognized as services are provided, including estimated amounts for which claims are incurred but not yet reported to Chartered. The liability for healthcare costs is based on historical payment patterns using actuarial techniques. As part of the estimate of the cost of all claims reported but unpaid and claims incurred but not reported, Chartered accrued $422,070 and $392,739 at December 31, 2005 and 2004, respectively, as an estimate of the expense to settle these claims.

(h) Income Taxes

In accordance with the tax sharing agreement with DCHSI, Chartered files a consolidated federal and state income tax return with DCHSI, using an April 30 fiscal year end. Deferred tax assets, deferred tax liabilities, and income tax expense or benefit associated with Chartered have been provided for

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on a separate company basis. In addition, Chartered determines its deferred income taxes on a separate company basis and remits its tax payment to DCHSI.

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

(i) Goodwill

Chartered adopted the provisions of Statement of Financial Accounting Standards (SFAS) No. 142, *Goodwill and Other Intangible Assets* (SFAS No. 142), as of January 1, 2002. SFAS No. 142 requires that goodwill and intangible assets with indefinite useful lives no longer be amortized, but instead be tested for impairment at least annually. As of the date of adoption of SFAS No. 142, Chartered had unamortized goodwill in the amount of $1,460,583, which was subject to the provisions of this statement. During 2002, Chartered completed its analysis pursuant to the transitional provisions of SFAS No. 142 and determined that no impairment charge was necessary. Accumulated amortization related to this goodwill was $554,018 at December 31, 2005 and 2004.

Prior to the adoption of SFAS No. 142, goodwill was amortized on a straight-line basis over 20 years. At each repotting date, Chartered assessed the recoverability of goodwill by determining whether the balance can be recovered through estimated undiscounted future operating cash flows.

(j) Certificates of Deposit

Certificates of deposit are deposits held by financial institutions and are carried at cost. Accrued interest earned on these certificates of deposit are included in investment income due and accrued on the accompanying balance sheets.

(k) Claims Payable – Uninsured

Claims payable – uninsured represent cash received in advance from DOH for the reimbursement of healthcare claims paid by Chartered in accordance with the administrative services agreement.

(l) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

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(m) Reclassifications

Certain reclassifications have been made to the prior year financial statements to conform to the current year presentation.

(2) Property and Equipment

Property and equipment consisted of the following as of December 31:

	2005	2004
Computer software	$ 3,408,951	3,056,454
Computer and office equipment	2,517,115	2,446,191
Office furniture	766,632	766,632
Leasehold improvements and office fixtures	2,844,293	2,820,147
Total cost	9,536,991	9,089,424
Less accumulated depreciation and amortization	7,258,812	6,611,134
Property and equipment, net	$ 2,278,179	2,478,290

Depreciation expense related to property and equipment and amortization expense related to the leasehold improvements and equipment under capital leases was $534,271 and $455,326 for the years ended December 31, 2005 and 2004, respectively. Amortization of capitalized software development costs was $113,407 and $115,730 for the years ended December 31, 2005 and 2004, respectively.

(3) Minimum Net Worth and Regulatory and Contractual Requirements

As required by the District of Columbia's Health Maintenance Organization Act of 1996 (the Act), Chartered entered into a Health Maintenance Organization Custodial Agreement dated February 27, 1998. Chartered maintains a certificate of deposit of $300,000 which is included in certificates of deposit -pledged on the balance sheets at December 31, 2005, for the sole benefit of Chartered's members in the event of Chartered's insolvency. Under the laws of the Act, Chartered is also required to maintain a minimum net worth equal to the greater of (1) $1,000,000; (2) the sum of all uncovered healthcare expenditures for the latest three-month periods ending December 31, March 31, June 30, or September 30; (3) 2% of its annual revenues; or (4) a prescribed percentage of annual healthcare expenditures. At December 31, 2005 and 2004, Chartered's statutory net worth was $15,945,518 and $11,843,556, respectively. Chartered was in compliance with its statutory net worth requirements.

Under the terms of its Medicaid contract with DOH dated August 1, 2002, Chartered is also required to meet certain financial requirements to maintain compliance with these contract terms. As such, chartered is required to maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the District of Columbia's Department of Insurance, Securities and Banking Regulation as a condition for maintaining a certificate of authority to operate an HMO in the District. These requirements establish a minimum reserve or deposits balance threshold of the greater of (1) $1,000,000, or (2) 2% of 2005 Chartered revenue, net of reinsurance expense (see note 6), of $98,538,389 which is $1,970,768. Chartered maintained a Medicaid escrow deposit of $1,940,077, which is included in certificates of deposit – pledged on the balance sheets at December 31, 2005 and 2004. Chartered intends to increase the escrow deposit up to $1,970,768 by the end of 2006 to satisfy the contractual requirements. Therefore, the insolvency reserve or deposits balance requirement for compliance with the Medicaid contract will and have been met by the Company.

The National Association of Insurance Commissioners developed the Managed Care Organization Risk-Based Capital Report and required all HMOs to complete the report beginning with the year ended December 31, 1998. Risk-based capital (RBC) was developed as a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. A company's RBC is calculated by applying certain factors to various asset, premium, and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. These levels range from Company Action Level (CAL) to Mandatory Control Level (MCL). Effective January 1, 2001, all HMOs licensed in the District of Columbia became subject to the RBC provisions. Chartered's RBC exceeded all action levels as of December 31, 2005 and 2004.

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(4) Commitments and Contingencies

(a) Leases

Chartered is obligated under several noncancelable operating and capital leases for office space, office equipment, and vehicles. Future amounts due under these leases are as follows:

	Operating	Capital
2006	$ 847,378	$ 130,611
2007	868,563	87,586
2008	890,277	32,246
2009	912,533	—
2010	935,347	—
Thereafter	3,458,546	—
	$ 7,912,644	250,443
Less amounts representing interest		23,942
		226,501
Less current portion of capital lease obligation		113,936
		$ 112,565

Total rent expense was $915,780 and $1,007,647 for the years ended December 31, 2005 and 2004, respectively.

(b) Litigation and Contingencies

Chartered is from time to time subject to claims and suits arising in the ordinary course of business. In the opinion of management, the ultimate resolution of pending legal proceedings will not have a material effect on the financial statements.

(c) Employment Contracts

Chartered has entered into employment agreements with its key executives, establishing minimum compensation levels, severance and certain other benefits.

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(5) Related-Party Transactions

Chartered has entered into various management and services arrangements with certain related parties, including DCHSI, CFHC, and RapidTrans. These arrangements do not include an accrued interest component and are expected to be recovered within one year of the balance sheet date, and are therefore classified as current assets in the accompanying balance sheets. Management believes that all amounts due from affiliates are fully collectible and expects that they will be repaid during 2006. Amounts due from affiliates are comprised of the following at December 31:

	2005	2004
Due from DCHSI	$ 1,713,246	26,000
Due from CFHC	214,108	133,296
Due from RapidTrans	38,071	296,853
	$ 1,965,425	456,149

(a) DC Healthcare Systems, Inc.

Chartered has an agreement with DCHSI for technical and professional consulting services in connection with the HMO business and healthcare insurance business of Chartered. In exchange for these services received from DCHSI, Chartered is obligated to pay consulting fees and related expenses to DCHSI. The term of the consulting agreement is three years and can be terminated by DCHSI at any time. Chartered recorded consulting fees and related expenses of approximately $1,800,000 under the terms of this agreement for each of the years ended December 31, 2005 and 2004, respectively.

On August 29, 2003, Chartered entered into a noncancelable operating lease agreement to lease office space from DCHSI. The lease commenced July 1, 2004 and expires on June 30, 2014. The base annual rent is $25 per square foot for 32,660 square feet space with 2.5% annual rate increase.

At December 31, 2005, amounts due from DCHSI of $1,713,246 is primarily related to overpayment of federal and state income taxes and adjustment for expense allocation by Chartered to DCHSI.

(b) Chartered Family Health Center

CFHC, a wholly owned subsidiary of DCHSI, is an 18,000 square foot health center on Minnesota Avenue in the District of Columbia. It has full-time staff of board-certified family physicians, pediatricians, internists, and OB-GYNs backed by an ancillary staff of nurses, radiology and laboratory technicians, pharmacists, and medical assistants. Chartered pays capitation fees to CFHC for professional medical services performed on behalf of Chartered members enrolled at CFHC. Chartered paid capitation fees to CFHC in the amounts of $6,566,840 and $6,236,729 for the years ended December 31, 2005 and 2004, respectively. All amounts due from CFHC at December 31, 2005 and 2004 are included in due from affiliates in the accompanying financial statements.

At December 31, 2005, amounts due from CFHC of $214,108 is related to the payroll and related benefit expenses paid by Chartered for CFHC employees.

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(c) RapidTrans

RapidTrans, a wholly owned subsidiary of DCHSI, provides transportation services to Chartered's Medicaid members and Chartered provides certain management services to RapidTrans. Chartered pays capitation fees to RapidTrans for the transportation services and receives payment to cover the value of services provided. Chartered paid capitation fees to RapidTrans in the amounts of $2,940,569 and $2,385,802 for the years ended December 31, 2005 and 2004, respectively, which are included in healthcare costs in the accompanying financial statements. All amounts due from RapidTrans at December 31, 2005 and 2004 are included in due from affiliates in the accompanying financial statements. In the event that RapidTrans' revenues do not cover its expenses, Chartered agreed to cover the excess expenses on RapidTrans' behalf. In 2005, no additional amounts are due to RapidTrans under the terms of the agreements.

At December 31, 2005, amounts due from RapidTrans of $38,071 is related to the payroll and related benefit expenses paid by Chartered for RapidTrans employees.

(d) Thompson, Cobb, Bazilio and Associates, PC

Thompson, Cobb, Bazilio & Associates, PC (TCBA) is an accounting and management consulting firm that is 79.5% owned by the owner of DCHSI. During 2005, TCBA provided certain professional consulting services to Chartered. In exchange for these services, Chartered paid TCBA $235,827 during 2005 as a reimbursement for its actual labor cost plus overhead and general and administrative costs calculated at TCBA's approved Federal Government GSA overhead and General and Administrative rates, without any profit markup to TCBA. The amount paid to TCBA under this cost reimbursement agreement is included in general and administrative expenses in the accompanying statements of operations.

(6) Reinsurance Coverage

Chartered has entered into a reinsurance agreement with an insurance company to limit its losses on individual claims. The contract provides coverage for 80% of hospital claims in excess of $90,000, subject to certain limitations, with an annual limit of $1,000,000 per enrollee and a lifetime limit of $2,000,000 per enrollee. Total reinsurance premiums expense for the years ended December 31, 2005 and 2004 was $509,860 and $754,419, respectively, and is included in healthcare costs in the accompanying statements of operations. Claim recoveries of $297,177 and $558,884 for the years ended December 31, 2005 and 2004, respectively, were netted against healthcare costs in the accompanying statements of operations.

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(7) Income Taxes

Income tax expense (benefit) related to the continuing operations for the years ended December 31, 2005 and 2004 consisted of the following:

		Current	Deferred	Total
Year ended December 31, 2005:				
U.S. federal	$	2,194,240	(59,358)	2,134,882
State and local		682,822	(18,791)	664,031
	$	2,877,062	(78,149)	2,798,913
Year ended December 31, 2004:				
U.S. federal	$	2,099,181	(26,806)	2,072,375
State and local		642,491	(8,486)	634,005
	$	2,741,672	(35,292)	2,706,380

Income tax expense was $2,798,913 and $2,706,380 for the years ended December 31, 2005 and 2004, respectively. The income tax expenses differed from the amounts computed by applying the U.S. federal statutory income tax rate of 35% to pretax income as a result of the following:

		2005	2004
Computed "expected" tax expense	$	2,310,256	2,095,464
Increase in income taxes resulting from:			
State and local income taxes, net of federal income tax benefit		427,975	388,185
Other, net		60,682	222,731
Income tax expense		2,798,913	2,706,380

(Continued)

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets at December 31, 2005 and 2004 are presented below:

	2005	2004
Deferred tax assets:		
Accounts receivable principally due to allowance for doubtful accounts	$ 9,908	9,908
Compensated absences, principally due to accrual for financial reporting purposes	42,019	61,056
Amortization of membership list	127,672	140,767
Property and equipment principally due to difference in depreciation	458,757	385,003
Deferred straight line lease expense	56,907	20,380
	$ 695,263	617,114

The Company establishes valuation allowances in accordance with the provisions of SFAS No. 109, *Accounting for Income Taxes*. A valuation allowance was not recognized as of December 31, 2005 and 2004, because it is more likely than not that the deferred tax assets will be realized.

Utilization of the Company's net operating loss carryforwards may be subject to limitation under the Internal Revenue Code Section 382 (Section 382). Generally, these limitations restrict the availability of net operating loss carryforwards upon certain changes in ownership by 5% shareholders which, in aggregate, exceed fifty percentage points in value in a three-year period. As a result of the transfer of title of Chartered stock to the Collateral Trust effective December 31, 1999 and the purchase of the Chartered stock in May 2000 by DCHSI, the ownership change provisions of Section 382 may apply. Management has not yet fully determined the amount of the net operating loss carryforwards that might exist at December 31, 2005; therefore, no amount was reported in the accompanying financial statements.

(Continued)

(8) Healthcare Costs Payable

A summary of the activity for healthcare costs payable is as follows:

	2005	2004
Balance at January 1	$ 13,091,300	9,911,387
Plus incurred related to:		
Current year	64,368,683	55,617,404
Prior years	(2,196,682)	(286,580)
Total incurred	62,172,001	55,330,824
Less paid related to:		
Current year	50,396,532	42,133,365
Prior years	11,219,851	10,017,546
Total incurred	61,616,383	52,150,911
Balance at December 31	$ 13,646,918	13,091,300

Chartered uses actuarial techniques based on historical experience to estimate incurred claims. Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred related to prior years result from claims being settled for amounts less than originally estimated. This experience is primarily attributable to actual medical cost experience more favorable than that assumed at the time the liability was established. The Company incurred other healthcare costs, which primarily consisted of capitation payments to providers of healthcare services for Chartered's members of $19,593,778 and $19,271,211 for the years ended December 31, 2005 and 2004, respectively.

(9) Professional Liability Insurance

During 2005 and 2004, Chartered maintained a medical professional liability insurance policy, which is written on a claims-made basis. The coverage limits for the primary medical professional liability policy are $1,000,000 per loss event and a $3,000,000 policy limit per physician. This policy remained in full force and effect during 2005 and 2004 and has been renewed through May 2006. Chartered has not accrued for claims incurred but not reported as of December 31, 2005 and 2004 as these amounts are not reasonably estimable. Management believes that these amounts would not have a material impact on Chartered's financial statements as of December 31, 2005 and 2004.

Chartered is required to maintain deposits in accordance with the terms of the medical professional liability policy. In accordance with this policy, Chartered maintained a certificate of deposit of $200,000 at December 31, 2005 and 2004, which is included in the balance of certificates of deposit – pledged in the accompanying balance sheets.

(Continued)

In management's opinion, there are no pending or anticipated claims against the Company that will have a material effect on the financial position, results of operations, or cash flows of the Company.

(10) Defined Contribution 401(k) Plan

Chartered sponsors a 401(k) plan (the Plan) for its employees. Employees are eligible to participate in the Plan if they are at least 21 years of age and have worked 90 days or longer at Chartered. Employees may contribute between 1% and 12% of eligible salary on a pre-tax basis. Chartered may make a discretionary matching contribution to the Plan of 12% of each employees' contribution amount. Chartered contributed $27,705 and $26,498 to the Plan for the years ended December 31, 2005 and 2004, respectively.

(11) Subsequent Event

On March 12, 2006 the Board of Directors of Chartered approved an ordinary dividend distribution to its parent holding company, D.C. Healthcare Systems, Inc., in the amount of $1,536,543. The dividend was for the year ended December 31, 2005 and made pursuant to District of Columbia regulation DC ST Section 31-706. Chartered paid the amount in full on April 13, 2006.

KPMG

D.C. CHARTERED HEALTH PLAN, INC.

(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Financial Statements

December 31, 2006 and 2005

(With Independent Auditors' Report Thereon)

D.C. CHARTERED HEALTH PLAN, INC
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

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KPMG LLP
1660 International Drive
McLean, VA 22102

Independent Auditors' Report

The Board of Directors
D.C. Chartered Health Plan, Inc.:

We have audited the accompanying balance sheets of D.C. Chartered Health Plan, Inc. (Chartered), a wholly owned subsidiary of DC Healthcare Systems, Inc., as of December 31, 2006 and 2005, and the related statements of operations, stockholder's equity, and cash flows for the years then ended. These financial statements are the responsibility of the Chartered's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Chartered's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Chartered's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of D.C. Chartered Health Plan, Inc. as of December 31, 2006 and 2005, and the results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

May 24, 2007

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Balance Sheets

December 31, 2006 and 2005

Assets	2006	2005
Current assets:		
Cash and cash equivalents	$ 19,340,509	20,803,904
Premiums receivable, net	8,718,874	1,930,172
Reinsurance receivable	184,974	82,624
Due from affiliates (note 5)	593,270	1,965,425
Prepaid expenses and other current assets	545,896	683,712
Interest income receivable	441,213	304,134
Deferred income taxes (note 7)	156,565	83,493
Total current assets	29,981,301	25,853,464
Certificates of deposit-long term	11,051,013	5,741,811
Certificates of deposit – pledged (notes 3, 4(a), and 9)	2,828,007	2,828,007
Property and equipment, net (note 2)	1,873,536	2,278,179
Goodwill, net	1,460,583	1,460,583
Noncurrent deferred income taxes (note 7)	740,160	611,770
Other assets	144,734	144,734
Total assets	$ 48,079,334	38,918,548
Liabilities and Stockholder's Equity		
Current liabilities:		
Accrued salaries and benefits	$ 829,200	735,560
Accounts payable and accrued expenses	1,094,138	1,041,668
Current portion, capital lease obligation (note 4)	81,072	113,936
Healthcare costs payable (note 8)	19,801,826	13,646,918
Claims payable – uninsured (note 1(k))	479,145	2,037,653
Unpaid claims adjustment expenses (note 1(g))	612,428	422,070
Total current liabilities	22,897,809	17,997,805
Noncurrent capital lease obligation (note 4)	31,493	112,565
Deferred rent liability	204,560	137,178
Other noncurrent liabilities	—	24,198
	23,133,862	18,271,746
Commitments and contingencies (notes 3, 4, 5, 8 and 9)		
Stockholder's equity:		
Class A common stock; $0.10 par value. Authorized, issued, and outstanding 1,000 shares in 2006 and 2005	100	100
Additional paid-in capital	4,690,419	4,690,419
Retained earnings	20,254,953	15,956,283
Total stockholder's equity	24,945,472	20,646,802
Total liabilities and stockholder's equity	$ 48,079,334	38,918,548

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Operations

Years ended December 31, 2006 and 2005

	2006	2005
Revenues:		
Medicaid premiums	$ 103,205,005	99,048,249
Alliance premiums	28,839,763	—
Administrative services fees (note 1(e))	3,829,691	6,946,625
Total revenues	135,874,459	105,994,874
Expenses:		
Healthcare costs, net (notes 5, 6 and 8)	111,237,638	81,765,779
General and administrative costs (notes 1(a), 2, 4, 5 and 10)	16,934,025	18,705,754
Total expenses	128,171,663	100,471,533
Operating income	7,702,796	5,523,341
Other income and expense, net	2,329,280	1,077,390
Income before income taxes	10,032,076	6,600,731
Provision for income taxes (note 7)	4,196,862	2,798,913
Net income	$ 5,835,214	3,801,818

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Cash Flows

Years ended December 31, 2006 and 2005

	2006	2005
Cash flows from operating activities:		
Net income	$ 5,835,214	3,801,818
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	668,455	647,678
Changes in operating assets and liabilities:		
Premiums receivable	(6,788,702)	(21,249)
Reinsurance receivable	(102,350)	146,814
Income tax receivable	—	115,507
Due from affiliates	1,372,155	(1,509,276)
Interest income receivable, prepaid expenses and other current assets	737	(273,609)
Deferred income taxes	(201,462)	(78,149)
Other assets	—	(11,898)
Accrued salaries and benefits	93,640	147,416
Accounts payable and accrued expenses	52,470	137,006
Healthcare costs payable	6,154,908	555,618
Uninsured claims payable	(1,558,508)	1,838,211
Unpaid claims adjustment expenses	190,358	29,331
Other noncurrent liabilities	(24,198)	(91,117)
Deferred rent liability	67,382	88,050
Net cash provided by operating activities	5,760,099	5,522,151
Cash flows from investing activities:		
Additions to property and equipment	(263,812)	(447,567)
Purchase of certificates of deposit	(5,309,202)	(200,535)
Net cash used in investing activities	(5,573,014)	(648,102)
Cash flows from financing activities:		
Dividends paid	(1,536,544)	—
Principal payments on capital lease obligation	(113,936)	(104,451)
Net cash used in financing activities	(1,650,480)	(104,451)
Net increase (decrease) in cash and cash equivalents	(1,463,395)	4,769,598
Cash and cash equivalents, beginning of year	20,803,904	16,034,306
Cash and cash equivalents, end of year	$ 19,340,509	20,803,904
Supplemental disclosure of cash flow information:		
Income taxes paid	$ 2,700,146	3,065,904
Interest paid	23,582	41,857

See accompanying notes to financial statements.

(1) Summary of Significant Accounting Policies

(a) Corporate Information and Basis of Accounting

D.C. Chartered Health Plan, Inc. (Chartered) was established on December 31, 1986 under the laws of the District of Columbia. Chartered's primary purpose is to provide quality healthcare within a managed care framework. Chartered accomplishes this primarily through a contract with the District of Columbia Department of Health (the DOH), which requires Chartered to provide healthcare services to the residents of the District of Columbia that qualify under the Medicaid, Temporary Aid to Needy Families (TANF), and Alliance programs through a Health Maintenance Organization (HMO). Alliance enrollees represent the population not eligible for Medicaid but whose income falls 200% or more below the poverty level. Chartered currently provides healthcare services to approximately 60,000 beneficiaries receiving assistance under Medicaid, Alliance and TANF. Approximately 97% and 93% of Chartered's revenue was earned from its contracts with the DOH for the years ended December 31, 2006 and 2005, respectively. The contract with the DOH requires Chartered to provide transportation services to its Medicaid members. Chartered provides these services through a contract with RapidTrans, Inc. (RapidTrans), a wholly owned subsidiary of Chartered's parent, DC Healthcare Systems, Inc. (DCHSI). Chartered also provides the services of a health center to members through a contract with Chartered Family Health Center, P.C. (CFHC), a wholly owned subsidiary of DCHSI.

Chartered's business strategy lies in its fundamental commitment to promoting access and emphasizing prevention and health maintenance, as well as treatment. Each member enrolled in Chartered is assigned a primary care physician. Chartered has over 1,365 physicians under contract, including 314 primary care physicians. Chartered's members receive prescriptions, health education, nutrition counseling, and when necessary, referrals to specialists and hospital services. Chartered focuses on increasing access to its services by (i) improving knowledge and awareness of benefits; (ii) providing extensive wellness and preventative healthcare services; and (iii) directly providing transportation to and from healthcare appointments.

Medicaid beneficiaries in the District of Columbia are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DOH commencing May 1, 1998, under which Chartered is designated as the default plan for one-third of the Medicaid beneficiaries who do not voluntarily select a plan. The terms of this 5-year contract extend through July 31, 2007 and the contract is renewable annually, subject to rate negotiations. The rates for the contract year ending July 31, 2007 have been negotiated and signed by Chartered and the DOH. In addition, the rates for contract year beyond July 31, 2007 are in the process of being finalized between Chartered and the DOH.

Alliance beneficiaries in the District of Columbia are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DOH commencing June 1, 2006, under which Chartered is designated as the default plan for one-half of the Alliance beneficiaries who do not voluntarily select a plan. The Alliance program is administered by the Healthcare Safety Net Administration (HSNA), a department of the DOH. The terms of this contract

(Continued)

extend through July 31, 2007 and the contract is renewable annually, subject to rate negotiations. The rates for the contract year ending July 31, 2007 have been negotiated and signed by Chartered and the DOH. In addition, the rates for contract year beyond July 31, 2007 are in the process of being finalized between Chartered and the DOH.

As a result of the bankruptcy proceedings of PHP Corporation, Chartered's previous parent company, the stock of Chartered was held in a trust (the Collateral Trust), and Bank of America, N.A. (BOA) was designated and appointed as the Collateral Trustee, obtaining full legal title to the collateral and full legal power and authority to transfer, sell, assign, or dispose of the collateral, including the stock of Chartered. The Collateral Trust entered into a stock sale and transfer agreement pursuant to which the stock of Chartered was sold to DCHSI on May 17, 2000. DCHSI financed the purchase through a $3,500,000 bank loan at a floating prime rate of interest. Payments of interest on the loan commenced on June 12, 2000, and continued monthly through May 12, 2001. Payments of principal and interest on the loan commenced on June 12, 2001, and will continue monthly through May 12, 2011. The outstanding principal balance on the loan was $1,131,276 and $1,313,778 at December 31, 2006 and 2005, respectively. Chartered and the owner of DCHSI are guarantors on the loan. This loan is partially collateralized by a $1,000,000 certificate of deposit from DCHSI that will be held for the entire term of the loan. The balance of the certificate of deposit held by DCHSI, including accrued interest was $1,313,047 and $1,255,386 at December 31, 2006 and 2005, respectively. Additionally, Chartered granted the lender a first security interest in certain collateral held by Chartered, except for the $2,828,007 certificates of deposit discussed in notes 3, 4(a), and 9; however, in the event the lender exercises its rights under the guaranty, the owner of DCHSI has agreed in writing to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered may be obligated to pay under the guaranty.

The accompanying financial statements are presented on the historical basis of accounting and do not reflect any allocation of the purchase price based on the fair value of the assets acquired and the liabilities assumed on May 17, 2000, pursuant to the May 17, 2000 stock sale and transfer agreement with the Collateral Trust.

(b) Cash and Cash Equivalents

Cash and cash equivalents are generally comprised of highly liquid instruments with original maturities of three months or less.

(c) Property and Equipment

Property and equipment are stated at cost and are depreciated using the straight-line method over a period of three to seven years. Chartered capitalized external direct costs of materials and services and internal payroll costs related to the implementation of a claims management system. Leasehold improvements are also stated at cost and are amortized using the straight-line method over the term of the related lease or the estimated useful life of the improvement, whichever is shorter. Equipment under capital leases is stated at the present value of minimum lease payments and is amortized using the straight-line method over the term of the lease.

(d) Premium Revenue

Medicaid

Chartered recognizes premiums received from the DOH for members enrolled in the Medicaid program as revenue in the period to which healthcare coverage relates. Member premiums are paid on a fixed monthly fee per capita basis.

Alliance

Effective June 1, 2006, the DOH terminated the administrative services agreement for the Alliance program and entered into a new contract with Chartered.

Under the new contract with the DOH, effective June 1, 2006, Chartered will provide healthcare services to approximately 50% of the uninsured population of the District of Columbia and receive premiums based on a fixed fee per capita basis. Chartered is expected to provide healthcare services to approximately 22,000 beneficiaries under this contract, as of December 31, 2006.

(e) Administrative Services Revenue

Prior to June 1, 2006, Chartered had an administrative services agreement (the Agreement) with DOH to provide administrative services supporting a program that provides comprehensive, integrated, and coordinated healthcare services for the uninsured population of the District of Columbia. Chartered provided administrative services for approximately 32,000 members under the Agreement. Under the terms of the Agreement, Chartered was expected to maintain and administer a network of healthcare providers, provide for the enrollment of eligible individuals in the program, provide general administrative services including claims administration, and provide quality and utilization management services for the program. The effective date of the Agreement was June 1, 2001, the Agreement extended through May 31, 2006. Revenue under the Agreement was due monthly and is recognized during the period in which Chartered is obligated to provide administrative services. Chartered's fees for these services are negotiated with the DOH annually, and was $3,829,691 and $6,946,625 in 2006 and 2005, respectively. Chartered incurred expenses of $3,100,704 and $7,751,682 in 2006 and 2005, respectively, to administer the Agreement. Effective June 1, 2006, the administrative services agreement with the DOH ended and Chartered entered into a new contract with the DOH.

(f) Reinsurance

Reinsurance premiums and recoveries are reported net as a component of healthcare costs.

(g) Healthcare Costs and Unpaid Claims Adjustment Expenses

Chartered has entered into hospital service contracts, to provide the necessary inpatient and outpatient hospital services to its enrollees. Under the contracts, Chartered pays the participating hospitals at the fee-for-service rates in effect at the time the services were provided to its enrollees less any discounts which are available. Chartered has also entered into several agreements with network physicians and suppliers to provide medical services and supplies to Chartered's enrollees at agreed upon fee-for-service rates or at fixed fees per member per month (capitation).

(Continued)

Monthly capitation payments to primary care physicians and other health care providers are expensed as incurred. Healthcare costs and healthcare costs payable include amounts for known services rendered and an estimate of incurred but not reported services rendered by hospitals, physicians, and other health care providers. The estimated incurred but not reported healthcare costs payable has been actuarially determined based on relevant industry data and Chartered's historical trends. Management believes that the methodologies employed to estimate the healthcare costs payable are reasonable and that the amount accrued is appropriate. Due to uncertainties inherent in the medical claims estimation process, there is a reasonable possibility that actual experience may vary from accrued amounts.

As part of the estimate of the cost of all claims reported but unpaid and claims incurred but not reported, Chartered accrued $612,428 and $422,070 at December 31, 2006 and 2005, respectively, as an estimate of the expense to settle these claims.

(h) Income Taxes

In accordance with the tax allocation agreement with DCHSI, Chartered files a consolidated federal and state income tax return with DCHSI, using an April 30 fiscal year end. Deferred tax assets, deferred tax liabilities, and income tax expense or benefit associated with Chartered have been provided for on a separate company basis. In addition, Chartered determines its deferred income taxes on a separate company basis and remits its tax payment to DCHSI.

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

(i) Goodwill

Goodwill is primarily attributable to acquisitions made by Chartered. An impairment evaluation of goodwill, is conducted annually, or more frequently if events or changes in circumstances indicate that an asset might be impaired. The estimated fair value is determined on the basis of discounted future cash flows and is compared with the carrying amount. If the estimated fair value of the goodwill is less than the carrying amount, then an impairment charge is recorded for the difference.

(j) Certificates of Deposit

Certificates of deposit are deposits held by financial institutions and are carried at cost. Accrued interest earned on these certificates of deposit are included in prepaid expenses and other current assets on the accompanying balance sheets.

(Continued)

(k) Claims Payable – Uninsured

Claims payable – uninsured represent cash received in advance from the DOH for the reimbursement of healthcare claims paid by Chartered in accordance with the administrative services agreement.

(l) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(m) Reclassifications

Certain items in the 2005 financial statements have been reclassified to conform to 2006 presentation.

(2) Property and Equipment

Property and equipment consisted of the following as of December 31:

		2006	2005
Computer software	$	3,280,727	3,408,951
Computer and office equipment		2,588,211	2,517,115
Office furniture		699,137	766,632
Leasehold improvements and office fixtures		2,871,961	2,844,293
Total cost		9,440,036	9,536,991
Less accumulated depreciation and amortization		7,566,500	7,258,812
Property and equipment, net	$	1,873,536	2,278,179

Depreciation expense related to property and equipment and amortization expense related to the leasehold improvements and equipment under capital leases was $594,277 and $534,271 for the years ended December 31, 2006 and 2005, respectively. Amortization of capitalized software development costs was $74,178 and $113,407 for the years ended December 31, 2006 and 2005, respectively.

(3) Minimum Net Worth and Regulatory and Contractual Requirements

As required by the District of Columbia's Health Maintenance Organization Act of 1996 (the Act), Chartered entered into a Health Maintenance Organization Custodial Agreement dated February 27, 1998. Chartered maintains a certificate of deposit of $300,000, which is included in certificates of deposit -pledged on the balance sheets at December 31, 2006, for the sole benefit of Chartered's members in the event of Chartered's insolvency. Under the laws of the Act, Chartered is also required to maintain a minimum net worth equal to the greater of (1) $1,000,000; (2) the sum of all uncovered healthcare expenditures for the latest three-month periods ending December 31, March 31, June 30, or September 30;

(3) 2% of its annual revenues; or (4) a prescribed percentage of annual healthcare expenditures. At December 31, 2006 and 2005, Chartered's statutory net worth was $20,717,538 and $15,945,518, respectively. Chartered was in compliance with its statutory net worth requirements.

Under the terms of its Medicaid contract with the DOH dated August 1, 2002, Chartered is also required to meet certain financial requirements to maintain compliance with these contract terms. As such, Chartered is required to maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the District of Columbia's Department of Insurance, Securities and Banking Regulation as a condition for maintaining a certificate of authority to operate an HMO in the District. Chartered met or exceeded the minimum net worth, insolvency reserve, and deposit balance requirements as of December 31, 2006 and 2005. Pursuant to the terms of the Medicaid contract with the DOH, Chartered maintained an escrow deposit of $1,940,077, which is included in certificates of deposit – pledged on the balance sheets at December 31, 2006 and 2005.

The National Association of Insurance Commissioners developed the Managed Care Organization Risk-Based Capital Report and required all HMOs to complete the report beginning with the year ended December 31, 1998. Risk-based capital (RBC) was developed as a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. A company's RBC is calculated by applying certain factors to various asset, premium, and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. These levels range from Company Action Level (CAL) to Mandatory Control Level (MCL). All HMOs licensed in the District of Columbia are subject to the RBC provisions. Chartered's RBC exceeded all action levels as of December 31, 2006 and 2005.

(4) Commitments and Contingencies

(a) Leases

Chartered is obligated under several noncancelable operating and capital leases for office space, office equipment, and vehicles. Future amounts due under these leases are as follows:

	Operating	Capital
2007	$ 868,563	$ 87,587
2008	890,277	31,844
2009	912,533	—
2010	935,347	—
	$ 3,606,720	119,431
Less amounts representing interest		6,866
		112,565
Less current portion of capital lease obligation		81,072
		$ 31,493

(Continued)

Total rent expense was $913,017 and $915,780 for the years ended December 31, 2006 and 2005, respectively.

Chartered is required to maintain deposits in accordance with certain capital lease agreements. Accordingly, Chartered maintained a certificate of deposit of $387,930 at December 31, 2006 and 2005, which is included in certificate of deposit – pledged in the accompanying balance sheets.

(b) Litigation and Contingencies

Chartered is from time to time subject to claims and suits arising in the ordinary course of business. In the opinion of management, the ultimate resolution of pending legal proceedings will not have a material effect on the financial statements.

(c) Employment Contracts

Chartered has entered into employment agreements with its key executives, establishing minimum compensation levels, performance requirements, severance and certain other benefits.

(5) Related-Party Transactions

Chartered has entered into various management and services arrangements with certain related parties, including DCHSI, CFHC, and RapidTrans. Payments under these arrangements do not include an accrued interest component and are expected to be recovered within one year of the balance sheet date, and are therefore classified as current assets in the accompanying balance sheets. Management believes that all amounts due from affiliates are fully collectible and expects that they will be repaid during 2007. Amounts due from affiliates are comprised of the following at December 31:

	2006	2005
Due from DCHSI	$ 15,069	1,713,246
Due from CFHC	354,526	214,108
Due from RapidTrans	223,675	38,071
	$ 593,270	1,965,425

(a) DC Healthcare Systems, Inc.

Chartered has a management service and cost allocation agreement with DCHSI for technical and professional consulting services in connection with the HMO business and healthcare insurance business of Chartered. In exchange for these services received from DCHSI, Chartered is obligated to pay consulting fees and related allocated costs and expenses to DCHSI. The term of the agreement is from May 18, 2000 to September 30, 2007 and can be terminated by DCHSI at any time. Chartered recorded consulting fees and related allocated costs and expenses of approximately $1,800,000 under the terms of this agreement for each of the years ended December 31, 2006 and 2005, respectively.

On August 29, 2003, Chartered entered into a noncancelable operating lease agreement to lease office space from DCHSI. The lease commenced July 1, 2004 and expires on June 30, 2014. The

(Continued)

base annual rent is $25 per square foot for 32,660 square feet of space with a 2.5% annual rate increase. Chartered recorded rent expense of $913,017 and $915,780 under the terms of this agreement for the years ended December 31, 2006 and 2005, respectively.

Amounts due from DCHSI are primarily related to overpayment of federal and state income taxes and adjustment for expense allocation by Chartered to DCHSI and were $15,069 and $1,713,246 for the years ended December 31, 2006 and 2005, respectively.

(b) Chartered Family Health Center

CFHC, a wholly owned subsidiary of DCHSI, is an 18,000 square foot full service health center on Minnesota Avenue in the District of Columbia. It has full-time staff of board-certified family physicians, pediatricians, internists, OB-GYNs, and other medical specialists backed by an ancillary staff of nurses, radiology and laboratory technicians, pharmacists, and medical assistants. Chartered pays capitation fees to CFHC for professional medical services performed on behalf of Chartered members enrolled at CFHC. Chartered paid capitation fees to CFHC in the amounts of $6,116,592 and $6,566,840 for the years ended December 31, 2006 and 2005, respectively. All amounts due from CFHC at December 31, 2006 and 2005, are included in due from affiliates in the accompanying financial statements.

Amounts due from CFHC are related primarily to management fees Chartered assessed CFHC for accounting and administrative services, payroll and related benefits expenses paid by Chartered and were $354,526 and $214,108 for the years ended December 31, 2006 and 2005, respectively.

(c) RapidTrans

RapidTrans, a wholly owned subsidiary of DCHSI, provides transportation services to Chartered's Medicaid members and Chartered provides certain management services to RapidTrans. Chartered pays capitation fees to RapidTrans for the transportation services and receives payment to cover the value of services provided. Chartered paid capitation fees to RapidTrans in the amounts of $2,468,729 and $2,940,569 for the years ended December 31, 2006 and 2005, respectively, which are included in healthcare costs in the accompanying financial statements. All amounts due from RapidTrans at December 31, 2006 and 2005 are included in due from affiliates in the accompanying financial statements. In the event that RapidTrans' revenues do not cover its expenses, Chartered agreed to cover the excess expenses on RapidTrans' behalf. In 2006, no additional amounts are due to RapidTrans under the terms of the agreements.

Amounts due from RapidTrans are related primarily to management fees Chartered assessed RapidTrans for accounting and administrative services, payroll and related benefits expenses paid by Chartered and were $223,675 and $38,071 for the years ended December 31, 2006 and 2005, respectively.

(d) Thompson, Cobb, Bazilio and Associates, PC

Thompson, Cobb, Bazilio & Associates, PC (TCBA) is an accounting and management consulting firm that is 79.5% owned by the owner of DCHSI. TCBA provides certain professional consulting services to Chartered. In exchange for these services, Chartered reimburses TCBA for its actual labor

(Continued)

cost plus overhead and general and administrative costs calculated at TCBA's approved Federal Government GSA overhead and General and Administrative rates, without any profit markup to TCBA. The amounts paid to TCBA under this cost reimbursement agreement were $381,031 and $235,827 for the years ended December 31, 2006 and 2005, respectively, and are included in general and administrative expenses in the accompanying statements of operations.

(6) Reinsurance Coverage

The Company is financially responsible for the cost of each enrollee's annual medical services. Annual inpatient hospital services per enrollee were limited as follows for the years ended December 31, 2006 and 2005:

Effective dates	Limits of coverage
October 1, 2005 through September 30, 2006	$90,000 plus 20% of paid services in excess of the $90,000 stop-loss amount
October 1, 2006 through September 30, 2007	$125,000 plus 20% of paid services in excess of the $125,000 stop-loss amount

Coverage above these stop-loss amounts is provided by an insurance company. The maximum reimbursement per enrollee is limited to $2,000,000 in aggregate over all contract years.

For the years ended December 31, 2006 and 2005, the Company incurred stop-loss insurance premium expense of $559,548 and $509,860, respectively. For the years ended December 31, 2006 and 2005, the Company had stop-loss insurance recoveries of $340,625 and $297,177, respectively. These amounts related to the stop-loss insurance arrangement are included in medical services in the accompanying statements of operations.

(7) Income Taxes

Income tax expense (benefit) related to the continuing operations for the years ended December 31, 2006 and 2005 consisted of the following:

	Current	Deferred	Total
Year ended December 31, 2006:			
U.S. federal	$ 3,341,195	(153,019)	3,188,176
State and local	1,057,129	(48,443)	1,008,686
	$ 4,398,324	(201,462)	4,196,862
Year ended December 31, 2005:			
U.S. federal	$ 2,194,240	(59,358)	2,134,882
State and local	682,822	(18,791)	664,031
	$ 2,877,062	(78,149)	2,798,913

(Continued)

Chartered is required to maintain deposits in accordance with the terms of the medical professional liability policy. In accordance with this policy, Chartered maintained a certificate of deposit of $200,000 at December 31, 2006 and 2005, which is included in the balance of certificates of deposit – pledged in the accompanying balance sheets.

In July 2006, Chartered acquired an umbrella liability insurance policy that provides an additional coverage limit of $5,000,000 per loss event. This policy expires in July 2007.

In management's opinion, there are no pending or anticipated claims against the Company that will have a material effect on the financial position, results of operations, or cash flows of the Company.

(10) Defined Contribution 401(k) Plan

Chartered sponsors a 401(k) plan (the Plan) for its employees. Employees are eligible to participate in the Plan if they are at least 21 years of age and have worked 90 days or longer at Chartered. Employees may contribute between 1% and 12% of eligible salary on a pre-tax basis. Chartered makes a discretionary matching contribution to the Plan of 12% of each employees' contribution amount. Chartered contributed $25,344 and $27,705 to the Plan for the years ended December 31, 2006 and 2005, respectively.

(11) Dividend paid

On March 12, 2006, the Board of Directors of Chartered approved an ordinary dividend distribution to its parent holding company, DCHSI, in the amount of $1,536,544. The dividend was for the year ended December 31, 2005 and made pursuant to District of Columbia regulation DC ST Section 31-706. Chartered paid the amount in full on April 13, 2006.

(12) Subsequent event

On March 26, 2007, the Board of Directors of Chartered approved an ordinary dividend distribution to its parent holding company, DCHSI, in the amount of $2,022,671. The dividend was for the year ended December 31, 2006 and made pursuant to District of Columbia regulation DC ST Section 31-706. Chartered paid the amount in full on March 29, 2007.

KPMG

D.C. CHARTERED HEALTH PLAN, INC.

(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Financial Statements

December 31, 2008 and 2007

(With Independent Auditors' Report Thereon)

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Table of Contents

KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
D.C. Chartered Health Plan, Inc.:

We have audited the accompanying balance sheets of D.C. Chartered Health Plan, Inc. (Chartered), a wholly owned subsidiary of DC Healthcare Systems, Inc., as of December 31, 2008 and 2007, and the related statements of income, stockholder's equity, and cash flows for the years then ended. These financial statements are the responsibility of Chartered management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Chartered's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in note 1(c) to the financial statements, effective January 1, 2008, Chartered adopted Statement of Financial Accounting Standards (SFAS) No. 157, *Fair Value Measurements*, SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities – Including an amendment of Financial Accounting Standards Board (FASB Statement No. 115).*

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of D.C. Chartered Health Plan, Inc. as of December 31, 2008 and 2007, and the results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

June 5, 2009

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Balance Sheets

December 31, 2008 and 2007

Assets		2008	2007
Current assets:			
Cash and cash equivalents	$	5,272,970	19,332,943
Short-term investments		13,231,483	5,279,780
Premiums receivable, net		8,439,721	7,857,734
Reinsurance receivable		277,414	146,930
Due from affiliates		2,844,073	1,940,330
Prepaid expenses and other current assets		1,912,646	854,881
Interest income receivable		60,597	583,203
Deferred income taxes		381,313	408,628
Total current assets		32,420,217	36,404,429
Certificates of deposit-long term		—	6,314,165
Certificates of deposit – pledged		15,781,440	2,828,007
Property and equipment, net		1,761,648	1,621,684
Goodwill, net		1,460,583	1,460,583
Noncurrent deferred income taxes		900,482	842,846
Other assets		148,800	132,837
Total assets	$	52,473,170	49,604,551
Liabilities and Stockholder's Equity			
Current liabilities:			
Accrued salaries and benefits	$	1,047,098	1,140,465
Accounts payable and accrued expenses		1,136,276	1,083,222
Current portion, capital lease obligation		17,616	36,575
Healthcare costs payable		21,482,835	20,571,067
Claims payable – uninsured		688,039	—
Unpaid claims adjustment expenses		637,630	636,219
Total current liabilities		25,009,494	23,467,548
Noncurrent capital lease obligation		92,430	63,317
Deferred rent liability		275,242	250,758
		25,377,166	23,781,623
Commitments and contingencies			
Stockholder's equity:			
Class A common stock; $0.10 par value. Authorized, issued, and outstanding 1,000 shares in 2008 and 2007		100	100
Additional paid-in capital		4,690,419	4,690,419
Retained earnings		22,405,485	21,132,409
Total stockholder's equity		27,096,004	25,822,928
Total liabilities and stockholder's equity	$	52,473,170	49,604,551

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Income

Years ended December 31, 2008 and 2007

	2008	2007
Revenues:		
Medicaid premiums	$ 130,803,456	106,670,840
Alliance premiums	51,234,168	59,293,809
Other	64,000	79,860
Total revenues	182,101,624	166,044,509
Expenses:		
Healthcare costs, net	153,041,625	137,006,151
General and administrative	24,731,005	22,910,230
Total expenses	177,772,630	159,916,381
Operating income	4,328,994	6,128,128
Investment income	1,446,858	2,330,160
Income before income taxes	5,775,852	8,458,288
Provision for income taxes	2,402,776	3,558,162
Net income	$ 3,373,076	4,900,126

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Stockholder's Equity

Years ended December 31, 2008 and 2007

	Class A common stock ($0.10 par value; 1,000 shares authorized, issued, and outstanding)	Additional paid-in capital	Retained earnings	Total stockholder's equity
Balance at December 31, 2006	$ 100	4,690,419	20,254,953	24,945,472
Net income	—	—	4,900,126	4,900,126
Dividends	—	—	(4,022,670)	(4,022,670)
Balance at December 31, 2007	100	4,690,419	21,132,409	25,822,928
Net income	—	—	3,373,076	3,373,076
Dividends	—	—	(2,100,000)	(2,100,000)
Balance at December 31, 2008	$ 100	4,690,419	22,405,485	27,096,004

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Cash Flows

Years ended December 31, 2008 and 2007

	2008	2007
Cash flows from operating activities:		
Net income	$ 3,373,076	4,900,126
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	643,771	618,228
Changes in operating assets and liabilities:		
Premiums receivable	(581,987)	861,140
Reinsurance receivable	(130,484)	38,044
Due from affiliates	(903,743)	(1,347,060)
Interest income receivable, prepaid expenses and other current assets	(535,159)	(450,975)
Deferred income taxes	(30,321)	(354,749)
Other assets	(15,963)	11,897
Accrued salaries and benefits	(93,367)	311,265
Accounts payable and accrued expenses	53,054	(10,916)
Healthcare costs payable	911,768	769,241
Uninsured claims payable	688,039	(479,145)
Unpaid claims adjustment expenses	1,411	23,791
Deferred rent liability	24,484	46,198
Net cash provided by operating activities	3,404,579	4,937,085
Cash flows from investing activities:		
Additions to property and equipment	(733,224)	(297,976)
Sale of certificates of deposit	6,314,165	4,736,848
Purchase of certificates of deposit	(20,905,136)	(5,279,780)
Net cash used in investing activities	(15,324,195)	(840,908)
Cash flows from financing activities:		
Dividends paid	(2,100,000)	(4,022,670)
Principal payments on capital lease obligation	(40,357)	(81,073)
Net cash used in financing activities	(2,140,357)	(4,103,743)
Net decrease in cash and cash equivalents	(14,059,973)	(7,566)
Cash and cash equivalents, beginning of year	19,332,943	19,340,509
Cash and cash equivalents, end of year	$ 5,272,970	19,332,943
Supplemental disclosures of cash flow information:		
Income taxes paid	$ 2,152,009	3,027,375
Interest paid	32,503	6,910
Purchase of office equipment through capital lease obligation	50,511	68,400

See accompanying notes to financial statements.

(1) Summary of Significant Accounting Policies

(a) Corporate Information and Basis of Accounting

D.C. Chartered Health Plan, Inc. (Chartered) was established on December 31, 1986 under the laws of the District of Columbia. Chartered's primary purpose is to provide quality healthcare within a managed care framework. Chartered accomplishes this primarily through a contract with the District of Columbia Government Department of Health (the DOH), which requires Chartered to provide healthcare services to the residents of the District of Columbia that qualify under the Medicaid, Temporary Aid to Needy Families (TANF), and Alliance programs through a Health Maintenance Organization (HMO). Alliance enrollees represent the population not eligible for Medicaid but whose income falls 200% or more below the poverty level. Chartered currently provides healthcare services to approximately 81,000 beneficiaries receiving assistance under Medicaid, Alliance and TANF. All of Chartered's revenue was earned from its contracts with the DOH for the years ended December 31, 2008 and 2007, respectively. The contract with the DOH requires Chartered to provide transportation services to its Medicaid members. Prior to June 1, 2008, Chartered provided these services through a contract with RapidTrans, Inc. (RapidTrans), a wholly owned subsidiary of Chartered's parent, DC Healthcare Systems, Inc. (DCHSI). RapidTrans ceased operations in May 2008 and the contract was terminated. Chartered also provides the services of a health center to members through a contract with Chartered Family Health Center, P.C. (CFHC), a wholly owned subsidiary of DCHSI. In 2008, Chartered's contract with the DOH was assumed by the District of Columbia Department of Healthcare Finance (DHCF).

Chartered's business strategy lies in its fundamental commitment to promoting access and emphasizing prevention and health maintenance, as well as treatment. Each member enrolled in Chartered is assigned a primary care physician. Chartered has over 3,335 physicians under contract, including 350 primary care physicians. Chartered's members receive prescriptions, health education, nutrition counseling, and when necessary, referrals to specialists and hospital services. Chartered focuses on increasing access to its services by (i) improving knowledge and awareness of benefits; (ii) providing extensive wellness and preventative healthcare services; and (iii) directly providing transportation to and from healthcare appointments.

Medicaid beneficiaries in the District of Columbia are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DOH commencing May 1, 1998, under which Chartered is designated as the default plan for one-third of the Medicaid beneficiaries who do not voluntarily select a plan. The terms of this contract were amended to extend through April 30, 2008. Chartered was awarded a contract for an additional five years, beginning May 1, 2008. The terms of the new five year contract with the DHCF extend through April 30, 2013. The contract is renewable annually, subject to rate negotiations. The rates for the contract year ending April 30, 2010 have been negotiated, agreed to, and implemented by Chartered and the DHCF.

Alliance beneficiaries in the District of Columbia are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DOH commencing

June 1, 2006, under which Chartered is designated as the default plan for one-half of the Alliance beneficiaries who do not voluntarily select a plan. The Alliance program was administered by the Healthcare Safety Net Administration (HSNA), a department of the DOH and in 2008, DHCF assumed oversight of this program. The contract was amended to extend through April 30, 2008. Chartered was awarded a contract for up to an additional five years, beginning May 1, 2008. The terms of the new contract with the DOH may extend through April 30, 2013. The new contract is renewable annually, subject to rate negotiations. The rates for the contract year ending April 30, 2010 have been negotiated, agreed to, and implemented by Chartered and the DHCF.

As a result of the bankruptcy proceedings of PHP Corporation, Chartered's previous parent company, the stock of Chartered was held in a trust (the Collateral Trust), and Bank of America, N.A. (BOA) was designated and appointed as the Collateral Trustee, obtaining full legal title to the collateral and full legal power and authority to transfer, sell, assign, or dispose of the collateral, including the stock of Chartered. The Collateral Trust entered into a stock sale and transfer agreement pursuant to which the stock of Chartered was sold to DCHSI on May 17, 2000. DCHSI financed the purchase through a $3,500,000 bank loan at a floating prime rate of interest. Payments of principal and interest on the loan will continue monthly through May 12, 2011. The outstanding principal balance on the loan was $824,255 and $987,607 at December 31, 2008 and 2007, respectively. Chartered and the owner of DCHSI are guarantors on the loan. This loan is partially collateralized by a $1,000,000 certificate of deposit from DCHSI that will be held for the entire term of the loan. The balance of the certificate of deposit held by DCHSI, including accrued interest was $1,457,333 and $1,389,300 at December 31, 2008 and 2007, respectively. Additionally, Chartered granted the lender a first security interest in certain collateral held by Chartered, except for the $15,781,440 certificates of deposit discussed in notes 3 and 4(c); however, in the event the lender exercises its rights under the guaranty, the owner of DCHSI has agreed in writing to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered may be obligated to pay under the guaranty.

(b) Cash and Cash Equivalents

Cash and cash equivalents are generally comprised of cash, money market accounts, and certificates of deposits with original maturities of three months or less. Cash and cash equivalents consisted of cash and money market funds of $5,272,970 and $19,332,943 at December 31, 2008 and 2007, respectively.

(c) Short-Term Investments

Short-term investments consist of certificates of deposit with original maturities of twelve months or less. The certificates of deposit are held by financial institutions and are carried at cost, which approximates fair value.

In 2006, the Financial Accounting Standards Board (FASB) issued Statement of Financial Standards (SFAS) No. 157, *Fair Value Measurements*, which establishes a framework for measuring fair value in U.S. generally accepted accounting principles (GAAP) and expands disclosures about fair value measurements. SFAS No. 157 applies to the accounting for assets and liabilities required or permitted to be measured at fair value. SFAS No. 157 prioritizes the inputs used to measure fair

value as follows: quoted prices in active markets for identical assets or liabilities (level 1), significant other observable inputs (level 2), and significant unobservable inputs (level 3). The fair value measurement is assigned an overall input level based on the lowest level input that is significant to the fair value measurement in its entirety.

In 2008, SFAS No. 157 was amended by FASB Staff Position No. 157-1, *Application of FASB Statement No. 157 to FASB Statement No. 13 and Other Accounting Pronouncements That Address Fair Value Measurements for Purposes of Lease Classification or Measurement under Statement 13* (FSP 157-1), FASB Staff Position No. 157-2, *Effective Date of FASB Statement 157* (FSP 157-2), and FASB Staff Position No. 157-3, *Determining the Fair Value of a Financial Asset When the Market for That Asset is Not Active* (FSP 157-3). FSP 157-1 exempts FASB Statement No. 13, *Accounting for Leases,* from application of SFAS No. 157 to FASB Statement No. 13, except with respect to business combinations. FSP 157-2 permits delayed implementation of SFAS No. 157 to nonfinancial assets and liabilities for nonrecurring fair value measurements until fiscal years beginning after November 15, 2008. FSP 157-3 provides additional guidance on determining fair value of a financial asset when the market for that asset is not active. All were effective when issued.

Effective January 1, 2008, the Company adopted SFAS No. 157. This pronouncement did not require any new fair value measurements and its adoption did not affect the results of operations or financial position of Chartered.

In 2006, FASB issued SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities*. SFAS No. 159 permits entities to choose to measure many financial instruments and certain other items at fair value mitigating volatility in reported earnings caused by measuring related assets and liabilities differently without having to apply complex hedge accounting provisions. Effective January 1, 2008, Chartered adopted SFAS No. 159 and elected fair value option for financial investments that would otherwise be recorded using either the cost or equity method. This election applies to all such investments owned at January 1, 2008. Chartered made this election in order to ensure that the accounting treatment of these investments was comparable between categories, regardless of the current organizational structure of the various investments. This election did not have a material effect on the financial statements of Chartered.

(d) Property and Equipment

Property and equipment are stated at cost and are depreciated using the straight-line method over a period of three to seven years. Chartered capitalized external direct costs of materials and services and internal payroll costs related to the implementation of a claims management system. Leasehold improvements are also stated at cost and are amortized using the straight-line method over the term of the related lease or the estimated useful life of the improvement, whichever is shorter. Equipment under capital leases is stated at the present value of minimum lease payments and is amortized using the straight-line method over the term of the lease.

(e) Premium Revenue

Medicaid

Chartered recognizes premiums received from the DOH and DHCF for members enrolled in the Medicaid program as revenue in the period to which healthcare coverage relates. Member premiums are paid on a fixed monthly fee per capita basis.

Alliance

Chartered recognizes premiums received from the DOH and DHCF for members enrolled in the Alliance program as revenue in the period to which healthcare coverage relates. Member premiums are paid on a fixed monthly fee per capita basis

(f) Reinsurance

Reinsurance premiums and recoveries are reported net as a component of healthcare costs.

(g) Healthcare Costs and Unpaid Claims Adjustment Expenses

Chartered has entered into hospital service contracts, to provide the necessary inpatient and outpatient hospital services to its enrollees. Under the contracts, Chartered pays the participating hospitals at the fee-for-service rates in effect at the time the services were provided to its enrollees less any discounts which are available. Chartered has also entered into several agreements with network physicians and suppliers to provide medical services and supplies to Chartered's enrollees at agreed upon fee-for-service rates or at fixed fees per member per month (capitation).

Monthly capitation payments to primary care physicians and other healthcare providers are expensed as incurred. Healthcare costs and healthcare costs payable include amounts for known services rendered and an estimate of incurred but not reported services rendered by hospitals, physicians, and other healthcare providers. The estimated incurred but not reported healthcare costs payable have been actuarially determined based on relevant industry data and Chartered's historical trends. Management believes that the methodologies employed to estimate the healthcare costs payable are reasonable and that the amount accrued is appropriate. Due to uncertainties inherent in the medical claims estimation process, there is a reasonable possibility that actual experience may vary from accrued amounts.

As part of the process to estimate the cost of all claims reported but unpaid and claims incurred but not reported, Chartered accrued $637,630 and $636,219 at December 31, 2008 and 2007, respectively, as an estimate of the expense to settle these claims.

(h) Income Taxes

In accordance with the tax allocation agreement with DCHSI, Chartered is included in a consolidated federal and state income tax return with DCHSI, using an April 30 fiscal year-end. Deferred tax assets, deferred tax liabilities, and income tax expense or benefit associated with Chartered have been provided for on a separate company basis. In addition, Chartered determines its deferred income taxes on a separate company basis and remits its estimated tax payment to DCHSI.

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

(i) Goodwill

Goodwill is primarily attributable to acquisitions made by Chartered. An impairment evaluation of goodwill is conducted annually, or more frequently if events or changes in circumstances indicate that an asset might be impaired. The estimated fair value is determined on the basis of discounted future cash flows and is compared with the carrying amount. If the estimated fair value of the goodwill is less than the carrying amount, then an impairment charge is recorded for the difference.

(j) Certificates of Deposit

Certificates of deposit are deposits held by financial institutions and are carried at cost, which approximates fair value. Accrued interest earned on these certificates of deposit are included in interest income receivable on the accompanying balance sheets.

(k) Claims Payable – Uninsured

Claims payable – uninsured represent cash received in advance from the DOH for the reimbursement of healthcare claims paid by Chartered in accordance with a previous administrative services agreement.

(l) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(2) Property and Equipment

Property and equipment consisted of the following as of December 31:

		2008	2007
Computer software	$	3,873,843	3,427,670
Computer and office equipment		2,431,156	2,263,269
Office furniture		799,484	705,115
Leasehold improvements and office fixtures		3,015,298	2,939,992
Total cost		10,119,781	9,336,046
Less accumulated depreciation and amortization		8,358,133	7,714,362
Property and equipment, net	$	1,761,648	1,621,684

Depreciation expense related to property and equipment and amortization expense related to the leasehold improvements and equipment under capital leases was $515,018 and $533,515 for the years ended December 31, 2008 and 2007, respectively. Amortization of capitalized software development costs was $128,753 and $84,713 for the years ended December 31, 2008 and 2007, respectively.

(3) Minimum Net Worth and Regulatory and Contractual Requirements

As required by the District of Columbia's Health Maintenance Organization Act of 1996 (the Act), Chartered entered into a Health Maintenance Organization Custodial Agreement dated February 27, 1998. Chartered maintains a certificate of deposit of $2,447,872 and $300,000, which are included in certificates of deposit pledged on the balance sheets at December 31, 2008 and 2007, respectively, for the sole benefit of Chartered's members in the event of Chartered's insolvency. Under the laws of the Act, Chartered is also required to maintain a minimum net worth equal to the greater of (1) $1,000,000; (2) the sum of all uncovered healthcare expenditures for the latest three-month periods ending December 31, March 31, June 30, or September 30; (3) 2% of its annual revenues; or (4) a prescribed percentage of annual healthcare expenditures. At December 31, 2008 and 2007, Chartered's statutory net worth was $21,059,187 and $21,312,995, respectively. Chartered was in compliance with its statutory net worth requirements.

Under the terms of its Medicaid contract with the DOH dated May 1, 2008, Chartered is also required to meet certain financial requirements to maintain compliance with these contract terms. As such, Chartered is required to maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the District of Columbia's Department of Insurance, Securities and Banking Regulation as a condition for maintaining a certificate of authority to operate an HMO in the District of Columbia. Chartered met or exceeded the minimum net worth, insolvency reserve, and deposit balance requirements as of December 31, 2008 and 2007. Pursuant to the terms of the Medicaid contract with the DOH and DHCF, Chartered maintained an escrow deposit of $2,447,872 and $1,940,077, which are included in certificates of deposit – pledged on the balance sheets at December 31, 2008 and 2007, respectively.

The National Association of Insurance Commissioners developed the Managed Care Organization Risk-Based Capital Report and required all HMOs to complete the report beginning with the year ended December 31, 1998. Risk-based capital (RBC) was developed as a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. A company's RBC is calculated by applying certain factors to various asset, premium, and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. These levels range from Company Action Level (CAL) to Mandatory Control Level (MCL). All HMOs licensed in the District of Columbia are subject to the RBC provisions. Chartered's RBC exceeded all action levels as of December 31, 2008 and 2007.

(4) Commitments and Contingencies

(a) Leases

Chartered is obligated under several noncancelable operating and capital leases for office space, office equipment, and vehicles. Future amounts due under these leases are as follows:

	Operating	Capital
2009	$ 912,533	51,564
2010	935,347	51,564
2011	958,730	51,564
2012	982,699	46,899
2013	1,007,266	—
Thereafter	509,851	—
	$ 5,306,426	201,591
Less amounts representing interest		91,545
		110,046
Less current portion of capital lease obligation		17,616
		$ 92,430

Total rent expense was $979,084 and $914,761 for the years ended December 31, 2008 and 2007, respectively.

Chartered was required to maintain deposits in accordance with certain capital lease agreements during 2007. Accordingly, Chartered maintained a certificate of deposit of $387,930 at December 31, 2007, which is included in certificate of deposit – pledged in the accompanying balance sheets. The lease agreements terminated in 2008 and Chartered was no longer required to maintain these deposits.

(b) Litigation and Contingencies

Chartered is from time to time subject to claims and suits arising in the ordinary course of business. In the opinion of management, the ultimate resolution of pending legal proceedings will not have a material effect on the financial statements.

(c) Risk-Based Contract Dispute Settlement

In March 2008, the District of Columbia filed a civil complaint in the Superior Court for the District of Columbia against Chartered. The complaint pertains to disagreements and disputes on certain contract related items under Chartered's actuarially rate determined risk based contract with the DOH. Chartered vigorously contested the complaint and the complaint was dismissed "with prejudice" by the District of Columbia in October 2008.

In the third quarter of 2008, Chartered's parent company, DCHSI, executed a settlement and dispute resolution agreement for contractual disputes from January 1, 2001 through April 30, 2008 with the Office of Attorney General for the District of Columbia (OAG of DC), which required DCHSI to pay $12,000,000. DCHSI financed the settlement payment through a $12,000,000 long term Bank Loan Payable (Loan). Payments of interest only on the outstanding principal balance are due monthly through November 10, 2012; thereafter, payments of principal and interest will continue monthly through November 10, 2018, based on a 25-year amortization schedule. Interest is calculated at an annual fixed rate of 5.65% for the first five years, thereafter adjusting to a rate equal to the Federal Home Loan Bank five-year rate plus 1.50%. Chartered and the owner of DCHSI are co-guarantors of the Loan. Pursuant to the Loan, Chartered is required to pledge investments in the amount of $13,333,567 as collateral for the Loan, which is included in the accompanying balance sheet at December 31, 2008. In the event that DCHSI defaults on or is not able to meet it's obligations under the provisions of the Loan, the owner of DCHSI has executed an Indemnification Agreement to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered is or may be obligated to pay under the guaranty agreement and pledge and security agreement, including but not limited to any liquidation of the pledged collateral.

(d) Contingent Contributions

In September 2008, in addition to the Settlement Agreement, DCHSI, Chartered, and the owner of DCHSI entered into a Letter Agreement (Agreement) with the District of Columbia that requires DCHSI, Chartered, and the owner of DCHSI to make contributions to the District of Columbia Department of Health's Immunization Program and several other not-for-profit organizations, including the District of Columbia Public Education Fund, of approximately $1,050,000 each year for a period of five years beginning January 1, 2009. Under the Agreement, these contributions will be made subject to the following conditions being met: (1) the funds received by the various organizations from the previous year were used for the purposes outlined in the Agreement, (2) the submission of a report that demonstrates that the funds were expended in compliance with the Agreement, and (3) Chartered and DCHSI are able to maintain "normal operations" during that year. Therefore, if the District fails to use the funds provided as required, the District is unable to account for related expenditures, or either Chartered or DCHSI suffer adverse financial circumstances, the Agreement may be voided or are subject to renegotiation. Management believes that there is more

than a remote likelihood that the above mentioned conditions will not be met as of December 31, 2008, and accordingly has not accrued a liability. Chartered will record the expense in the period in which the payments are made. As of December 31, 2008, Chartered paid $500,000 to the District of Columbia Public Education Fund program under the terms of this agreement and accordingly has included this amount in prepaid expenses in the accompanying 2008 balance sheet.

(e) Employment Contracts

Chartered has entered into employment agreements with its key executives, establishing minimum compensation levels, performance requirements, severance and certain other benefits.

(5) Related-Party Transactions

Chartered has entered into various management and services arrangements with certain related parties, including DCHSI, CFHC, and RapidTrans. The arrangements with DCHSI expired September 30, 2007 and the transportation service agreement with RapidTrans was terminated on May 30, 2008. Payments under these arrangements do not include an accrued interest component and are expected to be recovered within one year of the balance sheet date, and are therefore classified as current assets in the accompanying balance sheets. Management believes that all amounts due from affiliates are fully collectible and expects that they will be repaid during 2009. Amounts due from affiliates are comprised of the following at December 31:

	2008	2007
Due from DCHSI, net	$ 2,679,058	1,310,147
Due from CFHC	163,687	493,412
Due from RapidTrans	1,328	136,771
	$ 2,844,073	1,940,330

(a) DC Healthcare Systems, Inc.

From May 18, 2000 through September 30, 2007, Chartered had a management service and cost allocation/reimbursement agreement with DCHSI for technical and professional consulting services in connection with the HMO business and healthcare insurance business of Chartered. In exchange for these services received from DCHSI, Chartered is obligated to pay consulting fees and related allocated costs and expenses to DCHSI. The term of the agreement was from May 18, 2000 to September 30, 2007. Chartered did not renew the agreement for fiscal year 2008. The terms of the agreement for fiscal year 2009 are currently under negotiation between DCHSI and Chartered. Chartered recorded consulting fees and related allocated costs and expenses of approximately $1,350,000 under the terms of this agreement for the period from January 1 to September 30, 2007.

Chartered has a noncancelable operating lease agreement to lease office space from DCHSI. The lease commenced July 1, 2004 and expires on June 30, 2014. The base annual rent is $25 per square foot for 32,660 square feet of space with a 2.5% annual rate increase. Chartered recorded rent expense of $979,084 and $914,761 under the terms of this agreement for the years ended December 31, 2008 and 2007, respectively.

Amounts due from DCHSI, net are primarily related to over or under payments of estimated federal and state income taxes, adjustments for expense allocation by Chartered to DCHSI through September 30, 2007, and management service agreement fees through September 30, 2007.

(b) Chartered Family Health Center (CFHC)

CFHC, which became a wholly owned subsidiary of DCHSI on August 14, 2003, is an 18,000-square-foot, full service health center on Minnesota Avenue in the District of Columbia which was opened in December 1997. It has a staff of board-certified family physicians, pediatricians, internists, OB-GYNs, and other medical specialists backed by an ancillary staff of nurses, radiology and laboratory technicians, pharmacists, and medical assistants. Under the terms of the agreement effective May 1, 2008, Chartered reimburses CFHC for actual operating costs incurred by CFHC in providing services to Chartered's members, without any profit markup to CFHC. Actual operating costs include the expenses incurred in the operation of CFHC after deducting all revenues collected from third-party payors (other than Chartered) for services rendered to non-Chartered members. Prior to this agreement, Chartered paid capitation fees to CFHC for professional medical services performed on behalf of Chartered members enrolled at CFHC. Chartered paid capitation fees and net reimbursement costs to CFHC in the amounts of $4,560,837 and $5,535,052 for the years ended December 31, 2008 and 2007, respectively. All amounts due from CFHC at December 31, 2008 and 2007 are included in due from affiliates in the accompanying balance sheets. DCHSI is in active discussions and negotiations with several providers to divest itself of CFHC, while continuing the provision of professional medical services at CFHC.

Amounts due from CFHC are related primarily to management fees Chartered assessed CFHC for accounting and administrative services, payroll and related benefits expenses paid by Chartered and were $163,687 and $493,412 for the years ended December 31, 2008 and 2007, respectively.

(c) RapidTrans

Effective May 30, 2008, RapidTrans no longer provides transportation services to Chartered's members. Accordingly, RapidTrans ceased operations as of May 31, 2008. RapidTrans, which became a wholly owned subsidiary of DCHSI on August 14, 2003, provided transportation services to Chartered's Medicaid members prior to June 1, 2008, and Chartered provides certain management services to RapidTrans. Chartered pays capitation fees to RapidTrans for the transportation services and receives payment to cover the value of services provided. Chartered paid capitation fees to RapidTrans in the amounts of $1,036,900 and $2,479,960 for the years ended December 31, 2008 and 2007, respectively, which are included in healthcare costs, net in the accompanying balance sheets. All amounts due from RapidTrans at December 31, 2008 and 2007 are included in due from affiliates in the accompanying balance sheets. In the event that RapidTrans' revenues do not cover its expenses, Chartered agreed to cover the excess expenses on RapidTrans' behalf. In 2008 and 2007, no additional amounts are due to RapidTrans under the terms of the agreements.

Amounts due from RapidTrans are related primarily to cost reimbursements to Chartered for RapidTrans accounting and administrative services, payroll, and related benefits expenses paid by Chartered and were $1,328 and $136,771 for the years ended December 31, 2008 and 2007, respectively.

(d) Thompson, Cobb, Bazilio and Associates, PC (TCBA)

TCBA is an accounting and management consulting firm that is 79.5% owned by the owner of DCHSI. Under an agreement that terminated December 31, 2007, TCBA provided certain professional consulting services to Chartered. In exchange for these services, Chartered reimbursed TCBA for its actual labor cost plus overhead and general and administrative costs calculated at TCBA's approved Federal Government GSA overhead and General and Administrative rates, without any profit markup to TCBA. The amount paid to TCBA under this cost reimbursement agreement was $78,949 for the year ended December 31, 2007, and is included in general and administrative expenses in the accompanying 2007 statement of income.

(6) Reinsurance Coverage

Chartered is financially responsible for the cost of each enrollee's annual medical services. Annual inpatient hospital services per enrollee were limited as follows for the years ended December 31, 2008 and 2007:

Effective dates	Limits of coverage
October 1, 2007 through September 30, 2008	$125,000 plus 20% of paid services in excess of the $125,000 stop-loss amount
October 1, 2008 through September 30, 2009	$125,000 plus 20% of paid services in excess of the $125,000 stop-loss amount

Coverage above these stop-loss amounts is provided by an insurance company. The maximum reimbursement per enrollee is limited to $2,000,000 in the aggregate over all contract years.

For the years ended December 31, 2008 and 2007, Chartered incurred stop-loss insurance premium expense of $1,045,562 and $860,942, respectively. For the years ended December 31, 2008 and 2007, Chartered had stop-loss insurance recoveries of $563,766 and $593,946, respectively. These amounts related to the stop-loss insurance arrangement are included in healthcare costs, net in the accompanying statements of income.

(7) Income Taxes

Income tax expense (benefit) related to the continuing operations for the years ended December 31, 2008 and 2007 consisted of the following:

		Current	Deferred	Total
Year ended December 31, 2008:				
U.S. federal	$	1,848,045	(4,740)	1,843,305
State and local		585,052	(25,581)	559,471
	$	2,433,097	(30,321)	2,402,776
Year ended December 31, 2007:				
U.S. federal	$	2,972,054	(299,331)	2,672,723
State and local		940,857	(55,418)	885,439
	$	3,912,911	(354,749)	3,558,162

Income tax expense was $2,402,776 and $3,558,162 for the years ended December 31, 2008 and 2007, respectively. The income tax expenses differed from the amounts computed by applying the U.S. federal statutory income tax rate to pretax income as a result of the following:

		2008	2007
Computed "expected" tax expense	$	2,006,965	2,977,026
Increase in income taxes resulting from:			
State and local income taxes, net of federal income tax benefit		371,790	551,494
Other, net		24,021	29,642
Income tax expense	$	2,402,776	3,558,162

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets at December 31, 2008 and 2007 are presented below:

	2008	2007
Deferred tax assets:		
Compensated absences, principally due to accrual for financial reporting purposes	$ 80,069	98,341
Amortization of membership list	88,388	101,483
Performance bonus, due to accrual for financial reporting	113,292	129,638
Property and equipment principally due to difference in depreciation and amortization	708,959	648,385
Discounted incurred but not reported healthcare costs	176,904	169,601
Deferred straight-line lease expense	114,183	104,026
Total deferred tax	1,281,795	1,251,474
Less current portion, net	381,313	408,628
	$ 900,482	842,846

The Company establishes valuation allowances in accordance with the provisions of SFAS No. 109, *Accounting for Income Taxes*. A valuation allowance was not recognized as of December 31, 2008 and 2007 because it is more likely than not that the deferred tax assets will be realized.

(8) Healthcare Costs Payable

A summary of the activity for healthcare costs payable is as follows:

	2008	2007
Balance at January 1	$ 20,571,067	19,801,826
Plus incurred related to:		
Current year	134,563,396	121,424,217
Prior years	481,798	(954,172)
Total incurred	135,045,194	120,470,045
Less paid related to:		
Current year	118,565,614	102,624,840
Prior years	15,567,812	17,075,964
Total incurred	134,133,426	119,700,804
Balance at December 31	$ 21,482,835	20,571,067

Chartered uses actuarial techniques based on historical experience to estimate incurred claims. Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and reestimated as information regarding actual claims

payments becomes known. This information is compared to the originally established year-end liability. Positive or negative amounts reported for incurred related to prior years result from claims being settled for amounts greater or less, respectively, than originally estimated. This experience is primarily attributable to actual medical cost experience more favorable than that assumed at the time the liability was established. The Company incurred other healthcare costs, which primarily consisted of capitation payments to providers of healthcare services for Chartered's members of $17,996,431 and $16,536,106 for the years ended December 31, 2008 and 2007, respectively.

(9) Professional Liability Insurance

During 2008 and 2007, Chartered maintained a medical professional liability insurance policy, which is written on a claims-made basis. The coverage limits for the primary medical professional liability policy are $1,000,000 per loss event and a $3,000,000 policy limit per physician. This policy remained in full force and effect during 2008 and 2007 and has been renewed through May 2009. Chartered has not accrued for claims incurred but not reported as of December 31, 2008 and 2007 as these amounts are not reasonably estimable. Management believes that these amounts would not have a material impact on Chartered's financial statements as of December 31, 2008 and 2007.

Chartered was required to maintain deposits in accordance with the terms of the medical professional liability policy through May 2008. In accordance with this policy, Chartered maintained a certificate of deposit of $200,000 at December 31, 2007, which is included in certificates of deposit – pledged in the accompanying balance sheets.

In July 2007, Chartered acquired an umbrella liability insurance policy that provides an additional coverage limit of $5,000,000 per loss event. This policy has been renewed through July 2009.

In management's opinion, there are no pending or anticipated claims against the Company that will have a material effect on the financial position, results of operations, or cash flows of the Company.

(10) Defined Contribution 401(k) Plan

Chartered sponsors a 401(k) plan (the Plan) for its employees. Employees are eligible to participate in the Plan if they are at least 21 years of age and have worked 90 days or longer at Chartered. Employees may contribute between 1% and 12% of eligible salary on a pretax basis. Chartered makes a discretionary matching contribution to the Plan of 12% of each employees' contribution amount. Chartered contributed $26,947 and $29,730 to the Plan for the years ended December 31, 2008 and 2007, respectively.

(11) Dividends paid

On December 12, 2008, the board of directors of Chartered approved an ordinary dividend distribution to its parent holding company, DCHSI, in the amount of $2,100,000. The dividends were for the year ended December 31, 2007 and made pursuant to District of Columbia regulation DC ST Section 31-706. Chartered paid the amounts in full on December 24, 2008.

On March 26, 2007 and July 2, 2007, the board of directors of Chartered approved ordinary dividend distributions to its parent holding company, DCHSI, in the amount of $2,022,670 and $2,000,000, respectively. The dividends were for the year ended December 31, 2006 and made pursuant to District of Columbia regulation DC ST Section 31-706. Chartered paid the amounts in full on March 29, 2007 and July 20, 2007.

KPMG

D.C. CHARTERED HEALTH PLAN, INC.

(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Financial Statements

December 31, 2010 and 2009

(With Independent Auditors' Report Thereon)

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

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KPMG LLP
1 East Pratt Street
Baltimore, MD 21202-1128

Independent Auditors' Report

The Board of Directors
D.C. Chartered Health Plan, Inc.:

We have audited the accompanying balance sheets of D.C. Chartered Health Plan, Inc. (Chartered), a wholly owned subsidiary of DC Healthcare Systems, Inc., as of December 31, 2010 and 2009, and the related statements of operations, stockholder's equity, and cash flows for the years then ended. These financial statements are the responsibility of Chartered's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Chartered's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of D.C. Chartered Health Plan, Inc. as of December 31, 2010 and 2009, and the results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

KPMG LLP

October 28, 2011

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Balance Sheets

December 31, 2010 and 2009

Assets	2010	2009
Current assets:		
Cash and cash equivalents	$ 10,791,099	—
Short-term investments	14,192,167	13,762,527
Premiums receivable, net	7,859,616	4,463,848
Reinsurance receivable	157,939	210,611
Due from DCHSI, net	5,039,029	6,073,734
Due from CFHC, net	—	45,456
Healthcare provider receivables	5,101,903	3,621,825
Prepaid expenses and other current assets	2,163,856	1,741,539
Interest income receivable	155,428	30,410
Deferred income taxes	1,842,127	292,926
Total current assets	47,303,164	30,242,876
Certificates of deposit – pledged	15,966,095	15,966,095
Property and equipment, net	1,068,448	1,703,196
Goodwill, net	1,460,583	1,460,583
Noncurrent deferred income taxes	1,147,127	1,382,512
Other assets	162,405	148,800
Total assets	$ 67,107,822	50,904,062
Liabilities and Stockholder's Equity		
Current liabilities:		
Accrued salaries and benefits	$ 499,098	555,388
Accounts payable and accrued expenses	2,039,064	1,600,070
Premium tax payable	3,959,356	—
Current portion, capital lease obligation	37,947	25,209
Healthcare costs payable	37,071,098	25,352,717
Unpaid claims adjustment expenses	954,072	760,582
Due to CFHC, net	2,015,240	—
Total current liabilities	46,575,875	28,293,966
Noncurrent capital lease obligation	47,164	86,449
Deferred rent liability	256,884	277,469
Total liabilities	46,879,923	28,657,884
Commitments and contingencies		
Stockholder's equity:		
Class A common stock; $0.10 par value. Authorized, issued, and outstanding 1,000 shares in 2010 and 2009	100	100
Additional paid-in capital	4,690,419	4,690,419
Retained earnings	15,537,380	17,555,659
Total stockholder's equity	20,227,899	22,246,178
Total liabilities and stockholder's equity	$ 67,107,822	50,904,062

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Operations

Years ended December 31, 2010 and 2009

	2010	2009
Revenues:		
Medicaid premiums	$ 256,400,778	183,826,685
Alliance premiums	41,822,799	47,085,005
Total revenues	298,223,577	230,911,690
Expenses:		
Healthcare costs, net	271,862,090	215,598,919
General and administrative	29,377,350	24,697,598
Total expenses	301,239,440	240,296,517
Operating loss	(3,015,863)	(9,384,827)
Investment income	738,996	1,119,653
Loss before income taxes	(2,276,867)	(8,265,174)
Income tax benefit	(258,588)	(3,415,348)
Net loss	$ (2,018,279)	(4,849,826)

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Stockholder's Equity

Years ended December 31, 2010 and 2009

	Class A common stock ($0.10 par value; 1,000 shares authorized, issued, and outstanding)	Additional paid-in capital	Retained earnings	Total stockholder's equity
Balance at December 31, 2008	$ 100	4,690,419	22,405,485	27,096,004
Net loss	—	—	(4,849,826)	(4,849,826)
Balance at December 31, 2009	100	4,690,419	17,555,659	22,246,178
Net loss	—	—	(2,018,279)	(2,018,279)
Balance at December 31, 2010	$ 100	4,690,419	15,537,380	20,227,899

See accompanying notes to financial statements.

D.C. CHARTERED HEALTH PLAN, INC.
(A Wholly Owned Subsidiary of DC Healthcare Systems, Inc.)

Statements of Cash Flows

Years ended December 31, 2010 and 2009

	2010	2009
Cash flows from operating activities:		
Net loss	$ (2,018,279)	(4,849,826)
Adjustments to reconcile net loss to net cash provided by (used in) operating activities:		
Depreciation and amortization	758,773	742,022
Deferred income taxes	(1,313,816)	(393,643)
Changes in operating assets and liabilities:		
Premiums receivable	(3,395,768)	3,975,873
Reinsurance receivable	52,672	66,802
Due from affiliates, including DCHSI and CFHC	3,095,401	(3,275,117)
Healthcare provider receivables	(1,480,078)	(3,621,825)
Interest income receivable, prepaid expenses, and other current assets	(547,335)	201,294
Other assets	(13,605)	—
Accrued salaries and benefits	(56,290)	(491,710)
Accounts payable and accrued expenses	4,398,350	(224,245)
Healthcare costs payable	11,718,381	3,869,883
Unpaid claims adjustment expenses	193,490	122,952
Deferred rent liability	(20,586)	2,227
Net cash provided by (used in) operating activities	11,371,310	(3,875,313)
Cash flows from investing activities:		
Additions to property and equipment	(107,650)	(667,195)
Purchase of short-term investments, net	(429,640)	(715,699)
Net cash used in investing activities	(537,290)	(1,382,894)
Cash flows from financing activities:		
Principal payments on capital lease obligation	(42,921)	(14,763)
Net cash used in financing activities	(42,921)	(14,763)
Net increase (decrease) in cash and cash equivalents	10,791,099	(5,272,970)
Cash and cash equivalents, beginning of year	—	5,272,970
Cash and cash equivalents, end of year	$ 10,791,099	—
Supplemental disclosures of cash flow information:		
Interest paid	$ 27,825	43,106
Purchase of office equipment through capital lease obligation	16,375	16,375

See accompanying notes to financial statements.

(1) Description of Business

D.C. Chartered Health Plan, Inc. (Chartered) was established on December 31, 1986 under the laws of the District of Columbia. Chartered's primary purpose is to provide quality healthcare within a managed care framework. Chartered accomplishes this primarily through a contract with the District of Columbia Government Department of Healthcare Finance (the DHCF), which requires Chartered to provide healthcare services to the residents of the District of Columbia (the District) that qualify under the Medicaid, Temporary Aid to Needy Families (TANF), and Alliance programs through a Health Maintenance Organization (HMO). Alliance enrollees represent the population not eligible for Medicaid but whose income falls below 200% of the poverty level. Chartered currently provides healthcare services to approximately 110,000 beneficiaries receiving assistance under Medicaid, Alliance, and TANF. All of Chartered's revenue was earned from its contracts with the DHCF for the years ended December 31, 2010 and 2009. Chartered also provides the services of a health center to members through a contract with Chartered Family Health Center, P.C. (CFHC), a wholly owned subsidiary of Chartered's parent, D.C. Healthcare Systems, Inc. (DCHSI).

Chartered's business strategy lies in its fundamental commitment to promoting access and emphasizing prevention and health maintenance, as well as treatment. Each member enrolled in Chartered is assigned a primary care physician. Chartered has 4,318 physicians under contract, including 464 primary care physicians. Chartered's members receive prescriptions, health education, nutrition counseling, and when necessary, referrals to specialists and hospital services. Chartered focuses on increasing access to its services by (i) improving knowledge and awareness of benefits and (ii) providing extensive wellness and preventative healthcare services.

Medicaid beneficiaries in the District are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DHCF, under which Chartered is designated as the default plan for one-half of the Medicaid beneficiaries who do not voluntarily select a plan. The current contract extends through April 30, 2013 and is renewable annually subject only to rate negotiations. The rates for the contract year ended April 30, 2012 have been negotiated, agreed to, and implemented by Chartered and the DHCF.

Alliance beneficiaries in the District are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DHCF, under which Chartered is designated as the default plan for one-half of the Alliance beneficiaries who do not voluntarily select a plan. Chartered was awarded a new contract with the DHCF that extends through April 30, 2013. The new contract is renewable annually, subject only to rate negotiations. The rates for the contract year ending April 30, 2012 have been negotiated, agreed to, and implemented by Chartered and the DHCF.

Until May 17, 2000, Chartered was owned by PHP Corporation. As a result of the bankruptcy proceedings of PHP Corporation, the stock of Chartered was held in a trust (the Collateral Trust), and Bank of America, N.A. (BOA) was designated and appointed as the Collateral Trustee, obtaining full legal title to the collateral and full legal power and authority to transfer, sell, assign, or dispose of the collateral, including the stock of Chartered. The Collateral Trust entered into a stock sale and transfer agreement pursuant to

(Continued)

which the stock of Chartered was sold to DCHSI on May 17, 2000. DCHSI financed the purchase through a $3,500,000 bank loan at a floating prime rate of interest. Payments of principal and interest on the loan will continue monthly through May 12, 2011. The outstanding principal balance on the loan was $569,461 and $719,084 at December 31, 2010 and 2009, respectively. Chartered and the owner of DCHSI are guarantors on the loan. This loan is collateralized by a certificate of deposit from DCHSI that will be held for the entire term of the loan. The balance of the certificate of deposit held by DCHSI, including accrued interest, was $787,612 and $770,000 at December 31, 2010 and 2009, respectively. Additionally, Chartered granted the lender a first security interest in certain collateral held by Chartered, except for the $15,966,095 of certificates of deposit – pledged at December 31, 2010 and 2009, discussed in notes 8 and 9(c). In the event the lender exercises its rights under the guaranty, the owner of DCHSI has agreed in writing to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered may be obligated to pay under the guaranty.

(2) Summary of Significant Accounting Policies

(a) Basis of Presentation

The accompanying financial statements have been prepared in accordance with U.S. generally accepted accounting principles. Management has evaluated subsequent events through October 28, 2011, which is the date that these financial statements were issued.

(b) Cash and Cash Equivalents

Cash and cash equivalents generally comprise cash, money market accounts, and certificates of deposits with original maturities of three months or less from the date of purchase. Cash and cash equivalents that are restricted per regulatory or other requirements are classified as certificates of deposits – pledged and excluded from cash and cash equivalents. Cash equivalents were $3,351,572 and $0 for the years ended December 31, 2010 and 2009, respectively.

(c) Short-Term Investments

Short-term investments consist of certificates of deposit with original maturities of twelve months or less. The certificates of deposit are held by financial institutions and are carried at cost, which approximates fair value. Chartered classifies its short-term investments as trading securities. Trading securities are bought and held principally for the purpose of selling them in the near term.

Chartered records its investments in accordance with Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*. ASC Topic 820 defines fair value, establishes a framework for measuring fair value in accordance with U.S. generally accepted accounting principles, and expands disclosures about fair value measurements.

(Continued)

(d) Property and Equipment

Property and equipment are stated at cost and are depreciated using the straight-line method over a period of three to seven years. Leasehold improvements are also stated at cost and are amortized using the straight-line method over the term of the related lease or the estimated useful life of the improvement, whichever is shorter. Equipment under capital leases is stated at the present value of minimum lease payments and is amortized using the straight-line method over the term of the lease.

(e) Premium Revenue

Chartered recognizes premiums received for members enrolled in the Medicaid and Alliance programs as revenue in the period to which healthcare coverage relates. Member premiums are paid on a fixed monthly fee per capita basis. During 2010 and 2009, the DHCF withheld one percent of Chartered's premiums revenue. The amount withheld is payable under DHCF's incentive program if certain criteria are met by the Chartered during the contract period. In 2010 and 2009, $2,600,000 and $1,200,000, respectively, were withheld from Chartered. Chartered recorded premium revenue of $2,104,095 and $600,000 in 2010 and 2009, respectively, for amounts expected to be received in accordance with DHCF's incentive program.

(f) Healthcare Provider Receivables

Healthcare provider receivables primarily consist of amounts due from providers relating to overpayments of healthcare claims.

(g) Reinsurance

Reinsurance premiums and recoveries are reported net as a component of healthcare costs.

(h) Healthcare Costs and Unpaid Claims Adjustment Expenses

Chartered has entered into hospital service contracts to provide the necessary inpatient and outpatient hospital services to its enrollees. Under the contracts, Chartered pays the participating hospitals at the fee-for-service rates in effect at the time the services were provided to its enrollees. Chartered has also entered into several agreements with network physicians and suppliers to provide medical services and supplies to Chartered's enrollees at agreed-upon fee-for-service rates or at fixed fees per member per month (capitation).

Monthly capitation payments to primary care physicians and other healthcare providers are expensed as incurred. Healthcare costs and healthcare costs payable include amounts for known services rendered and an estimate of incurred-but-not-reported services rendered by hospitals, physicians, and other healthcare providers. The estimated incurred-but-not-reported healthcare costs payable have been actuarially determined based on relevant industry data and Chartered's historical trends. Management believes that the methodologies employed to estimate the healthcare costs payable are reasonable and that the amount accrued is appropriate. Due to uncertainties inherent in the medical claims estimation process, there is a reasonable possibility that actual experience may vary from accrued amounts.

(Continued)

As part of the process to estimate the cost of all claims reported but unpaid and claims incurred but not reported, Chartered accrued $954,072 and $760,582 at December 31, 2010 and 2009, respectively, as an estimate of the expense to settle these claims.

(i) Income Taxes

In accordance with the tax allocation agreement with DCHSI, Chartered is included in a consolidated federal and state income tax return with DCHSI, using an April 30 fiscal year-end. Deferred tax assets, deferred tax liabilities, and income tax expense or benefit associated with Chartered have been provided for on a separate company basis. In addition, Chartered determines its deferred income taxes on a separate company basis and remits its estimated tax payment to DCHSI.

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date.

(j) Goodwill

Goodwill is primarily attributable to the acquisition of Chartered by PHP Corporation. An impairment evaluation of goodwill is conducted annually, or more frequently if events or changes in circumstances indicate that an asset might be impaired. The estimated fair value is determined on the basis of discounted future cash flows and is compared with the carrying amount. If the estimated fair value of the goodwill is less than the carrying amount, then an impairment charge is recorded for the difference.

(k) Certificates of Deposit

Certificates of deposit are deposits held by financial institutions and are carried at cost, which approximates fair value. Accrued interest earned on these certificates of deposit is included in interest income receivable on the accompanying balance sheets.

(l) Premium Deficiency Reserve

Premium deficiency reserves and the related expense are recognized when it is probable that expected future healthcare and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the remaining lives of the contracts. The methods for making such estimates and for establishing the resulting reserves are continually reviewed and updated, and any adjustments resulting therefrom are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. At December 31, 2010 and 2009, the need for a premium deficiency reserve was assessed and management is of the opinion that no premium deficiency reserve was required.

(Continued)

(m) Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosures of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

(n) Reclassifications

Certain reclassifications have been made in the 2009 financial statements to conform to the 2010 presentation.

(3) Property and Equipment

Property and equipment consisted of the following as of December 31:

		2010	2009
Computer software	$	4,379,411	4,379,411
Computer and office equipment		2,532,095	2,488,176
Office furniture		889,146	844,852
Leasehold improvements and office fixtures		3,126,724	3,090,912
Total cost		10,927,376	10,803,351
Less accumulated depreciation and amortization		9,858,928	9,100,155
Property and equipment, net	$	1,068,448	1,703,196

Depreciation expense related to property and equipment and amortization expense related to the leasehold improvements and equipment under capital leases was $399,675 and $431,930 for the years ended December 31, 2010 and 2009, respectively. Amortization of capitalized software development costs was $359,098 and $310,092 for the years ended December 31, 2010 and 2009, respectively.

(Continued)

(4) Investments

Investments by level at December 31, 2010 were as follows:

	Fair value measurements at December 31, using			
	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Total
Investments:				
Current:				
Certificates of deposit	$ —	14,192,167	—	14,192,167
Noncurrent:				
Certificates of deposit	—	15,966,095	—	15,966,095
Total investments	$ —	30,158,262	—	30,158,262

There were no unrealized holding gains or losses as of December 31, 2010.

Investments by level at December 31, 2009 were as follows:

	Fair value measurements at December 31, using			
	Quoted prices in active markets for identical assets (Level 1)	Significant other observable inputs (Level 2)	Significant unobservable inputs (Level 3)	Total
Investments:				
Current:				
Certificates of deposit	$ —	13,762,527	—	13,762,527
Noncurrent:				
Certificates of deposit	—	15,966,095	—	15,966,095
Total investments	$ —	29,728,622	—	29,728,622

There were no unrealized holding gains or losses as of December 31, 2009.

(5) Fair Value of Financial Instruments

The carrying amounts reported in the balance sheet for cash and cash equivalents, premiums receivable, interest income receivable, due from affiliates, other current assets, accounts payable and accrued

(Continued)

expenses, accrued salaries and benefits, and healthcare costs payable approximate fair value based on the short maturity of those items.

Investments are reported at fair value. Fair values for Chartered's fixed maturity securities are based on prices provided by its investment managers and its custodian bank. Both the investment managers and the custodian bunk use a variety or pricing sources to determine market valuations. Each designates specific pricing services or indexes for each sector of the market based upon the provider's expertise. The fair values of investments are based on quoted market prices, if available, or estimated using quoted market prices for similar investments. If listed prices or quotes are not available, fair value is based upon models that primarily use as inputs market-based or independently sourced market parameters. In addition to market information, models also incorporate transaction details such as maturity. Fair value adjustments, including credit, liquidity, and other factors, are included, as appropriate, to arrive at a fair value measurement.

Chartered utilizes a three-level valuation hierarchy for fair value measurements. An instrument's categorization within the hierarchy is based upon the lowest level of input that is significant to the fair value measurement. For instruments classified in Level 1 of the hierarchy, valuation inputs are quoted prices in active markets as of the measurement date for identical instruments. For instruments classified in Level 2 of the hierarchy, valuation inputs are directly observable but do not qualify as Level 1 inputs. Examples of Level 2 inputs include: quoted prices for similar instruments in active markets; quoted prices for identical or similar instruments in nonactive markets; other observable inputs such as interest rates and yield curves observable at commonly quoted intervals, volatilities, prepayment speeds, loss severities, credit risks, and default rates; and market-correlated inputs that are derived principally from or corroborated by observable market data. For instruments classified in Level 3 of the hierarchy, valuation inputs are unobservable inputs for the instrument. Level 3 inputs incorporate assumptions about the factors that market participants would use in pricing the instrument.

(6) Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets consisted of the following as of December 31:

		2010	2009
Prepaid expenses	$	936,770	927,811
Notes receivable		669,481	263,662
Other current assets		557,605	550,066
	$	2,163,856	1,741,539

(7) Risk-Based Capital

The National Association of Insurance Commissioners developed the Managed Care Organization Risk-Based Capital Report and required all HMOs to complete the report beginning with the year ended December 31, 1998. Risk-based capital (RBC) was developed as a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. A company's RBC target is calculated by applying certain factors

(Continued)

to various asset, premium, and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. The specific capital levels, in declining order are as follows: 1) Company Action Level (CAL), 2) Regulatory Action Level (RAL), 3) Authorized Control Level (ACL), and 4) Mandatory Control Level (MCL). Companies at the Company Action Level must submit a comprehensive financial plan to the insurance commissioner of the state of domicile. Companies at the Regulatory Action Level are subject to a mandatory examination or analysis by the commissioner and possible required corrective actions. At the Authorized Control Level, a company is subject to, among other things, the commissioner placing it under regulatory control. At the Mandatory Control Level, the insurance commissioner is required to place a company under regulatory control. All HMOs licensed in the District are subject to the RBC provisions. Chartered was within the Company Action Level RBC at 160% and 152% as of December 31, 2010 and 2009, respectively.

In April 2010, Chartered submitted a comprehensive financial plan with the Department of Insurance, Securities and Banking Regulation of the District of Columbia (the Department) outlining its plans for attaining all of the required levels of RBC by the year ending December 31, 2011. To date, Chartered has not received notification of rejection from the Department regarding their comprehensive financial plan. Failure to meet the capital requirements and interim capital targets included in Chartered's comprehensive financial plan would expose Chartered to regulatory sanctions that may include restrictions on operations and growth, mandatory asset dispositions, and placing Chartered under regulatory control. The ultimate outcome of this situation cannot presently be determined. These financial statements do not include any adjustments that might result from the outcome of these uncertainties. Achievement of the comprehensive financial plan depends on future events and circumstances, the outcome of which cannot be assured. The comprehensive financial plan includes the following initiatives to meet the RBC requirements by the year ending December 31, 2011:

- Chartered has signed its annual contract renewal with DHCF for the period August 1, 2011 through April 30, 2012. The new actuarially determined rates will add approximately $9 per member per month, which at the current membership will increase premium revenues by approximately $9.5 million for the year ended December 31, 2011.
- Chartered renegotiated new rates with its largest hospital provider effective September 15, 2011. The estimated savings of the new rates, based upon current utilization rates, is $1.6 million in the year ending December 31, 2011.
- Chartered engaged a specialized claims review and recovery contractor on August 1, 2011 to review claims to major providers and ensure that claims payments were in accordance with contracted terms. As of August 29, 2011, approximately $4 million of net claims adjustment recoveries were identified which related to 2010 and 2011. The Company has a plan to charge back these amounts to the providers by reducing future claims payments over a three- to four-month period which began in September 2011. Management plans to continue this process until all such claims recoveries have been identified and adjusted.
- On September 9, 2011, Chartered obtained a signed order of judgment from the District's Contract Appeals Board to obtain an equitable rate adjustment for the dental program. The total settlement amount was approximately $7.5 million and was paid in full to Chartered by Department of Healthcare Finance of DC on September 23, 2011 (see note 16).

(Continued)

(8) Minimum Net Worth and Regulatory and Contractual Requirements

As required by the District of Columbia's Health Maintenance Organization Act of 1996 (the Act), Chartered entered into a Health Maintenance Organization Custodial Agreement dated February 27, 1998. Chartered maintains a certificate of deposit of $300,000, which is included in certificates of deposit pledged on the balance sheets at December 31, 2010 and 2009 for the sole benefit of Chartered's members in the event of Chartered's insolvency. Under the laws of the Act, Chartered is also required to maintain a minimum net worth equal to the greater of (1) $1,000,000; (2) the sum of all uncovered healthcare expenditures for the latest three-month periods ending December 31, September 30, June 30, or March 31; (3) 2% of its annual revenues; or (4) a prescribed percentage of annual healthcare expenditures. According to the Act, a health maintenance organization shall not be required to maintain a net worth in excess of $4,000,000. At December 31, 2010 and 2009, Chartered's statutory net worth was $17,444,611 and $13,656,951, respectively. Chartered was in compliance with its minimum statutory net worth requirements.

Under the terms of its Medicaid contract with DHCF, Chartered is also required to meet certain financial requirements. As such, Chartered is required to maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the Department as a condition for maintaining a certificate of authority to operate an HMO in the District. Chartered met or exceeded the minimum net worth, insolvency reserve, and deposit balance requirements as of December 31, 2010 and 2009. The Medicaid contract also requires Chartered to maintain escrow deposits of $2,000,000, which are included in certificates of deposit – pledged on the balance sheets at December 31, 2010 and 2009.

(9) Commitments and Contingencies

(a) Leases

Chartered is obligated under several noncancelable operating and capital leases for office space, office equipment, and vehicles. Future amounts due under these leases are as follows:

	Operating	Capital
2011	$ 958,730	56,090
2012	982,699	51,425
2013	1,007,266	6,645
2014	509,851	—
2015	—	—
Thereafter	—	—
	$ 3,458,546	114,160
Less amounts representing interest		29,049
		85,111
Less current portion of capital lease obligation		37,947
		$ 47,164

(Continued)

Total rent expense was $1,132,553 and $1,109,866 for the years ended December 31, 2010 and 2009, respectively.

(b) Litigation and Contingencies

Chartered is from time to time subject to claims and suits arising in the ordinary course of business. In the opinion of management, the ultimate resolution of pending legal proceedings will not have a material effect on the financial statements.

(c) Risk-Based Contract Dispute Settlement

Chartered's parent company, DCHSI, executed a settlement and dispute resolution agreement for contractual disputes from January 1, 2001 through April 30, 2008 with the Office of Attorney General for the District of Columbia (OAG of DC), which required DCHSI to pay $12,000,000. DCHSI financed the settlement payment through a $12,000,000 long-term Bank Loan Payable (Loan). Payments of interest only on the outstanding principal balance are due monthly through November 10, 2012; thereafter, payments of principal and interest will continue monthly through November 10, 2018, based on a 25-year amortization schedule. Interest is calculated at an annual fixed rate of 5.65% for the first five years, thereafter adjusting to a rate equal to the Federal Home Loan Bank five-year rate plus 1.50%. Chartered and the owner of DCHSI are co-guarantors of the Loan. Pursuant to the Loan, Chartered is required to pledge investments in the amount of $13,666,095 as collateral for the Loan, which is included in certificates of deposits – pledged in the accompanying balance sheets at December 31, 2010 and 2009. In the event that DCHSI defaults on or is not able to meet its obligations under the provisions of the Loan, the owner of DCHSI has executed an Indemnification Agreement to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered is or may be obligated to pay under the guaranty agreement and pledge and security agreement, including but not limited to any liquidation of the pledged collateral.

(d) Contingent Contributions

In September 2008, in addition to the Settlement Agreement, DCHSI, Chartered, and the owner of DCHSI entered into a Letter Agreement (Agreement) with the District that requires DCHSI, Chartered, and the owner of DCHSI to make contributions to the District of Columbia Department of Health's Immunization Program and several other not-for-profit organizations, including the District of Columbia Public Education Fund, of approximately $1,050,000 each year for a period of five years beginning January 1, 2009. Under the Agreement, these contributions will be made subject to the following conditions being met: (1) the funds received by the various organizations from the previous year were used for the purposes outlined in the Agreement, (2) the submission of a report that demonstrates that the funds were expended in compliance with the Agreement, and (3) Chartered and DCHSI are able to maintain "normal operations" during that year. Therefore, if the District fails to use the funds provided as required, the District is unable to account for related expenditures, or either Chartered or DCHSI suffer adverse financial circumstances, the Agreement may be voided, or are subject to renegotiation. Management believes that there is more than a remote likelihood that the above-mentioned conditions will not be met as of December 31, 2010 and 2009, and, accordingly, has not accrued a liability. Chartered will record the expense in the period in which

(Continued)

the payments are made. Chartered recorded contributions expense of $700,000 and $1,050,000 for the years ended December 31, 2010 and 2009, respectively.

(e) Employment Contracts

Chartered has entered into employment agreements with its key executives, establishing minimum compensation levels, performance requirements, severance, and certain other benefits.

(10) Related-Party Transactions

Chartered has entered into various services arrangements with certain related parties, including DCHSI and CFHC. Payments due under these arrangements do not include an accrued interest component and are expected to be recovered within one year of the balance sheet date and are, therefore, classified as current assets in the accompanying balance sheets. Management believes that all amounts due from affiliates related to the tax-sharing arrangement are fully collectible and will be repaid upon settlement of federal and/or state income tax refund. Management believes that all other amounts due from affiliates are fully collectible and expects that they will be repaid during 2011. Amounts due from (to) affiliates are recorded as assets or liabilities in the accompanying balance sheets, and comprise the following at December 31:

	2010	2009
Due from DCHSI, net	$ 5,039,029	6,073,734
Due (to) from CFHC, net	(2,015,240)	45,456
	$ 3,023,789	6,119,190

(a) DC Healthcare Systems, Inc.

Chartered has a noncancelable operating lease agreement to lease office space from DCHSI. The lease commenced July 1, 2004 and expires on June 30, 2014. The base annual rent is $25 per square foot for 32,660 square feet of space with a 2.5% annual rate increase. Chartered recorded rent expense of $914,761 and $912,533 under the terms of this agreement for the years ended December 31, 2010 and 2009, respectively.

Amounts due from DCHSI, net, are primarily related to net over/payments of estimated federal and state income taxes that Chartered has made to DCHSI during 2010 and 2009.

(b) Chartered Family Health Center, P.C.

CFHC, which became a wholly owned subsidiary of DCHSI on August 14, 2003, is an 18,000-square-foot, full service health center on Minnesota Avenue in the District, which was opened in December 1997. It has a staff of board-certified family physicians, pediatricians, internists, OB-GYNs, and other medical specialists backed by an ancillary staff of nurses, radiology and laboratory technicians, pharmacists, and medical assistants. Under the terms of a Group Provider Agreement (the Provider Agreement) effective May 1, 2008, Chartered reimburses CFHC for actual operating costs incurred by CFHC in providing services to Chartered's members, without any profit markup. Actual operating costs include the expenses incurred in the operation of CFHC after

(Continued)

deducting all revenues collected from third-party payors (other than Chartered) for services rendered to non-Chartered members. Prior to this Provider Agreement, Chartered paid capitation fees to CFHC for professional medical services performed on behalf of Chartered members enrolled at CFHC. Chartered paid capitation fees and net reimbursement costs to CFHC in the amounts of $4,643,603 and $4,857,357 for the years ended December 31, 2010 and 2009, respectively. All amounts due (to) from CFHC at December 31, 2010 and 2009 are included in due (to) from affiliates in the accompanying balance sheets. In February 2011, DCHSI ceased the operations of CFHC.

Amounts due (to) from CFHC are related primarily to unpaid fees under the Provider Agreement and management fees Chartered assessed CFHC for accounting and administrative services, payroll and related benefits expenses paid by Chartered, and were $(2,015,240) and $45,456 at December 31, 2010 and 2009, respectively.

(11) Reinsurance Coverage

Chartered is financially responsible for the cost of each enrollee's annual medical services. Annual inpatient hospital services per enrollee were limited as follows for the years ended December 31, 2010 and 2009:

Effective dates	Limits of coverage
October 1, 2008 through September 30, 2009	$125,000 plus 20% of paid services in excess of the $125,000 stop-loss amount
October 1, 2009 through September 30, 2010	$250,000 plus 20% of paid services in excess of the $250,000 stop-loss amount
October 1, 2010 through September 30, 2011	$300,000 plus 50% of paid services in excess of the $300,000 stop-loss amount

Coverage above these stop-loss amounts is provided by an insurance company. The maximum reimbursement per enrollee is limited to $1,000,000 per contract year with no lifetime maximum.

For the years ended December 31, 2010 and 2009, Chartered incurred stop-loss insurance premium expense of $1,608,563 and $1,277,697, respectively. For the years ended December 31, 2010 and 2009, Chartered had stop-loss insurance recoveries of $806,010 and $569,252, respectively. These amounts related to the stop-loss insurance arrangement are included in healthcare costs, net in the accompanying statements of operations.

(Continued)

(12) Income Taxes

Income tax expense (benefit) related to the continuing operations for the years ended December 31, 2010 and 2009 consisted of the following:

	Current	Deferred	Total
Year ended December 31, 2010:			
U.S. Federal	$ 960,718	(1,575,689)	(614,971)
State and local	94,510	261,873	356,383
	$ 1,055,228	(1,313,816)	(258,588)
Year ended December 31, 2009:			
U.S. Federal	$ (2,295,203)	(298,989)	(2,594,192)
State and local	(726,502)	(94,654)	(821,156)
	$ (3,021,705)	(393,643)	(3,415,348)

Income tax benefit was $258,588 and $3,415,348 for the years ended December 31, 2010 and 2009, respectively. The income tax benefit differed from the amounts computed by applying the U.S. federal statutory income tax rate to pretax income as a result of the following:

	2010	2009
Computed "expected" tax benefit	$ (796,903)	(2,892,811)
State and local income taxes, net of federal income tax expense	61,432	(472,226)
Reversal of state deferred tax assets	261,873	—
Other, net	215,010	(50,311)
Income tax benefit	$ (258,588)	(3,415,348)

Effective May 1, 2010, Chartered is no longer subject to State income taxes. As a result, the Company wrote off $261,873 in state deferred tax assets during 2010. In lieu of State income taxes, Chartered is subject to a 2% premium tax. Chartered has included $3,959,356 in general and administrative expenses in the accompanying statement of operations, and premium taxes payable in the accompanying balance sheet for the year ended December 31, 2010.

(Continued)

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets at December 31, 2010 and 2009 are presented below:

	2010	2009
Deferred tax assets:		
Compensated absences, principally due to accrual for financial reporting purposes	$ 14,025	79,497
Amortization of membership list	52,477	75,293
Property and equipment, principally due to difference in depreciation and amortization	467,249	777,273
Discounted incurred but not reported healthcare costs	2,183,600	213,429
Charitable contribution carryforward	537,491	414,840
Unearned premiums	29,083	—
Deferred straight-line lease expense	89,910	115,106
Total deferred tax assets	3,373,835	1,675,438
Deferred tax liabilities:		
Claims overpayments recoveries	(384,581)	—
Total deferred tax assets, net	2,989,254	1,675,438
Less current portion, net	1,842,127	292,926
	$ 1,147,127	1,382,512

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities, projected future taxable income, and tax planning strategies in making this assessment. Based upon operating trends through fiscal 2010, and projections for future taxable income, management believes that it is more likely than not that Chartered will realize the benefits of certain deductible differences at December 31, 2010. Therefore, management does not believe it is necessary to record a valuation allowance as of December 31, 2010 and 2009.

As of December 31, 2010, Chartered has no unrecognized tax benefits. Therefore Chartered does not expect any impact on the effective tax rate related to recognition of unrecognized tax benefits. In addition, there are no anticipated reversals of uncertain tax positions in the next twelve months. Chartered's policy is to recognize interest and penalties related to unrecognized tax benefits as a component of income tax expense. As of December 31, 2010, Chartered had no accrued interest or penalties related to uncertain tax positions.

(Continued)

(13) Healthcare Costs Payable

A summary of the activity for healthcare costs payable is as follows:

	2010	2009
Balance at January 1	$ 25,352,717	21,482,835
Plus incurred related to:		
Current year	248,529,260	196,055,227
Prior years	4,278,216	2,309,504
Total incurred	252,807,476	198,364,731
Less paid related to:		
Current year	211,458,231	170,971,024
Prior years	29,630,864	23,523,825
Total paid	241,089,095	194,494,849
Balance at December 31	$ 37,071,098	25,352,717

Chartered uses actuarial techniques based on historical experience to estimate incurred claims. Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated, as information regarding actual claims payments become known. This information is compared to the originally established year-end liability. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience being less favorable than that assumed at the time the liability was established. Chartered incurred other healthcare costs, which primarily consisted of capitation payments to providers of healthcare services for Chartered's members of $18,252,061 and $15,956,491 for the years ended December 31, 2010 and 2009, respectively.

(14) Professional Liability Insurance

During 2010 and 2009, Chartered maintained a medical professional liability insurance policy, which is written on a claims-made basis. The coverage limits for the primary medical professional liability policy are $1,000,000 per loss event and a $3,000,000 policy limit per physician. This policy remained in full force and effect during 2010 and 2009 and has been renewed through July 2011. Chartered has not accrued for claims incurred but not reported as of December 31, 2010 and 2009 as these amounts are not reasonably estimable. Management believes that these amounts would not have a material impact on Chartered's financial statements as of December 31, 2010 and 2009.

Chartered has an umbrella liability insurance policy that provides an additional coverage limit of $25,000,000 per loss event. This policy has been renewed through July 2011.

In management's opinion, there are no pending or anticipated claims against Chartered that will have a material effect on the financial position, results of operations, or cash flows of Chartered.

(Continued)

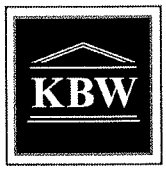
(15) Defined Contribution 401(k) Plan

Chartered sponsors a 401(k) plan (the Plan) for its employees. Employees are eligible to participate in the Plan if they are at least 21 years of age and have worked 90 days or longer at Chartered. Employees may contribute between 1% and 12% of eligible salary on a pretax basis. Chartered makes a discretionary matching contribution to the Plan of 12% of each employee's contribution amount. Chartered contributed $40,946 and $33,442 to the Plan for the years ended December 31, 2010 and 2009, respectively.

(16) Subsequent Event

Chartered filed a claim for $14.9 million with DC Contract Appeals Board (CAB) against the DHCF to obtain an equitable rate adjustment or payment if DHCF and the District's Attorney General's Office approve the claim that was filed. On September 9, 2011, Chartered obtained a signed order of judgment from the District's Contract Appeals Board to obtain an equitable rate adjustment for the dental program. The total settlement amount was approximately $7.5 million and was paid in full to Chartered by the DHCF on September 23, 2011.

EXHIBIT 6



KEEFE, BRUYETTE & WOODS

November 9, 2012

[Insert Name]
[Insert Title]
[Insert Company]

Dear [Name]:

Thank you for your interest in DC Chartered Health Plan, Inc. (the "Company"). On behalf of District of Columbia Insurance Commissioner William P. White, as Court-appointed rehabilitator of the Company (the "Rehabilitator"), Keefe, Bruyette & Woods, Inc. ("KBW') is inviting you to respond to a preliminary request for information in connection with your interest in a potential acquisition and recapitalization of the Company (the "Transaction").

1. Introduction

Pursuant to the Emergency Consent Order of Rehabilitation dated October 19, 2012, the Rehabilitator is vested with title to all of the Company's assets and the power to act as necessary to reform and revitalize the Company. Daniel Watkins has been appointed as Special Deputy Rehabilitator by the Rehabilitator and is responsible for the day-to-day operations of the Company. Faegre Baker Daniels LLP ("FBD") has been retained as legal counsel to the Rehabilitator (KBW, Special Deputy Rehabilitator and FBD collectively, the "Receivership Team"). The Receivership Team has been tasked by the Rehabilitator to conduct a confidential process (the "Process") with select qualified potential counterparties (each a "Counterparty") with respect to a Transaction. DC Healthcare Systems, Inc. is the current holding company of the Company.

2. The Process

The Process is being conducted in phases:

Phase 1: Request for Additional Information from Counterparties

- Your answers to the topics outlined below in *3. Request for Information* should be submitted to KBW via email no later than 5 p.m. Eastern Standard Time on November 14, 2012. Wed
- Representatives from the Receivership Team will be available to consult with you or your representatives to answer any questions you may have prior to the submission date. All communication and questions should be coordinated through KBW.

Additional Phases and Expected Timing

It is anticipated that a limited number of Counterparties may be invited to proceed in additional phases of the Process, at which point additional details regarding the Process shall be provided. It is expected that the prevailing Counterparty would sign a binding letter of intent by December 1, 2012, in advance of the Department of Health Care Finance's RFP (as defined in *DHCF RFP and Timing* below) response deadline of December 3, 2012. 12.1.

3. The Request for Information

Please include a detailed response to the subjects outlined below, as well as any other items that you believe should be considered by the Receivership Team in evaluating your ability to consummate a transaction with the Company:

- Capitalization: It is currently envisaged that any Transaction will be effected via the sale of 100% of the issued share capital of the Company. Upon closing of a Transaction, the prevailing Counterparty is also expected to capitalize the Company so as to satisfy the Company' RBC deficiency as required under D.C. Code § 31-3851.01 *et seq.* The Company and the Rehabilitator, based on the most recent financial information, estimate that the capital required to satisfy the RBC deficiency will be in excess of $30 million. Based upon this estimate, your response should indicate your ability to adequately capitalize the Company in connection with a Transaction.

- Financing: Your response should clearly outline your proposed sources of financing a Transaction. In the event that you intend to utilize third-party financing in connection with a Transaction, your response should include a summary financing plan, including the names and contact information of proposed third-party funding sources or partners and the steps and timing required to secure the necessary funds.

- Acquiring Entity: Your response should clearly identify the acquiring entity. The Rehabilitator expects that the acquiring entity will be a fully capitalized company capable of satisfying all Transaction obligations, including resolution of the Company's RBC deficiency as described above. Evidence of such capitalization should accompany your response.

- DHCF RFP and Timing: The Company's current contract with the Department of Health Care Finance ("DHCF") to provide health care coverage to the District of Columbia's Medicaid and Alliance population expires on April 30, 2013. The Company has received the DHCF's request for proposal (the "RFP"), due December 3, 2012, for award of a five year contract commencing on May 1, 2013 (the "Contract'). The RFP is included with this letter for your review. It is expected that the prevailing Counterparty sign a binding letter of intent prior to the Company submitting a response to the RFP, no later than December 1, 2012. The prevailing Counterparty will also be expected to review and approve a mutually-agreeable response to the RFP prior to its submission. Your response should indicate your ability to move quickly and devote the resources necessary to meet this accelerated timeframe, and should outline the due diligence and necessary approvals (internal or other) you will require prior to executing a binding letter of intent.

- Expertise in the Medicaid Market and Strategic Plans for the Company: Your response should describe in detail your expertise in the Medicaid managed care industry, including any existing operations serving Medicaid eligible beneficiaries. Your response should also include your strategic rationale for acquiring the business and your initial plans for current management. If you envision new management in conjunction with a Transaction, please identify the individuals in your response.
- Contact Information and Advisors: Please provide the names and contact information of those persons the Receivership Team should contact when responding to your proposal and the identity of any external advisors (financial, accounting, legal or other) you have engaged or plan to engage to assist you in connection with the Transaction.
- Other Considerations: Please include any other elements in your response that you would like the Receivership Team to consider.

4. Other Matters

The Rehabilitator reserves the right, in his absolute discretion, at any stage during the Process, to:

- change or alter any part of the Process, which may include ending the Process at any stage, not proceeding with additional phases, or not proceeding with a Transaction;
- exclude any Counterparty from the Process;
- consider any and all factors in evaluating each Counterparty's ability to consummate a Transaction; and
- select any Counterparty to continue discussions irrespective of the stage of the Process.

Neither the Rehabilitator nor the Receivership Team will have any liability or obligation to any Counterparty as a result of the rejection of any proposal or indication of interest. Each Counterparty shall bear all costs of its own investigation and evaluation of the Company and the Transaction, including the fees and disbursements of its own counsel and advisors.

For planning purposes, you should assume that any Transaction will likely be subject to (i) the approval process described in D.C. Code § 31-703(g), and (ii) approval by the Court overseeing the Company's rehabilitation.

You are reminded that all discussions regarding the Company and the Transaction remain subject to the terms of the previously executed confidentiality agreement ("Confidentiality Agreement"). The existence and terms of this letter should be considered to be Confidential Information for the purposes of that Confidentiality Agreement.

Under no circumstances should any contact be made with the Company or any of its employees, agents, customers, counterparties or third-party service providers (including auditors). All correspondence relating to the Company or the Transaction should be made through KBW, addressed to the individuals below:

James Sheehy
Principal
Keefe, Bruyette & Woods, Inc.
787 Seventh Avenue
New York, NY 10019
Email: jsheehy@kbw.com
Tel: 212-887-7785
Fax: 212-541-1799

Andrew Kuo
Associate
Keefe, Bruyette & Woods, Inc.
787 Seventh Avenue
New York, NY 10019
Email: akuo@kbw.com
Tel: 212-887-6761
Fax: 212-541-1799

We look forward to receiving your response by November 14, 2012. Feel free to contact us if you have any questions regarding the guidelines for submitting a response or any other matter related to the Company or the Transaction.

Thank you for your interest in this opportunity.

Sincerely,

James M. Sheehy
Principal

EXHIBIT 7

November 30, 2012

VIA EMAIL

Jay S. Feldstein, D.O.
Regional President
AmeriHealth Mercy Health Plan
200 Stevens Drive
Philadelphia, PA 19113

Dear Dr. Feldstein:

This Letter Agreement (the "Agreement") is hereby entered into among DC Chartered Health Plan, Inc., a health maintenance organization licensed in the District of Columbia ("Chartered") and AmeriHealth Mercy Health Plan ("Mercy"), and is intended to be a binding commitment among the parties hereto.

RECITALS

A. WHEREAS, on November 1, 2012, the District of Columbia's Department of Health Care Finance ("DHCF") released a Request for Proposals ("RFP") to solicit proposals from managed care organizations that are interested in coordinating the delivery of health care services provided to District of Columbia residents through the Medicaid and Alliance programs (each such managed care organization, a "Service Provider"). The RFP will be for a new five (5) year contract period beginning May 1, 2013 (the "Contract"); and

B. WHEREAS, with Chartered's assistance, resources, assets and know-how, Mercy intends to submit a response to this RFP, and Chartered has agreed to utilize its resources, assets, and know-how in support of Mercy's application based upon Mercy's commitments made herein.

C. NOW, THEREFORE, the parties hereto, for good and valuable consideration, the sufficiency of which is hereby acknowledged, agree as follows:

AGREEMENT

1. **Payment and Transition Services**. If Mercy or one of its affiliates is chosen as a Service Provider under the RFP and commences operations thereunder, then Mercy shall do the following:

   a. On the sooner of (i) the closing of the contemplated asset purchase transaction between Mercy and Chartered (the "Asset Purchase") or (ii) within five (5) business days after Mercy begins performing services on behalf of District of Columbia residents as a Service Provider under the RFP, Mercy shall pay Five Million Dollars ($5,000,000) to Chartered in immediately available funds, wired in accordance with instructions provided by Chartered.

b. Mercy shall provide claims processing, accounting, human resources, and related transition services requested by Chartered to assist Chartered as it transitions its business to Mercy upon commencement of the new Contract.

It is understood that Mercy is under no obligation to commence such operations as a Service Provider and will not commence such services if a closing in the Asset Purchase has not occurred.

2. **Choice of Law; Jurisdiction**. This Agreement is made in and shall be governed by and construed in accordance with the laws of the State of Delaware without regard to conflict of laws doctrines. Mercy and Chartered irrevocably consent and submit to the exclusive jurisdiction of the applicable court within the District of Columbia for enforcement by Mercy and Chartered of this Agreement. Mercy and Chartered irrevocably waive any objection they may have to venue in the defense of an inconvenient forum to the maintenance of such actions or proceedings to enforce this Agreement.

3. **Counterparts**. This Agreement may be executed in the original, by facsimile or by any generally accepted electronic means (including transmission of a pdf file containing an executed signature page) in any number of counterparts, each of which shall be deemed an original and all of which shall constitute one and the same instrument.

4. **Successors and Assigns**. This Agreement shall be binding upon and inure to the benefit of each of the parties hereto, and their respective successors, assigns, heirs and personal representatives. Nothing in this Agreement, express or implied, is intended to confer on any person other than the parties hereto, and their respective successors and permitted assigns any rights, remedies, obligations or liabilities under or by reason of this Agreement. This Agreement shall not be assignable by Mercy without the prior written consent of Chartered.

5. **Entire Agreement; Amendments.** This Agreement constitutes the entire agreement between the parties. This Agreement shall not be modified or amended except pursuant to an instrument in writing executed and delivered on behalf of each of the parties hereto.

If the terms and conditions set forth above are acceptable to Mercy, please sign this Letter Agreement where indicated below and return one counterpart hereof to the undersigned before the close of business on December 1, 2012.

Sincerely,

DC Chartered Health Plan, Inc.

By: Daniel Watkins
Daniel L. Watkins,
Special Deputy Rehabilitator

Accepted and agreed on
November 30, 2012

AmeriHealth Mercy Health Plan

By: Jay S Felostein D.O
Name: JAY S FELOSTEIN
Title: REGIONAL PRESIDENT

EXHIBIT 8

Receiver's Status Report on Chartered Health Plan Inc.

Dec. 3, 2002

The receiver is negotiating a transaction with health-insurer AmeriHealth Mercy headquartered in Philadelphia and has entered into a letter of intent which has the potential to best achieve value for Chartered and to best serve its members and providers and the District. Amerihealth has filed a proposal today to service the District's Medicaid clients.

Here are some questions and answers on Chartered's status:

Is the independent audit of Chartered's 2011 annual statement which was due November 30 completed?

Unfortunately, no. Chartered requested an extension of time to December 20 for the outside auditors to complete their work on the 2011 financial statement.

Chartered has been working diligently to provide the auditors with the necessary information and the auditors are performing appropriate tests of that data and reviewing the company's schedules and comments.

This process has taken more time than anticipated but it should be completed soon, and the audited statement will be made public when it is filed with the Department of Insurance, Securities and Banking.

Can Chartered pay its claims and perform on its current contract with the District?

Yes, Chartered is paying provider claims and continues to meet its obligations under its Medicaid contract with the District. That agreement runs to April 30, 2013. The Rehabilitator continues to seek a way forward that achieves the best value and utilization of Chartered's assets and which can help provide the best results for its members, providers and the District. We will take a plan to the Court with details of how this would be done when definitive terms for a plan are finalized.

Did Chartered file a response to the RFP for a new five year Medicaid contract?

No. Chartered entered a letter of intent with AmeriHealth Mercy regarding a potential transaction and AmeriHealth Mercy responded to the RFP.

How did Chartered determine not to bid on the RFP?

The Rehabilitator engaged an investment banking firm to conduct a process seeking a strategic partner with sufficient financial and operational resources to serve the District's Medicaid enrollees and their medical providers. In a very compressed timeframe, Chartered and its advisors are seeking a way forward that can realize value for Chartered's assets and best provide model services and improved health outcomes for District enrollees. We are negotiating a transaction with AmeriHealth Mercy to accomplish both of those goals.

Is there any agreement with the holding company or the holding company's stockholder?

There are no agreements with the holding company or its shareholder regarding any potential transaction or proceeds from such a transaction.

For more information, contact Michael Flagg at the Department of Insurance, Securities and Banking: Michael.flagg@dc.gov, 202 442-7756.

EXHIBIT 9

Exhibit A
Protest of D.C. Healthcare Systems, Inc.
CAB No. P-0930

GOVERNMENT OF THE DISTRICT OF COLUMBIA
CONTRACT APPEALS BOARD

PROTEST OF:	)	
	)	
D.C. Healthcare Systems, Inc.	)	
1920 N Street, NW – Suite 800	)	**CAB No. P-0930**
Washington, DC 20036	)	
	)	
Under Solicitation	)	
No. Doc70947/DHCF-2013-R-0003	)	

DECLARATION OF DANIEL L. WATKINS

I, DANIEL L. WATKINS, declare, in support of the District of Columbia's defense of the above-captioned protest, by D.C. Healthcare Systems, Inc., of the terms of Solicitation Number Doc70947/DHCF-2013-R-0003:

1. I am an adult over the age of 18 years old, and am competent to provide the information set forth herein.

2. On October 19, 2012, the Superior Court for the District of Columbia (the "Court") entered an Emergency Consent Order of Rehabilitation ("Rehabilitation Order") with respect to D.C. Chartered Health Plan, Inc. ("Chartered") in civil action 2012 CA 0082272. A copy of the Rehabilitation Order is attached as Exhibit 1. The Commissioner of the District of Columbia Department of Insurance, Securities and Banking, William P. White, was appointed Rehabilitator, and he appointed me Special Deputy to the Rehabilitator. A copy of the appointment order is attached as Exhibit 2.

3. Under the Rehabilitation Order and D.C. law, the Rehabilitator has (a) "[a]ll powers of the directors, officers and managers of Chartered, whose authority is suspended except as may be re-delegated by the Rehabilitator" (D.C. Code § 31-1312(c); Rehabilitation Order, p. 2); (b) "[a]uthority to take such action as deemed necessary or appropriate to reform and revitalize Chartered" (D.C. Code § 31-1312(c); Rehabilitation Order, p. 2); and (c) "[a]uthority to take possession and control of Chartered's assets and administer them under the general supervision of the Court." (D.C. Code § 31-1311(a); Rehabilitation Order, p. 2.) The Rehabilitator was under no obligation under D.C. law or the Rehabilitation Order to consult with or inform Chartered's parent company, D.C. Healthcare Systems, Inc. ("DCHSI"), or DCHSI's shareholder, Jeffrey Thompson, prior to taking action.

4. On October 25, 2012, just six days after entry of the Rehabilitation Order, Commissioner White and Director Turnage appeared before the Joint Oversight Roundtable on the D.C. Chartered Health Plan, Inc. Receivership of the Committee on Public Services and Consumer Affairs and the Committee on Health. Statements made by Commissioner

White and Director Turnage at the meeting reflected their views at that time and not any decisions about what could be accomplished.

5. The Office of Contracts and Procurement ("OCP") and the Department of Health Care Finance ("DHCF") required RFP responses to be submitted by December 3, 2012, and their announced timeline called for OCP to select MCO's to negotiate with in early-January 2013, so contracts could be presented to the District of Columbia Council for approval by February 1, 2013.

6. Chartered had significant challenges to overcome in order to submit a viable RFP response. DHCF made clear in numerous communications that while Chartered would be permitted to submit a bid for a new Medicaid contract while in rehabilitation, no new contract would be awarded to Chartered unless Chartered had a new owner and was out of rehabilitation by mid-January 2013. To make Chartered a viable applicant, the Rehabilitator immediately engaged an investment banker and sought to identify a credible partner willing to purchase and recapitalize Chartered as part of a transaction that needed to be negotiated, executed and closed in very little time. (See the Special Deputy Rehabilitator's First Status Report to the Court on January 11, 2013 (the "Report"), pp.2-5, a copy of which is attached as Exhibit 3.)

7. While the Rehabilitator was exploring alternatives, Chartered worked on an RFP response and monitored the OCP RFP process, submitting questions to clarify issues in the RFP through the on-line process required by OCP. OCP provided responses to Chartered's inquiries to all prospective bidders through its RFP process.

8. At the very end of November, the Rehabilitator determined that Chartered would not submit a response to the RFP in its own name. Instead, the Rehabilitator decided to pursue a transaction with AmeriHealth Mercy ("AHM") for the purchase of certain assets of Chartered and for AHM to submit an RFP response utilizing key Chartered personnel and experience. The Report sets out the reasons for that decision, which was not made in conjunction or consultation with, or with the knowledge of, OCP or DHCF. (Report pp. 5-7.)

9. On December 3, 2012, after the bid responses were due, the Rehabilitator issued a statement and answers to questions (the "Statement") regarding the status of Chartered's 2011 audit and the decision not to submit a response to the RFP. A copy of the Statement is attached as Exhibit 4. The Statement noted that Chartered had signed a letter of intent with AHM for the sale of certain assets.

10. The asset transaction contemplated by the agreement with AHM if completed and closed will utilize Chartered employees and provider relationships and realize value for the rehabilitation estate in meeting Chartered's liabilities.

I, DANIEL L. WATKINS, declare under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge and belief.

Dated: January 31, 2013

Daniel L. Watkins

EXHIBIT 1

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

Clerk of the Court

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

EXHIBIT 2

Government of the District of Columbia
Vincent C. Gray, Mayor
Department of Insurance, Securities and Banking

William P. White
Commissioner

ORDER APPOINTING A SPECIAL DEPUTY

WHEREAS, on October 19, 2012, Judge Rufus G. King, III, Superior Court of the District of Columbia, issued an Order of Rehabilitation ("Order") authorizing the Rehabilitation of DC Chartered Health Plan, Inc. ("Chartered") by William P. White, the Commissioner of the Department of Insurance, Securities and Banking ("Commissioner" and/or "Rehabilitator"), pursuant to D.C. Official Code §§ 31-1303, 1310-1312 and 3420, in the proceeding captioned *District of Columbia, Department of Insurance, Securities and Banking v. DC Chartered Health Plan, Inc.*, Civil Action No. 2012 CA 8227; and

WHEREAS, the Order attached hereto and incorporated within this Order, appoints the Commissioner and his successors in office as Rehabilitator of Chartered; and

WHEREAS, the Order authorizes the Rehabilitator to take possession and administer the assets of Chartered; and

WHEREAS, the Order vests title in the Rehabilitator of all assets of Chartered; and

WHEREAS, the Order grants the Commissioner all rights, power, and authority vested by law in a Rehabilitator; and

WHEREAS, the Order authorizes the Commissioner as Rehabilitator to appoint one or more special deputies who may exercise the powers and responsibilities of the Rehabilitator;

NOW, THEREFORE, IT IS ORDERED as follows:

1. That pursuant to the Rehabilitator's authority under the Order and the provisions of Title 31, Chapter 13 of the District of Columbia Official Code, Daniel L. Watkins is hereby appointed as Special Deputy to the Rehabilitator for the purposes of rehabilitating Chartered and for any related actions; and

2. That the reasonable compensation of Daniel L. Watkins as Special Deputy shall be determined pursuant to a letter of engagement entered into between the Rehabilitator and Daniel L. Watkins and attached hereto; and

3. That Daniel L. Watkins as Special Deputy, shall have all of the powers of the Rehabilitator under the Order and Title 31, Chapter 13 of the District of Columbia Official Code, and any other statutory or regulatory provisions granting the Commissioner powers or authority related to the Rehabilitation of an insurer, including the authority to appear in any court to enforce the Order; and

4. That Daniel L. Watkins as Special Deputy shall serve at the pleasure of the Rehabilitator.

5. This Order shall be effective *nunc pro tunc* as of the 19th day of October, 2012.

SO ORDERED.

WITNESS MY HAND AND THE OFFICIAL SEAL of the District of Columbia Department of Insurance, Securities and Banking, this Second day of November, 2012.

Government of the District of Columbia
Department of Insurance, Securities and Banking

William P. White, Commissioner/Rehabilitator

EXHIBIT 3

SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA, Department of Insurance, Securities and Banking, Petitioner, v. DC CHARTERED HEALTH PLAN, INC., Respondent.	Civil Action No.: 2012 CA 008227 2 Judge: Wright Calendar No.: 15 Next Event: Status – 1/15/13 at 9:30

NOTICE OF FILING SPECIAL DEPUTY TO THE REHABILITATOR'S FIRST STATUS REPORT

The District of Columbia and William P. White, Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("DISB"), by and through his attorneys, the Office of the Attorney General of the District of Columbia, files the attached Special Deputy to the Rehabilitator's First Status Report authored by Daniel L. Watkins, Special Deputy to the Rehabilitator.

Respectfully submitted,

IRVIN B. NATHAN
Attorney General for the
District of Columbia

ELLEN A. EFROS
Deputy Attorney General
Public Interest Division

/s/ Stephane J. Latour
STEPHANE J. LATOUR
Chief, Civil Enforcement Section

/s/ E. Louise R. Phillips
E. LOUISE R. PHILLIPS
Assistant Attorney General
Bar Number 422074
441 Fourth Street, N.W., 650N
Washington, D.C. 20001
202-727-0874, fax 202-730-0658
louise.phillips@dc.gov
Attorney for the DC and Commissioner

CERTIFICATE OF SERVICE

I hereby certify that on this 11th day of January, 2013, a copy of the foregoing was filed and served by email upon:

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

Charles T. Richardson, Esquire
FAEGRE BAKER DANIELS LLP
1050 K Street NW, Suite 400
Washington, DC 20001

Daniel Watkins, Esquire
Special Deputy to the Rehabilitator
Chartered Health Plan
1025 15th St. NW
Washington, DC 20005
danwatkins@sunflower.com

Stephen I. Glover, Esquire
Gibson, Dunn & Crutcher
1050 Connecticut Ave., NW
Washington, DC 20036
siglover@gibsondunn.com

/s/ E. Louise R. Phillips
E. Louise R. Phillips
Assistant Attorney General

From: notifications@cfxpress.com
Sent: Friday, January 11, 2013 11:17 AM
To: Phillips, Louise (OAG)
Subject: ACKNOWLEDGEMENT; Cause/Case: 2012 CA 008227 2; Document Type: Praecipe Filed:; Jurisdiction: D.C. Superior Court

CaseFileXpress NOTIFICATION LOGIN

ACKNOWLEDGMENT OF eFILING

This email acknowledges that a filing with the following information was received by CaseFileXpress and has been transmitted successfully to the clerk's office. Please do not reply to this email.

Case Title/Style Number:	2012 CA 008227 2
Document Type:	Praecipe Filed:
Filing Attorney:	Louise Phillips
Client Matter Number:	na
Case Title/Style:	District of Columbia v. DC Chartered Health Plan, Inc.
Judge:	Judge Wright
Status:	ACKNOWLEDGEMENT (filing information has been received and will be transmitted to the court)
Date of Status:	Friday, January 11, 2013 11:16:56 AM (Eastern (U.S. and Canada))
Court Assignment:	Civil Actions
Jurisdiction:	D.C. Superior Court
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SUPERIOR COURT FOR THE DISTRICT OF COLUMBIA
Civil Division

DISTRICT OF COLUMBIA,
Department of Insurance, Securities and Banking,

Petitioner,

v.

DC CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No.: 2012 CA 008227 2
Judge: Wright
Calendar No.: 15
Next Event: Status – 1/15/13 at 9:30

SPECIAL DEPUTY TO THE REHABILITATOR'S FIRST STATUS REPORT

Daniel L. Watkins, as Special Deputy to the Rehabilitator, files this first status report:

1. **Order of Rehabilitation.** The Emergency Consent Order of Rehabilitation was entered by the Court on October 19, 2012, and the Commissioner of the District of Columbia Department of Insurance, Securities and Banking, William P. White, was appointed Rehabilitator. Under the Court's Order and DC law, the Rehabilitator is charged with operating Chartered's business (including taking possession of Chartered's assets and pursuing legal claims on the company's behalf) and taking such steps as are necessary to reform, revitalize or otherwise deal with Chartered.

2. **Key Activities Immediately After Rehabilitation.** The Rehabilitator appointed Dan Watkins Special Deputy (order **attached** as Exhibit 1) and Faegre Baker Daniels as the Rehabilitator's counsel. There was a delegation by the Rehabilitator to Maynard McAlpin, CEO of Chartered, of certain day-to-day operational matters, followed by meetings with employees, lawyers and others conducting or having an impact on Chartered's business, including the Department of Health Care Finance (DHCF). From the beginning, the Rehabilitator has sought to ensure continuity of care for Chartered's 110,000 Medicaid and DC Alliance enrollees, make payments to over 5,000 providers and other creditors, consider the interests of Chartered's 160 employees and preserve any residual value for Chartered's shareholder. With those overarching goals in mind, the Rehabilitator's efforts to date have concentrated on: (a) seeking a solution to Chartered's financial issues through a transaction/plan, if feasible, (b) considering how best to respond to a request for proposals (RFP) from the DHCF regarding a new Medicaid agreement, either with or through a new partner, by the December 3, 2012 filing deadline, (c) facilitating completion of the outside audit of Chartered's December 31, 2011 statutory financial statements by the auditing firm of Brown Smith Wallace, as well as bringing Chartered's 2012 financial statements current, and (d) addressing legal matters facing Chartered.

3. **Initial Steps in Support of Those Activities.** The Rehabilitator hoped to find a partner who would acquire all of the outstanding shares of Chartered's common stock and recapitalize the company so as to cure its risk based capital deficiency. Toward that end, the Rehabilitator engaged the investment banking firm Keefe, Bruyette & Woods (KBW) as a financial advisor in the first week of Chartered's rehabilitation. KBW distributed a process letter and a draft of Chartered's unaudited summary 2011 statutory financial statements to those prospects who signed a confidentiality agreement with the Rehabilitator. Confidential meetings and discussions with several interested parties followed.

4. **Challenges Abound.** In searching for a partner willing to purchase and recapitalize Chartered, the Rehabilitator faced significant challenges, including:

A. Chartered's sole source of revenue (its Medicaid contract with the District) expires on April 30, 2013. Chartered required a new Medicaid contract with the District to be a viable acquisition candidate.

B. DHCF made clear in numerous communications to the District Council, District agencies and Chartered that while Chartered would be permitted to submit a bid for a new Medicaid contract (by the December 3, 2012 due date), no new contract would be awarded to Chartered unless Chartered had a new owner and was out of rehabilitation by mid-January 2013, when contract award recommendations were scheduled to be made to the Council. The Rehabilitator believed that meeting these requirements in the time allotted would not be possible – given the need to close a stock transaction and have it approved by the Court – but appreciated DHCF's concerns and imperatives.

C. DHCF's concerns were not limited to Chartered's financial condition, ownership and the fact that the company was in rehabilitation. DHCF also expressed increasing concerns with Chartered's performance and service levels, issuing a Corrective Action Plan/Non-Compliance letter on November 28, 2012. Given the scoring factors to be used in the RFP process, the Rehabilitator believed that performance and service level issues would present an additional obstacle to Chartered's securing a new Medicaid contract.

D. Chartered's financial picture was incomplete, but troubling. While year-end 2011 audited financials remained a work in progress, the unaudited financial statement for 2011 showed practically no remaining capital and surplus. Based on the

information available at the time the process letter was sent, the Rehabilitator calculated that approximately $30 million in new capital would be required to correct Chartered's risk based capital deficiency.

E. A significant portion of Chartered's assets relate to (i) Chartered's claims for premium owed under its existing Medicaid contract (which DHCF contests); and (ii) almost $14 million of investments that are pledged as security for a loan obligation owed by Chartered's parent, D.C. Healthcare Systems, Inc. (DCHSCI). Those assets are not currently available to pay claims and caused potential investors considerable concern.

F. In addition, potential investors were concerned because they could not adequately assess potential federal income tax implications involved with a purchase of Chartered, including the collectability from DCHSCI of an aged $4 million federal income tax asset recorded on Chartered's unaudited 2011 financial statement.

G. Potential acquirers had very little time to perform due diligence and secure financing, given the December 3, 2012 deadline for Chartered to bid on a new Medicaid contract with an acquirer.

H. Adverse publicity and speculation relating to an investigation of Chartered's ultimate controlling person and possible related party transactions raised questions among would-be acquirers.

In the months leading up to rehabilitation, DCHSI faced most of these same challenges when it tried (unsuccessfully) to sell Chartered.

5. **Discussions with Certain Prospects.** Starting the week of November 12, 2012, the Rehabilitator's efforts got down to specific discussions with strategic partners – firms that could bring clear financial strength and operational credibility to the DC Medicaid market very quickly. KBW ran the solicitation process, electronic data room and prospect discussions/due diligence, with support from the Special Deputy and Chartered employees. Transaction structure, given Chartered's legal and financial situation, was a key driver and consumer of time and effort as issues with prospects and their transaction teams were worked through. There were in-person meetings with three strategic partner prospects.

6. **The Choices Made.** During the week of November 26, 2012, the rehabilitation team, in consultation with the Rehabilitator and others at Chartered, determined that the best alternative for achieving value for Chartered under the circumstances was to enter into a letter of intent with AmeriHealth Mercy (AHM) (corporate overview **attached** as Exhibit 2) for the sale of certain Chartered assets, to work with AHM to complete a response to the DHCF RFP in AHM's name (utilizing key Chartered personnel and experience in the response), and to negotiate a definitive agreement with AHM that would be subject to Court approval. Here are the reasons for those choices:

   A. The Rehabilitator believed that Chartered's chances of winning a new Medicaid contract were not realistic, given: (i) the DHCF requirement that Chartered have a new owner and be out of rehabilitation in January 2013; (ii) the financial and legal obstacles to closing a sale of the company and emerging from rehabilitation within a six week period at the end

of the year; and (iii) DCHF's concerns about Chartered's performance and service levels. Instead, the Rehabilitator concluded that the best option to realize value for Chartered and participate in serving enrollees and providers under a new contract was to enter into an asset purchase agreement with a financially strong company with significant expertise in the Medicaid space and a strong chance of success in the DHCF's rating criteria for a new contract.

   B. With one exception, other parties expressing interest failed to provide certainty regarding their financing and capabilities in a timely manner or lacked experience in operating a Medicaid HMO.

   C. Our investment banker, KBW, has expressed the view that the transaction reflected in the AHM letter of intent, if negotiated to final terms and closed, is the best alternative available given the circumstances and represents a reasonable reflection of any inherent value in Chartered's business operation in its current state.

7. **The Financial Audit.** Chartered submitted unaudited 2011 financial statements to DISB in April 2012. Chartered filed an independently audited December 31, 2011 statutory financial statement with DISB on January 10, 2013. Brown Smith Wallace LLC performed the audit, and a copy of the independent auditor's report is **attached** as Exhibit 3. Here are the highlights:

   A. The statutory annual statement shows Chartered experienced a loss of $9.4 million in 2011 and ended the year with $5.9 million in capital and surplus. The financial results are somewhat stronger than reported in April 2012, due to the inclusion of a net $20 million retrospective premium receivable that had not been recorded as an asset in

the unaudited 2011 statutory financial statements filed in April 2012. This amount represents the estimated value of the company's net receivable for a premium claim under the existing Medicaid contract at December 31, 2011. The claim, which is pending before the District's Contract Appeals Board (CAB No. D-1445), is primarily driven by HIV pharmacy costs over and above Chartered's contracted premium rate with the District.

B. Chartered's audited statement also recognizes that some related party balances previously recorded as assets do not qualify for inclusion in Chartered's financial statement under DC law:

- A $1,027,504 receivable related to payments to the Chartered Family Health Center (CFHC), a former affiliate of Chartered, for which the auditors found inadequate documentation to support the transactions; and
- A $2,828,018 receivable for net federal income tax amounts currently due Chartered from DCHSI, which was deemed to not qualify for inclusion in Chartered's financial statement because it is long overdue.

Chartered is demanding that DCHSI (i) pay the $2,828,018 income tax receivable and (ii) provide appropriate documentation or pay Chartered $1,027,504 for the unsupported amounts paid to CFHC. Chartered also is demanding that the holding company account to Chartered on tax matters.

C. Other adjustments to Chartered's restated 2011 financials include:

- Reductions of $2.2 million in premium income and $2.9 million in healthcare recoverables previously booked as assets; and
- An increase of $5 million in claims liabilities based on claim trends and actual cost analysis in 2012. This adjustment to claims liability also caused an increase in claim adjustment expense liability.

8. **Other Matters.** As part of the matters described in paragraphs 1-7 above, the Rehabilitator has relied on Chartered's employees, counsel and advisors in conducting Chartered's business and moving forward in the receivership. The Rehabilitator has also authorized the continuation of the pursuit of claims and assets and the defense of any litigation, including litigation initiated in the DC Superior Court (Case No. 2012 CA 009510 B) on December 21, 2012, against Chartered by Washington Hospital Center Corporation and MedStar Georgetown Medical Center, Inc. for injunctive relief growing out of Chartered's contractual audit of claims paid to those two entities. Finally, the Rehabilitator has worked with the Office of Attorney General to respond to a protest filed by DCHSI with the Contract Appeals Board (CAB No. P-0930) in connection with the RFP for a new Medicaid contract.

9. **Where From Here.** Chartered's financial reality is that fair value on two currently illiquid assets on its balance sheet need to be realized – (i) the premium claim under Chartered's existing Medicaid contract and (ii) assets pledged to Cardinal Bank pursuant to a loan transaction with Chartered's holding company in 2008. That is a tall order, but the Rehabilitator is working diligently to achieve that fair value and marshal sufficient assets to satisfy claims and realize any residual value when the current Medicaid contract ends. The Rehabilitator believes an AHM transaction will help facilitate that desired result.

Negotiation of a definitive transaction agreement with AHM is underway, to be followed by a request for the Court's consideration and approval of that agreement. Hopefully, a successful result for AHM in the DHCF RFP process can lead to implementation of the Chartered solution being pursued by the Rehabilitator. In the meantime, the Rehabilitator and his Special Deputy will continue to follow the procedures outlined in the initial redelegation to management so that the day-to-day administration of Chartered's business occurs – principally, service to over 110,000 enrollees and payment to providers. The Rehabilitator and Special Deputy will also be carrying out their other responsibilities under the October 19 Emergency Consent Order of Rehabilitation.

Respectfully submitted,

/s/ Daniel L. Watkins
DANIEL L. WATKINS
Special Deputy Rehabilitator
Chartered Health Plan
1025 15th St. NW
Washington, DC 20005

EXHIBIT 1

Government of the District of Columbia
Vincent C. Gray, Mayor
Department of Insurance, Securities and Banking

William P. White
Commissioner

ORDER APPOINTING A SPECIAL DEPUTY

WHEREAS, on October 19, 2012, Judge Rufus G. King, III, Superior Court of the District of Columbia, issued an Order of Rehabilitation ("Order") authorizing the Rehabilitation of DC Chartered Health Plan, Inc. ("Chartered") by William P. White, the Commissioner of the Department of Insurance, Securities and Banking ("Commissioner" and/or "Rehabilitator"), pursuant to D.C. Official Code §§ 31-1303, 1310-1312 and 3420, in the proceeding captioned *District of Columbia, Department of Insurance, Securities and Banking v. DC Chartered Health Plan, Inc.*, Civil Action No. 2012 CA 8227; and

WHEREAS, the Order attached hereto and incorporated within this Order, appoints the Commissioner and his successors in office as Rehabilitator of Chartered; and

WHEREAS, the Order authorizes the Rehabilitator to take possession and administer the assets of Chartered; and

WHEREAS, the Order vests title in the Rehabilitator of all assets of Chartered; and

WHEREAS, the Order grants the Commissioner all rights, power, and authority vested by law in a Rehabilitator; and

WHEREAS, the Order authorizes the Commissioner as Rehabilitator to appoint one or more special deputies who may exercise the powers and responsibilities of the Rehabilitator;

NOW, THEREFORE, IT IS ORDERED as follows:

1. That pursuant to the Rehabilitator's authority under the Order and the provisions of Title 31, Chapter 13 of the District of Columbia Official Code, Daniel L. Watkins is hereby appointed as Special Deputy to the Rehabilitator for the purposes of rehabilitating Chartered and for any related actions; and

2. That the reasonable compensation of Daniel L. Watkins as Special Deputy shall be determined pursuant to a letter of engagement entered into between the Rehabilitator and Daniel L. Watkins and attached hereto; and

3. That Daniel L. Watkins as Special Deputy, shall have all of the powers of the Rehabilitator under the Order and Title 31, Chapter 13 of the District of Columbia Official Code, and any other statutory or regulatory provisions granting the Commissioner powers or authority related to the Rehabilitation of an insurer, including the authority to appear in any court to enforce the Order; and

4. That Daniel L. Watkins as Special Deputy shall serve at the pleasure of the Rehabilitator.

5. This Order shall be effective *nunc pro tunc* as of the 19th day of October, 2012.

SO ORDERED.

WITNESS MY HAND AND THE OFFICIAL SEAL of the District of Columbia Department of Insurance, Securities and Banking, this Second day of November, 2012.

Government of the District of Columbia
Department of Insurance, Securities and Banking

William P. White, Commissioner/Rehabilitator

EXHIBIT 2

AMERIHEALTH MERCY FAMILY OF COMPANIES

AmeriHealth traces its roots back to Dublin, Ireland. Catherine McAuley used her inheritance to serve the poor, especially women and children, and founded the Sisters of Mercy in 1831. The Sisters of Mercy arrived in Philadelphia in 1861 and immediately began visiting the sick in their homes and setting up schools for the instruction and care of children and adults.

The Sisters founded Misericordia Hospital (now known as Mercy Philadelphia Hospital) in 1918. In the late 1970's and early 1980's the hospital witnessed a troubling increase in the number of people, mostly on Medical Assistance (Pennsylvania's Medicaid program), using the emergency room to seek primary care. This was not a good solution, as the critical pace of an emergency room is not intended to foster a patient/physician relationship, and engenders high costs and poor stewardship of resources.

Thus the concept of Mercy Health Plan was born: a voluntary Medicaid managed care plan. In 1983, the leaders of Misericordia Hospital persuaded the Pennsylvania state government to let them start a pilot capitated health plan to give 300 Medicaid recipients a "medical home" to reduce dependence on the emergency room for primary care. The Plan would work to connect each member with a Primary Care Physician, to encourage consistent and proactive health care, to extend benefits beyond the state fee-for-service model and to encourage the use of the emergency room for emergencies only.

Mercy Health Plan grew quickly. And in 1996, the owners of Mercy Health Plan joined with Independence Blue Cross to form the partnership that served as the foundation for the Company's growth to date. In 2011, the original owners of Mercy Health Plan elected to return to their original mission of providing acute care services to the poor. Blue Cross Blue Shield of Michigan agreed to join Independence Blue Cross in owning AmeriHealth Mercy resulting in the current ownership structure of the Company.

The AmeriHealth Family of Companies has grown to be one of the largest organizations of government-sponsored managed care and administrative services entities in the United States, touching almost five million members. AmeriHealth serves its members through five major products:

Medicaid (including TANF, ABD, SSI and TPA)

- ☐ Programs for Dual Eligibles (including D-SNPs and FIDEs)
- ☐ Low-Income Products (including SCHIP and Uninsured products)
- ☐ Behavioral Health (risk and non-risk); and
- ☐ Pharmacy (Medicaid, Part D, and Commercial.

The states in which we have served Medicaid-eligible enrollees are as diverse as our enrollee population, including: Pennsylvania, New Jersey, Kentucky, South Carolina, Indiana, Louisiana and Nebraska. As of January 1, 2013, we will also serve members in Florida, and members enrolled in our D-SNPS in South Carolina and Pennsylvania. We also anticipate serving Medicaid members in Michigan during the first quarter of 2013.

Our areas of service have included both urban and rural populations. Enrollees benefit from an organization combining high-quality managed care expertise and a high-touch local presence.

AmeriHealth Mercy Family of Companies | *Current Markets*

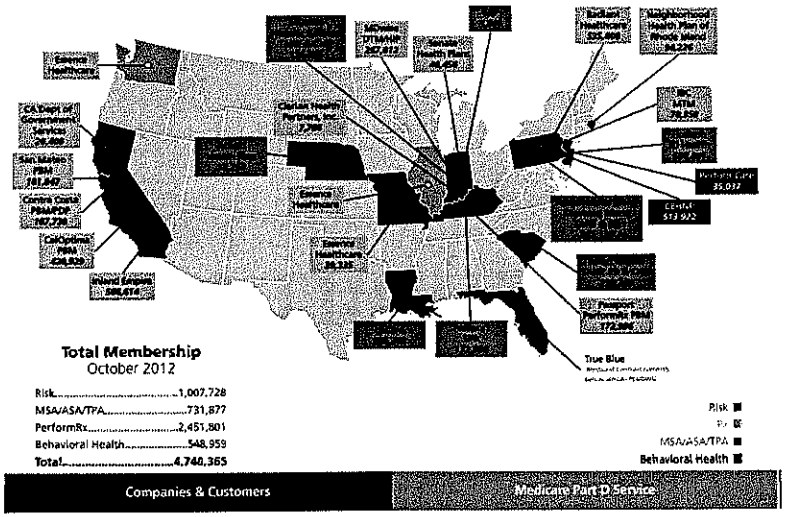

EXHIBIT 3

D.C. CHARTERED HEALTH PLAN, INC.

IN RECEIVERSHIP

(A WHOLLY OWNED SUBSIDIARY OF D.C. HEALTHCARE SYSTEMS, INC.)

STATUTORY FINANCIAL STATEMENTS

DECEMBER 31, 2011

(WITH INDEPENDENT AUDITORS' REPORT THEREON)

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BROWN SMITH WALLACE LLC
1050 N. LINDBERGH BOULEVARD ST. LOUIS, MO 63132 PH 314.983.1200 FX 314.983.1300 WWW.BSWLLC.COM
A MEASURABLE DIFFERENCE℠

Independent Auditors' Report

Commissioner as Rehabilitator
D.C. Chartered Health Plan, Inc. in Receivership
Washington, D.C.

We were engaged to audit the accompanying Statutory Statement of Admitted Assets, Liabilities, and Capital and Surplus of D.C. Chartered Health Plan, Inc. in Receivership ("Chartered"), a wholly owned subsidiary of D.C. Healthcare Systems, Inc. (the "Parent"), as of December 31, 2011 and the related Statutory Statements of Operations, Capital and Surplus, and Cash Flows for the year then ended. These statutory financial statements are the responsibility of Chartered's management and the Commissioner as Rehabilitator. Our responsibility is to express an opinion on the statutory financial statements based on our audit.

Except as discussed below, we conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Chartered's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the statutory financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As described more fully in Note 2 to the statutory financial statements, Chartered prepared these statutory financial statements using accounting practices prescribed or permitted by the Department of Insurance, Securities and Banking of the District of Columbia, which practices differ materially from accounting principles generally accepted in the United States of America.

Because of inadequacies in Chartered's accounting records and the inability to support certain transactions with related parties and other account balances, we were unable to rely on the amounts recorded in the Statement of Admitted Assets, Liabilities, Capital and Surplus as of December 31, 2010.

As discussed in Note 5 to the statutory financial statements, Chartered recognized a change in accounting principle to account for Chartered's contract with the Department of Health Care Finance for the District of Columbia as a retrospectively rated contract. Management has recorded a retrospective premium receivable as of December 31, 2011, based on their best estimate of collectability. This claim is currently under appeal with the Contract Appeals Board of the District of Columbia. The actual amount ultimately received could vary significantly from the recorded $20 million amount as of December 31, 2011. Additionally, Chartered recognized the change in accounting principle as of December 31, 2011, and failed to account for this change in accounting principle retrospectively.

We were unable to obtain a discussion or evaluation from Chartered's outside legal counsel of pending or threatened litigation described in Note 8(b). We were unable to obtain sufficient appropriate audit evidence by performing other auditing procedures.

As discussed in Note 8(c) to the statutory financial statements, Chartered has pledged $13,953,879, of investments as of December 31, 2011, as collateral to satisfy a long-term bank loan agreement for its Parent company.

It is our understanding that the Parent has not filed consolidated Federal Income Tax returns that include Chartered for any periods subsequent to April 30, 2010, the Parent company's fiscal year end.

Because of the significance of the matters discussed in the preceding paragraphs, the scope of our work was not sufficient to enable us to express, an unqualified opinion on the results of operations, changes in capital and surplus and cash flows for the year ended December 31, 2011.

In our opinion, except for the effects of such adjustments, if any, as might have been determined to be necessary regarding all of the above matters, the Statutory Statement of Admitted Assets, Liabilities, and Capital and Surplus as of December 31, 2011 presents fairly, in all material respects, the admitted assets, liabilities, and capital and surplus of D.C. Chartered Health Plan, Inc. as of December 31, 2011, on the basis of accounting described in Note 2.

The accompanying financial statements have been prepared assuming that Chartered will continue as a going concern. As discussed in Note 19 to the financial statements, on October 19, 2012, Chartered was placed into Rehabilitation by the Superior Court for the District of Columbia. This condition raises substantial doubt about Chartered's ability to continue as a going concern. The statutory financial statements do not include any adjustments that might result from the outcome of this uncertainty.

Our audit was conducted for the purpose of forming an opinion on the statutory basis financial statements taken as a whole. The accompanying Supplemental Summary Investment Schedule and Investment Risk Interrogatories (collectively referred to as "Supplemental Schedules") of Chartered as of December 31, 2011 are presented for purpose of additional analysis and are not a required part of the statutory basis financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the statutory financial statements. The information has been subjected to the auditing procedures applied in the audit of the statutory basis financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the statutory basis financial statements or to the statutory basis financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the statutory basis financial statements as a whole.

This report is intended solely for the information and use of the Commissioner as Rehabilitator and management of D.C. Chartered Health Plan, Inc. in Receivership and for filing with the Department of Insurance, Securities and Banking of the District of Columbia and should not be used for any other purpose.

Brown Smith Wallace, LLC

St. Louis, Missouri
January 9, 2013

D.C. CHARTERED HEALTH PLAN, INC., in Receivership
(A Wholly Owned Subsidiary of D.C. Healthcare Systems, Inc.)

Statutory Statement of Admitted Assets, Liabilities and Capital and Surplus
December 31, 2011
(See Independent Auditors' Report)

ADMITTED ASSETS	
Cash and Invested Assets	
Bonds, at cost which approximates fair value	$ 15,025,957
Cash and cash equivalents	16,975,318
Total Cash and Invested Assets	32,001,275
Accrued investment income	122,683
Uncollected premiums	5,299,409
Accrued retrospective premiums (See Note 5 regarding collectibility)	20,000,000
Reinsurance recoverable	277,703
Health care receivables	143,721
TOTAL ADMITTED ASSETS	$ 57,844,791
LIABILITIES AND CAPITAL AND SURPLUS	
Current Liabilities	
Claims unpaid	$ 43,000,000
Unpaid claims adjustment expenses	1,275,722
Other liabilities and accrued expenses	7,619,624
Total Current Liabilities	51,895,346
Capital and Surplus	
Class A common stock - $0.10 par value, 1,000 shares authorized, issued and outstanding	100
Gross paid-in and contributed surplus	4,690,419
Unassigned surplus	1,258,926
Total Capital and Surplus	5,949,445
TOTAL LIABILITIES AND CAPITAL AND SURPLUS	$ 57,844,791

The accompanying notes are an integral part of these statutory financial statements.

D.C. CHARTERED HEALTH PLAN, INC., in Receivership
(A Wholly Owned Subsidiary of D.C. Healthcare Systems, Inc.)

Statutory Statement of Operations
Year ended December 31, 2011
(See Independent Auditors' Report)

UNDERWRITING INCOME	
Net premium income	$ 383,743,178
Total Underwriting Income	383,743,178
UNDERWRITING EXPENSES	
Claims incurred, net of reinsurance	346,596,401
Claims adjustment expenses	12,344,020
General administrative expenses	26,915,784
Total Underwriting Expenses	385,856,205
Net Underwriting Loss	(2,113,027)
Net investment income	271,136
Allowance on accrued retrospective premiums	(10,000,000)
Related party bad debt expense	(3,855,522)
Other income	6,343,198
Net loss before federal taxes	(9,354,215)
Federal income tax expense	-
NET LOSS	$ (9,354,215)

The accompanying notes are an integral part of these statutory financial statements.

D.C. CHARTERED HEALTH PLAN, INC., in Receivership
(A Wholly Owned Subsidiary of D.C. Healthcare Systems, Inc.)

Statutory Statement of Capital and Surplus
Year ended December 31, 2011
(See Independent Auditors' Report)

	Common Stock	Additional Paid in Surplus	Unassigned Surplus	Total
Balance at December 31, 2010	$ 100	$ 4,690,419	$ 12,754,128	$ 17,444,647
Net loss	-	-	(9,354,215)	(9,354,215)
Deferred income tax	-	-	(3,319,807)	(3,319,807)
Change in nonadmitted assets	-	-	1,611,527	1,611,527
Prior period adjustment	-	-	(432,707)	(432,707)
Balance at December 31, 2011	**$ 100**	**$ 4,690,419**	**$ 1,258,926**	**$ 5,949,445**

The accompanying notes are an integral part of these statutory financial statements.

D.C. CHARTERED HEALTH PLAN, INC., in Receivership
(A Wholly Owned Subsidiary of D.C. Healthcare Systems, Inc.)

Statutory Statement of Cash Flows
Year ended December 31, 2011
(See Independent Auditors' Report)

Cash flows from operating activities:	
Premiums collected, net of reinsurance	**$ 366,272,113**
Benefit payments	**(333,628,360)**
General and administrative expenses paid	**(45,030,386)**
Net investment income	**303,881**
Federal income taxes	**3,368,587**
Net cash used in operating activities	**(8,714,165)**
Cash flows from investing activities:	
Proceeds from investments	**4,201,743**
Costs of investments acquired	**(7,049,630)**
Net cash used in investing activities	**(2,847,887)**
Cash flows from financing activities:	
Other cash provided, net	**(267,912)**
Net cash used in financing activities	**(267,912)**
NET DECREASE IN CASH AND CASH EQUIVALENTS	**(11,829,964)**
Cash and cash equivalents, beginning of year	**28,805,282**
Cash and cash equivalents, end of year	**$ 16,975,318**

The accompanying notes are an integral part of these statutory financial statements.

(1) Description of Business

D.C. Chartered Health Plan, Inc. in Receivership (Chartered) was established on December 31, 1986 under the laws of the District of Columbia. Chartered's primary purpose is to provide quality health care within a managed care framework. Chartered accomplishes this primarily through a contract with the District of Columbia Government Department of Health Care Finance (the DHCF), which requires Chartered to provide health care services to the residents of the District of Columbia (the District) who qualify under the Medicaid, Temporary Aid to Needy Families (TANF), and Alliance programs through a Health Maintenance Organization (HMO). Alliance enrollees represent the population not eligible for Medicaid but whose income falls below 200% of the poverty level. Chartered currently provides health care services to approximately 110,000 beneficiaries receiving assistance under Medicaid, Alliance, and TANF. All of Chartered's revenue was earned from its contracts with the DHCF for the year ended December 31, 2011. Chartered previously provided the services of a health center to members through a contract with an affiliated entity, Chartered Family Health Center, P.C. (CFHC). The Chartered Family Health Center ceased operations effective February 2011.

Chartered's business strategy lies in its fundamental commitment to promoting access and emphasizing prevention and health maintenance, as well as treatment. Each member enrolled in Chartered is assigned a primary care physician. Chartered has approximately 3,000 physicians under contract, including 500 primary care physicians. Chartered's members receive prescriptions, health education, nutrition counseling, and when necessary, referrals to specialists and hospital services. Chartered focuses on increasing access to its services by (i) improving knowledge and awareness of benefits and (ii) providing extensive wellness and preventative health care services.

Medicaid beneficiaries in the District are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DHCF, under which Chartered is designated as the default plan for one-half of the Medicaid beneficiaries who do not voluntarily select a plan. The current contract extends through April 30, 2013. Chartered received a rate adjustment effective May 1, 2012 from the DHCF. As discussed further in Note 19 Chartered chose not to bid on the subsequent contract that commences May 1, 2013.

Alliance beneficiaries in the District are required to enroll in an approved managed care plan, one of which is Chartered. Those beneficiaries who do not voluntarily select a managed care plan are assigned to a default plan. Chartered entered into a contract with the DHCF, under which Chartered is designated as the default plan for one-half of the Alliance beneficiaries who do not voluntarily select a plan. Chartered's contract with DHCF to cover Alliance beneficiaries extends through April 30, 2013. Chartered also received a rate adjustment for the Alliance program effective May 1, 2012. As discussed further in Note 19 Chartered chose not to bid on the subsequent contract that commences May 1, 2013.

Until May 17, 2000, Chartered was owned by PHP Corporation. As a result of the bankruptcy proceedings of PHP Corporation, the stock of Chartered was held in a trust (the Collateral Trust), and Bank of America, N.A. (BOA) was designated and appointed as the Collateral Trustee, obtaining full legal title to the collateral and full legal power and authority to transfer, sell, assign, or dispose of the collateral, including the stock of Chartered.

The Collateral Trust entered into a stock sale and transfer agreement pursuant to which the stock of Chartered was sold to D.C. Healthcare Systems, Inc. ("DCHSI") on May 17, 2000. DCHSI financed the purchase through a $3,500,000 bank loan at a floating prime rate of interest. Payments of principal and interest on the loan were scheduled to continue monthly through September 12, 2011. The outstanding principal balance on the loan was $425,863 at December 31, 2011. Chartered and the owner of DCHSI are guarantors on the loan. This loan is collateralized by a certificate of deposit from DCHSI that will be held for the entire term of the loan. The balance of the certificate of deposit held by DCHSI, including accrued interest, was $486,223 at December 31, 2011. Additionally, Chartered granted the lender a first security interest in certain collateral held by Chartered; however, in the event the lender exercises its rights under the guaranty, the owner of DCHSI has agreed in writing to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered may be obligated to pay under the guaranty. Although, statutory accounting pronouncements require that Chartered record a liability for the amount of the guarantee at December 31, 2011, management determined not to record such a liability as the underlying loan was paid off on February 2, 2012.

As discussed further in Note 19, Chartered was placed into Rehabilitation on October 19, 2012. This raises uncertainty about whether Chartered will be able to continue as a going concern. The Rehabilitator is working to sell Chartered and currently there is a non-binding Letter of Intent in place to sell certain assets to a third-party.

(2) Basis of Presentation and Summary of Significant Accounting Policies and Practices

(a) Basis of Presentation

The accompanying statutory financial statements of Chartered have been prepared on the statutory basis of accounting, in accordance with the accounting practices adopted by the National Association of Insurance Commissioners (NAIC) codification project (Codification) as prescribed or permitted by Department of Insurance, Securities and Banking of the District of Columbia (the Department). The Codification was adopted by the Department without significant modification. The Department has determined that certain of Chartered's pledged investments should be classified as admitted assets, and are included in bonds, pledged in the accompanying statements of admitted assets, liabilities, and capital and surplus, see note 8(c). Chartered has no material statutory accounting practices that differ from those of the Department or the Codification.

These statutory financial statements differ materially from financial statements prepared in accordance with principles generally accepted in the United States of America ("GAAP").

The principal differences are:

a) Deferred tax assets are limited to (1) the amount of federal income taxes paid in prior years that can be recovered through loss carrybacks for existing temporary differences that reverse by the end of the subsequent calendar year, plus (2) the lesser of the remaining gross deferred tax assets expected to be realized within one year of the balance sheet date or 10% of capital and surplus, excluding any net deferred tax assets, Electronic Data Processing (EDP) equipment and operating software, and any net positive goodwill, plus (3) the amount of remaining gross deferred tax assets that can be offset against existing gross deferred tax liabilities. The remaining deferred tax assets are non-admitted. Deferred taxes do not include amounts for state taxes. Under GAAP, state taxes are included in the computation of deferred taxes, a deferred tax asset is recorded for the amount of gross deferred tax assets expected to be realized in future years and a valuation allowance is established for deferred tax assets not realizable.

b) Certain assets such as uncollected premiums and other receivables over 90 days past due, prepaid expenses, provider advances, provider overpayments, pharmacy rebate receivable, leasehold improvements, certain furniture and equipment, computer software, and amounts due from affiliates are designated as non-admitted for statutory accounting purposes if they fail to meet certain tests and are excluded from the statutory statements of admitted assets, liabilities, and capital and surplus by a direct charge to capital and surplus. For GAAP, these amounts are carried as assets, net of a valuation allowance, if necessary.

c) Intangible assets, including goodwill, are non-admitted and, therefore, are not reflected in Chartered's statutory statements of admitted assets, liabilities, and capital and surplus.

d) Cash and cash equivalents in the statements of cash flows represent cash balances and investments with remaining maturities of one year of less. Under GAAP, the corresponding caption of cash and cash equivalents includes cash balances and investments with initial maturities of three months or less. Also, the statutory statements of cash flows do not include classifications consistent with GAAP and a reconciliation of net income to net cash provided by operating activities is not provided.

(b) Bonds

Bonds are comprised of certificates of deposits with original maturities greater than one year. The certificates are held by financial institutions and are carried at cost, which approximates fair value. Bonds totaled $15,025,957 as of December 31, 2011.

(c) Cash and Cash Equivalents

Cash and cash equivalents generally comprise of cash, money market accounts and certificates of deposits with original maturities of twelve months or less at the date of purchase. The certificates are held by financial institutions and are carried at cost, which approximates fair value. Cash and cash equivalents were $16,975,318 as of December 31, 2011.

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(d) Property and Equipment

Property and equipment are stated at cost and are depreciated using the straight-line method over a period not to exceed three years. Equipment under capital leases is stated at the present value of minimum lease payments and is amortized using the straight-line method over the term of the lease.

(e) Health Care Receivables

Health care receivables consist primarily of pharmaceutical rebate receivables, provider recoveries and provider advances. Pharmacy rebate receivables are estimated based on the most currently available data from Chartered's claims processing systems and from data provided by Chartered's pharmaceutical benefit manager. Provider recoveries consist of claim overpayments to providers, which are due back to Chartered. At December 31, 2011, admitted health care receivables of $143,721 consisted solely of pharmaceutical rebate receivables.

(f) Premium Revenue

Chartered recognizes premiums received for members enrolled in the Medicaid and Alliance programs as revenue in the period to which health care coverage relates. Member premiums are paid on a fixed monthly fee per capita basis. During 2011 the DHCF withheld one percent of Chartered's premium revenue. The amount withheld is payable under DHCF's incentive program if certain criteria are met by Chartered during the contract period. In 2011, $5,488,000 was withheld from Chartered. Chartered recorded no premium revenue or receivable for amounts expected to be received in accordance with DHCF's incentive program.

(g) Health Care Costs and Unpaid Claims Adjustment Expenses

Chartered has entered into hospital service contracts to provide the necessary inpatient and outpatient hospital services to its enrollees. Under the contracts, Chartered pays the participating hospitals at the fee-for-service rates in effect at the time the services were provided to its enrollees. Chartered has also entered into several agreements with network physicians and suppliers to provide medical services and supplies to Chartered's enrollees at agreed-upon fee-for-service rates or at fixed fees per member per month (capitation).

Monthly capitation payments to primary care physicians and other health care providers are expensed as paid. Health care costs and health care costs payable include amounts for known services rendered and an estimate of incurred but not reported services rendered by hospitals, physicians, and other health care providers. The estimated incurred but not reported health care costs payable have been actuarially determined based on relevant industry data and Chartered's historical trends. Management believes that the methodologies employed to estimate the health care costs payable are reasonable and that the amount accrued is appropriate.

As part of the process to estimate the cost of all claims reported but unpaid and claims incurred but not reported, Chartered accrued $1,275,722 at December 31, 2011, as an estimate of the expense to settle these claims.

(h) Income Taxes

In accordance with the tax allocation agreement with DCHSI, Chartered is included in a consolidated federal and state income tax return with DCHSI, using an April 30 fiscal year-end. Deferred tax assets, deferred tax liabilities, and income tax expense or benefit associated with Chartered have been provided for on a separate company basis. In addition, Chartered determines its deferred income taxes on a separate company basis and remits its estimated tax payment to DCHSI. DCHSI, including Chartered has filed Federal income tax returns through April 30, 2010. It is management's understanding that tax returns for fiscal years ended April 30, 2011 and 2012, have not been filed with the Internal Revenue Service, as of the date of this report.

Income taxes are accounted for under the asset and liability method. Deferred tax assets (DTAs) and liabilities (DTLs) are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. DTAs and DTLs are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on DTAs and DTLs from a change in tax rates is recognized in the period that includes the enactment date.

Pursuant to Statements of Statutory Accounting Principles (SSAP) No. 10R, *Income Taxes*, gross DTAs are first reduced by a statutory valuation allowance adjustment to an amount that is more likely than not to be realized (adjusted gross DTAs). Adjusted gross DTAs are then admitted in an amount equal to the sum of (1) previously paid federal income taxes, which are expected to be recovered through loss carrybacks or existing temporary differences, which reverse within a year and (2) the lesser of the amount of gross DTAs expected to be realized within one year of the balance sheet date after the application of (1) or 10% of statutory capital and surplus and (3) the amount of gross DTAs, after the application of (1) and (2) that can be offset against existing gross DTLs. Also pursuant to SSAP No. 10R, for reporting entities which are subject to risk-based capital (RBC) requirements or which are required to file a RBC report with its domiciliary state, when certain RBC thresholds are exceeded, the reporting entities have the option of calculating the admitted portion of adjusted gross DTAs in accordance with paragraph 10 of SSAP No. 10R, which would result in a higher admitted portion. Chartered did not qualify for such election for the year ended December 31, 2011.

(i) Premium Deficiency Reserve

Premium deficiency reserves and the related expense are recognized when it is probable that expected future health care and maintenance costs under a group of existing contracts will exceed anticipated future premiums and reinsurance recoveries over the remaining lives of the contracts. The methods for making such estimates and for establishing the resulting reserves are continually reviewed and updated, and any adjustments resulting therefrom are reflected in current operations. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided. As discussed further in Note 5, management has identified additional premiums due under terms within Chartered's contract with DHCF (retrospective premiums). At December 31, 2011 the need for a premium deficiency reserve was assessed and management is of the opinion that no premium deficiency reserve was required, after considering the affect of retrospective premiums.

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(j) Use of Estimates

Management of Chartered has made a number of estimates and assumptions relating to the reporting of admitted assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period to prepare these statutory financial statements in conformity with statutory accounting principles. Actual results could differ from those estimates.

(3) Investments

(a) Bonds

The cost, which approximates fair value, of bonds, comprised solely of certificates of deposit, at December 31, 2011 by contractual maturity, are shown below.

Maturing in one year or less	$ 4,689,260
Maturing after one year through five years	10,336,697
	$ 15,025,957

(b) Net Investment Income

The following table reflects net investment income by type of investment:

Bonds	$ 164,844
Cash and cash equivalents	188,536
Other	13,809
Gross investment income	367,189
Less investment expenses	96,053
	$ 271,136

(c) Regulatory Deposits

At December 31, 2011 investments with a carrying value of $317,000 were on deposit with the Department of Insurance, Securities and Banking of the District of Columbia.

(4) Property and Equipment

At December 31, 2011, Chartered's property and equipment was non-admitted based upon the requirements of SSAP No. 16R.

Depreciation and amortization expense related to property and equipment and software, including non-admitted assets, was $442,849 for the year ended December 31, 2011.

(5) Retrospective Premiums – Change in Accounting Principle

During 2012, management determined that contracts in force with DHCF should be treated as retrospectively rated contracts in accordance with SSAP No. 66 – *Retrospectively Rated Contracts*. This represents a change in accounting principle which management determined to apply as of December 31, 2011. This represents an exception to statutory accounting principles, as the change in accounting principle should have been applied retroactively.

As of December 31, 2011 Chartered recorded an Accrued Retrospective Premium Receivable net amount of $20 million for the period of August 2010 – December 31, 2011 related to the Medicaid contract, after consideration of a $10,000,000 allowance as reflected in the Statutory Statement of Operations, based on management's assessment of collectability. The gross retrospective premium represents 7.8% of premiums earned during 2011.

On April 10, 2012, Chartered filed a claim with the District's Contracts Appeals Board in the amount of $25.8 million for the 2010 – 2011 Contract for pharmacy losses incurred from August 1, 2010 – April 30, 2012 under the Medicaid contract, following denial of the claim by DHCF. Chartered had requested that the District review the Contract's pharmacy rates and make a rate adjustment for the 2010 – 2011 contract year, based on management's assumption that current rates were actuarially unsound. During 2012, Chartered has revised this calculation based on a limited scope examination performed by the DISB. Chartered calculated the amount of retrospective premium by comparing premiums earned under the contract to total claims paid and certain additional expenses during the period from August 1, 2010 – April 30, 2012 based on data provided to Charted as part of the annual rate setting process. Chartered's claim with the District's Contracts Appeals Board is currently being revised as of the date of this report.

Amounts recorded represent management's best estimate of the receivable after considering all potential outcomes of this litigation under the District's Contracts Appeals Board. Resolution of this claim and ultimate collectability of the receivable recorded as of December 31, 2011, could significantly differ from management's estimate.

In addition, Chartered has drafted and intends to submit a claim with the District in connection with their contract with DHCF related to the Alliance program. Management is currently unable to estimate the amount of retrospective premium due to Chartered under the Alliance contract and has not recorded the impact of any potential recovery as of December 31, 2011.

(6) Risk-Based Capital

The National Association of Insurance Commissioners developed the Managed Care Organization Risk-Based Capital Report and required all HMOs to complete the report beginning with the year ended December 31, 1998. Risk-based capital (RBC) was developed as a method of measuring the minimum amount of capital appropriate for a managed care organization to support its overall business operations in consideration of its size and risk profile. A company's RBC target is calculated by applying certain factors to various asset, premium and reserve items. Four action levels of RBC have been defined to set industry standards for regulatory intervention. The specific capital levels, in declining order are as follows: 1) Company Action Level (CAL), 2) Regulatory Action Level (RAL),

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3) Authorized Control Level (ACL), and 4) Mandatory Control Level (MCL). Companies at the Company Action Level must submit a comprehensive financial plan to the insurance commissioner of the state of domicile. Companies at the Regulatory Action Level are subject to a mandatory examination or analysis by the commissioner and possibly required corrective actions. At the Authorized Control Level, a company is subject to, among other things, the commissioner placing it under regulatory control. At the Mandatory Control Level, the insurance commissioner is required to place a company under regulatory control. All HMOs licensed in the District of Columbia are subject to the RBC provisions. Chartered's RBC ratio was approximately 42% as of December 31, 2011.

In May 2012, Chartered submitted a comprehensive financial plan with the Department of Insurance, Securities and Banking Regulation of the District of Columbia (the Department) outlining its plan for attaining all of the required levels of RBC. Chartered failed to make satisfactory progress in achieving the capital requirements to exit the MCL status and with the approval of Chartered's Board of Directors and its owner, on October 19, 2012 the Department placed Chartered into court receivership.

(7) Minimum Net Worth and Regulatory and Contractual Requirements

As required by the District of Columbia's Health Maintenance Organization Act of 1996 (the Act), Chartered entered into a Health Maintenance Organization Custodial Agreement dated February 27, 1998. Chartered maintains a certificate of deposit of $317,000 which is included in certificates of deposit, pledged on the statutory statements of admitted assets, liabilities, and capital and surplus at December 31, 2011, for the sole benefit of Chartered's members in the event of Chartered's insolvency. Under the laws of the Act, Chartered is also required to maintain a minimum net worth equal to the greater of (1) $1,000,000; (2) the sum of all uncovered health care expenditures for the latest three-month period ending December 31, March 31, June 30, or September 30; (3) 2% of its annual revenues; or (4) a prescribed percentage of annual health care expenditures. According to the Act a health maintenance organization shall not be required to maintain a net worth in excess of $4,000,000. At December 31, 2011, Chartered's statutory net worth was $5,949,445. Chartered was in compliance with its minimum statutory net worth requirements.

Under the terms of its Medicaid contract with the DHCF, Chartered is also required to meet certain financial requirements. As such, Chartered is required to maintain a positive net worth, and insolvency reserves or deposits that equal or exceed the minimum requirements established by the Department as a condition for maintaining a certificate of authority to operate an HMO in the District. Chartered met or exceeded the minimum net worth, insolvency reserve, and deposit balance requirements as of December 31, 2011.

(8) Commitments and Contingencies

(a) Leases

Chartered is obligated under several non-cancelable leases for office space, office equipment and vehicles. Future amounts due under these leases are as follows:

2012	$ 1,580,842
2013	1,251,284
2014	761,189
2015	258,878
2016	177,330

Total rent expense was $1,242,692 for the year ended December 31, 2011.

(b) Litigation

Chartered is from time to time subject to claims and suits arising in the ordinary course of business. In the opinion of management, the ultimate resolution of pending legal proceedings will not have a material effect on the statutory financial statements, except for litigation brought against the DHCF by Chartered. See Note 5 for further information on this litigation.

(c) Risk-Based Contract Dispute Settlement

In the third quarter of 2008, Chartered executed a co-guarantor agreement with its parent company, DCHSI, wherein Chartered guaranteed a $13,333,567 long term Bank Loan Payable (Loan). Chartered, DCHSI, and Cardinal Bank, an operating unit of Cardinal Financial Corporation, (NASDAQ; CFNL) executed an agreement under which Chartered serves as a co-guarantor on the loan and to collateralize the loan with specific securities currently held by Chartered.

The Loan originated from the settlement and dispute resolution agreement for contractual disputes with the Office of the Attorney General for the District of Columbia, which required DCHSI to pay $13,333,567. DCHSI financed the settlement payment through a $13,138,558 long term Bank Loan Payable. Payments of interest only on the outstanding principal balance are due monthly through November 12, 2012, thereafter payments of principle and interest will continue monthly through November 10, 2018, based on a 25 year amortization schedule. Interest is calculated at an annual fixed rate of 5.65% for the first five years, thereafter adjusting to a rate equal to the Federal Home Loan Bank 5 year rate plus 1.50%. Chartered and the owner of DCHSI are co-guarantors of the loan.

Pursuant to the Loan, Chartered is required to pledge investments in the amount of $13,333,567 as collateral for the Loan. In the event that DCHSI defaults on or is not able to meet its obligations under the provisions of the Loan, the owner of DCHSI has executed an Indemnification Agreement to irrevocably and unconditionally hold Chartered harmless and indemnify Chartered for any monies that Chartered is or may be obligated to pay under the guaranty agreement and pledge and security agreement, including but not limited to any liquidation of the pledged collateral.

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Management concluded that the pledged investments are an admitted asset under Statement of Statutory Accounting Principle 91R, *Accounting for Servicing of Financial Assets and Extinguishment of Liabilities* (SSAP No. 91R), paragraph No. 14, *Secured Borrowings and Collateral,* and Interpretation 01-31, *Assets Pledged as Collateral* (INT-01-31). Management communicated with the Department of Insurance, Securities and Banking of the District of Columbia which determined that the pledged investments, referred to above, should be classified as admitted assets. Accordingly, $13,953,879 of pledged investments is included as certificates of deposit, pledged in the accompanying statements of admitted assets, liabilities and capital and surplus at December 31, 2011.

Effective April 12, 2012, Cardinal Bank, executed a Modification Agreement to a certain "Pledge, Assignment and Security Agreement" dated October 10, 2008. The Modification Agreement is between D.C. Healthcare Systems, Inc., Jeffrey E. Thompson and D.C. Chartered Health Plan, Inc., wherein on the effective date, the Lender, Cardinal Bank, "releases and discharges D.C. Chartered Health from its obligation under the Guaranty".

The Modification Agreement releases Chartered as a guarantor on a loan between Cardinal Bank and the parent holding company DCHSI. This issue relates directly to new accounting guidance that requires a reporting entity to book a liability for any guarantees made on behalf of a parent entity. As this release was granted prior to the filing of the Statutory Statement it is treated as a Type I Subsequent Event and no liability was reported on Chartered's Statutory Statement in accordance with SSAP No. 9 – *Subsequent Events.* The Modification Agreement did not affect assets Chartered has pledged related to DCHSI's loan.

(d) Contingent Contributions

In addition to the Settlement Agreement, DCHSI, Chartered, and the owner of DCHSI entered into a Letter Agreement (Agreement) with the District that requires DCHSI, Chartered, and the owner of DCHSI to make contributions to the District of Columbia Department of Health's Immunization Program and several other not-for-profit organizations, including the District of Columbia Public Education Fund, of approximately $1,050,000 each year for a period of five years beginning January 1, 2009. Under the Agreement, these contributions will be made subject to the following conditions being met: (1) the funds received by the various organizations from the previous year were used for the purposes outlined in the Agreement, (2) the submission of a report that demonstrates that the funds were expended in compliance with the Agreement, and (3) Chartered and DCHSI are able to maintain "normal operations" during that year. Therefore, if the District fails to use the funds provided as required, the District is unable to account for related expenditures, or either Chartered or DCHSI suffer adverse financial circumstances, the commitments become void or are subject to renegotiation. Management believes that there is more than a remote likelihood that the above mentioned conditions were not be met as of December 31, 2011, and accordingly has not accrued a liability. Chartered will record the expense in the period in which the payments are made. Chartered did not record any contributions expense for the year ended December 31, 2011.

(e) Employment Contracts

Chartered has entered into employment agreements with its key executives, establishing minimum compensation levels, performance requirements, severance and certain other benefits.

(9) Reinsurance Coverage

Chartered is financially responsible for the cost of each enrollee's medical services. Annual inpatient hospital services per enrollee were reinsured by a third-party insurance carrier as follows:

Effective dates	Limits of coverage
October 1, 2010 through September 30, 2011	$300,000 plus 50% of paid services in excess of the $300,000 deductible amount
October 1, 2011 through September 30, 2012	$300,000 plus 50% of paid services in excess of the $300,000 deductible amount

The insurance company provides coverage above these deductible amounts. The maximum reimbursement per enrollee is limited to $1,000,000 and $2,000,000, in the aggregate, for contract years ending September 30, 2011 and 2012, respectively.

For the year ended December 31, 2011, Chartered incurred reinsurance premium expense of $1,399,379, which is included as a reduction to premium revenue in the accompanying statutory statement of operations. For the year ended December 31, 2011, Chartered had reinsurance recoveries of $702,156, which are included as a reduction to health care costs in the accompanying statutory statements of operations.

(10) Federal Income Taxes

The components of the net deferred tax asset in the accompanying statutory statement of admitted assets, liabilities and capital and surplus at December 31, 2011 are as follows:

	2011		
	Ordinary	Capital	Total
Gross deferred tax assets	$ 6,695,441	$ -	$ 6,695,441
Statutory valuation allowance adjustment	6,695,441	-	6,695,441
Adjusted gross deferred tax assets	-	-	-
Gross deferred tax liability	-	-	-
Net deferred tax assets	-	-	-
Nonadmitted deferred tax assets	-	-	-
Net admitted adjusted deferred tax assets	$ -	$ -	$ -
Increase (decrease) in nonadmitted deferred tax assets	$ -	$ -	$ -

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The components of the admissibility calculation, by tax character, as of December 31, 2011 are as follows:

	2011		
	Ordinary	Capital	Total
SSAP No. 10R, paragraph 10.a.	$ -	$ -	$ -
SSAP No. 10R, paragraph 10.b	-	-	-
The lesser of SSAP No. 10R, paragraph 10.b.i. and 10.b.ii.:			
SSAP No. 10R, paragraph 10.b.i.	-	-	-
SSAP No. 10R, paragraph 10.b.ii.	-	-	-
SSAP No. 10R, paragraph 10.c.	-	-	-
SSAP No. 10R, paragraph 10.e.	$ -	$ -	$ -
SSAP No. 10R, paragraph 10.e.ii.	-	-	-
The lesser of SSAP No. 10R, paragraph 10.e.ii.a. and 10.e.ii.b:			
SSAP No. 10R, paragraph 10.e.ii.a.	-	-	-
SSAP No. 10R, paragraph 10.e.ii.b.	-	-	-
SSAP No. 10R, paragraph 10.e.iii.	-	-	-

	2011
Used in SSAP No. 10R, paragraph 10.d.	
Total adjusted capital	$ 5,949,445
Authorized control level	-

The components of Chartered's provision for federal income taxes for the year ended December 31, 2011 are as follows:

	2011
Current year income tax	$ -
Tax on capital gains	-
Prior year tax over accrual	-
Federal income tax provision	$ -

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities at December 31, 2011are as follows:

	2011	
	Ordinary	Capital
Deferred tax assets:		
Discounting of unpaid losses	$ 287,026	$ -
Unearned premium reserve	-	-
Depreciation	828,892	-
Investments	-	-
Accrued expenses	91,697	-
Nonadmitted assets	2,121,899	-

Net operating loss carryforward	1,764,126	-
Charitable contributions	210,939	-
Tax credit carryforward	-	-
Other	1,390,862	-
Subtotal	6,695,441	-
Nonadmitted	6,695,441	-
Admitted deferred tax assets	$ -	$ -
Deferred tax liability:		
Investments	$ -	$ -
Depreciation	-	-
Deferred and uncollected premium	-	-
Unrealized gains	-	-
Deferred tax liability	-	-
Net admitted deferred tax assets	$ -	$ -

The change in net deferred income taxes as reported in the accompanying statements of changes in policyholders' surplus for the year ended December 31, 2011 are as follows:

	2011	
	Ordinary	Capital
Total deferred tax assets	$ 6,695,441	$ -
Total deferred tax liabilities	-	-
Net deferred tax asset	$ 6,695,441	$ -

The provision for federal income taxes incurred is different from that which would be obtained by applying the statutory federal income tax rate to income before income taxes. The significant items causing this difference are as follows:

	Amount	Tax Effect at 35%	Effective Tax Rate
Income before taxes	$ (9,354,215)	$ (3,273,976)	35.00%
DRD deduction and tax-exempt interest, net	-	-	0.00%
Penalties	1,581	553	-0.01%
Prior year under accrual	265,442	92,906	-0.99%
Change in nonadmitted assets	(577,930)	(202,276)	2.16%
Meals and entertainment	19,814	6,935	-0.07%
Other	640	224	0.00%
Change in Valuation Allowance	-	6,695,441	-36.09%
Total	$ (9,644,668)	$ 3,319,807	0.00%

At December 31, 2011, Chartered had approximately $5,000,000 of net operating loss carryforwards. The following income tax expense for 2011 would be available for recoupment in the event of future net losses:

2011	$ -

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Chartered is included in a consolidated federal income tax return with its parent company, D.C. Healthcare Systems, Inc. for the fiscal tax years through April 30, 2010. Chartered has a written agreement, approved by Chartered's Board of Directors, which sets forth the manner in which the total combined federal income tax is allocated to each entity that is a party to the consolidation.

(11) Health Care Costs Payable

A summary of the activity for health care costs payable is as follows:

Balance at January 1, 2011	$ 31,432,098
Plus incurred related to:	
Current year	341,924,875
Prior years	4,671,525
Total incurred	346,596,400
Less paid related to:	
Current year	301,351,842
Prior years	33,676,656
Total paid	335,028,498
Balance at December 31, 2011	$ 43,000,000

Chartered uses actuarial techniques based on historical experience to estimate incurred claims. Amounts incurred related to prior years may vary from previously estimated liabilities as the claims are ultimately settled at amounts different than initially estimated. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments becomes known. This information is compared to the originally established year-end liability. Positive amounts reported for incurred related to prior years result from claims being settled for amounts greater than originally estimated. This experience is primarily attributable to actual medical cost experience being less favorable than that assumed at the time the liability was established. Chartered incurred other health care costs, which primarily consisted of capitation payments to providers of health care services for Chartered's members of $13,536,294 for the year ended December 31, 2011.

(12) Professional Liability Insurance

During 2011, Chartered maintained a healthcare general liability insurance policy, which is written on a claims-made basis. The coverage limits for this policy are $1 million per occurrence and $3 million aggregate. Similarly, Chartered maintained a managed care liability insurance policy, which is also written on a claims-made basis. During 2011, the coverage limits were $1 million per claim and $3 million aggregate. Coverage limits were increased during 2012 to $6 million per claim and $8 million aggregate. These policies remained in full force and effect during 2011 and have been renewed through March 2013.

Chartered also has purchased an umbrella liability insurance policy that provides an additional coverage limit of $5 million per loss event. This policy has been renewed through March 2013.

In management's opinion, there are no pending or anticipated claims against Chartered for activities covered by the above-described liability insurance policies, which would have a material effect on the results of operations, cash flows, or financial position of Chartered.

(13) Related-Party Transactions

Chartered has entered into various services arrangements with certain related parties, including DCHSI and CFHC. Chartered has not been able to fully substantiate certain related party transactions. Chartered has evaluated known related party receivables for collectability and has determined them to be uncollectible as of December 31, 2011. At December 31, 2011, Chartered recognized a bad debt expense of $3,855,522 related to related party balances which is reflected on the statutory statement of operations.

(14) Defined Contribution 401(k) Plan

Chartered sponsors a 401(k) plan (the Plan) for its employees. Employees are eligible to participate in the Plan if they are at least 21 years of age and have worked 90 days or longer at Chartered. Employees may contribute between 1% and 12% of eligible salary on a pre-tax basis. Chartered makes a discretionary matching contribution to the Plan of 12% of each employee's contribution amount. Chartered contributed $41,827 to the Plan for the year ended December 31, 2011.

(15) Other Income

Chartered included in other income $7,500,000 related to a September 9, 2011 signed order of judgment from the District of Columbia Contracts Appeals Board. The settlement was related to a dispute over rates paid to Chartered for dental capitation. Chartered recorded $1,460,582 of other expense related to a permanent impairment of goodwill that was non-admitted in prior periods. Additionally, Chartered had miscellaneous income of $303,780 during 2011.

(16) Fair Value of Financial Instruments

Chartered's financial assets and liabilities carried at fair value have been classified, for disclosure purposes, based on a hierarchy defined by accounting standards prescribed or permitted by the DISB. The hierarchy gives the highest ranking to fair values determined using unadjusted quoted prices in active markets for identical assets and liabilities (Level 1), quoted prices from those willing to trade in markets that are not active, or other inputs that are observable or can be corroborated by market data for the term of the investment (Level 2), and the lowest ranking to fair values determined by using methodologies and models with unobservable inputs (Level 3). Classification is based on the lowest level input that is significant to its measurement. Assets and liabilities recorded at fair value in the statutory statements of admitted assets, liabilities, capital and surplus are categorized based upon the level of judgment associated with the inputs used to measure their fair value. At December 31, 2011, Chartered's bonds of $15,025,957 consisted entirely of Level 2 assets.

(17) Dividends Paid

There were no dividends approved or paid during the year ended December 31, 2011.

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(18) Concentrations

Chartered earns 100% of its premium revenue under contracts with the District. The current contract expires on April 30, 2013 and Chartered has chosen not to submit a bid for the subsequent contract.

Chartered is limited in both insureds and medical care providers to those within the geographic boundaries of the District of Columbia with limited exceptions.

(19) Subsequent Events

Management has evaluated subsequent events through January 9, 2013, which is the date that these statutory financial statements were issued.

Type I – Recognized Subsequent Events

Effective April 12, 2012, Cardinal Bank, executed a Modification Agreement to a certain "Pledge, Assignment and Security Agreement dated October 10, 2008. The Modification Agreement is between D.C. Healthcare Systems, Inc., Jeffrey E. Thompson and D.C. Chartered Health Plan, Inc., wherein on the effective date, the Lender, Cardinal Bank, "releases and discharges D.C. Chartered Health from its obligation under the Guaranty".

The Modification Agreement releases Chartered as a guarantor on a loan between Cardinal Bank and the parent holding company DCHSI. This issue relates directly to new accounting guidance that requires a reporting entity to book a liability for any guarantees made on behalf of a parent entity. As this release was granted prior to the filing of the Statutory Statement it is treated as a Type I Subsequent Event and no liability was reported on Chartered's Statutory Statement in accordance with SSAP No. 9 – *Subsequent Events.*

Type II – Nonrecognized Subsequent Events

The following subsequent events have occurred:

- The Chairman of the Board stepped down in April 2012.
- KPMG (the prior auditors) notified Chartered in April 2012 that they were resigning as Chartered's external auditors.
- The Audit Committee and Board of Directors approved Brown Smith Wallace, LLC as Chartered's new audit firm for the year ended December 31, 2011.
- On October 19, 2012 the Department of Insurance, Securities and Banking placed Chartered into court receivership as a result of the voluntary receivership action approved by Chartered's Board of Directors and authorized by its owner.
- Chartered elected not to submit a response on December 3, 2012 to the office of OCP's request for proposal for a new 5-year contract. Chartered's contract will end on April 30, 2013 and no further premiums will be received.
- Chartered has entered into a non-binding Letter of Intent on December 1, 2012, for the sale of certain assets with a third-party.

- On December 4, 2012, MedStar Health provided notice of contract terminations on behalf of Washington Hospital Center Corporation (WHC) and MedStar—Georgetown Medical Center, Inc. (GUH) effective January 4, 2013. Subsequently, MedStar filed a motion in the Superior Court for the District of Columbia seeking to prevent Chartered from recouping amounts on patient claims which Chartered asserts under the contracts. Chartered has not calculated the financial impact of the contract terminations or litigation as of the date of this report.

(20) Reconciliation of Amounts Reported in the Annual Statement and Statutory Financial Statements

The below schedule summarizes the differences between Chartered's 2011 annual statement and the statutory financial statements presented herein.

	Annual statement	Difference	Financial statements
Assets:			
Total Admitted Assets	$47,658,334	$10,186,457	$57,844,791
Liabilities and Capital and Surplus:			
Total Current Liabilities	$46,216,394	$5,678,952	$51,895,346
Total Capital and Surplus	$1,441,940	$4,507,505	$5,949,445
Net Loss:			
Total Underwriting Income	$355,498,611	$28,244,567	$383,743,178
Total Underwriting Expenses	378,642,292	7,213,913	385,856,205
Net investment income	432,338	(161,202)	271,136
Net loss on premium balances charged off	(1,027,504)	(8,972,496)	(10,000,000)
Other expense/income	7,815,547	5,327,871	2,487,676
Federal income tax expense	(960,716)	960,716	-
Net loss	$(14,962,584)	$5,608,369	$(9,354,215)
Cash Flows:			
Net cash used in operating activities	$(9,804,717)	$(1,090,552)	$(8,714,165)
Net cash used in investing activities	(972,248)	(1,875,639)	(2,847,887)
Net cash provided by financing activities	926,833	(1,194,745)	(267,912)
Cash and cash equivalents, end of year	$18,955,149	$(1,979,831)	$16,975,318

Summary Investment Schedule

Year ended December 31, 2011
(See Independent Auditors' Report on Supplemental Information)

Investment holdings	Admitted assets as reported in the statutory financial statements Amount	Percentage
Cash and cash equivalents:		
Cash and money market funds	$ 16,975,318	53.0%
Bonds:		
Certificates of deposit	15,025,957	47.0%
Total invested assets	$ 32,001,275	100.0%

See accompanying independent auditors' report.

D.C. CHARTERED HEALTH PLAN, INC., in Receivership
(A Wholly Owned Subsidiary of D.C. Healthcare Systems, Inc.)

Summary Investment Schedule - Continued

Year ended December 31, 2011

(See Independent Auditors' Report on Supplemental Information)

(1) Total admitted assets: $ 57,844,791

(2) 10 largest exposures to a single issuer/borrower/investment:

Investment category	Amount	Total admitted assets
Cardinal Bank	$ 9,591,714	16.58%
Premier Bank	$ 480,000	0.83
Aurora Bank FSBLEH	$ 250,000	0.43
First Bank of Puerto Rico FBP	$ 250,000	0.43
First Bank of Puerto Rico CEN	$ 250,000	0.43
Alliance Bernstein	$ 250,000	0.43
State Bank of India	$ 250,000	0.43
Communit National Bank of Waterloo, IA	$ 250,000	0.43
Tristate Capital Bank	$ 250,000	0.43
Bank of China	$ 250,000	0.43

(3) Total admitted assets held in bonds and preferred stocks by NAIC rating:

Bonds	Amount	Percentage	Stocks	Amount	Percentage
NAIC-1	$ 15,025,957	26.0%	P/RP-1	None	
NAIC-2			P/RP-2		
NAIC-3			P/RP-3		
NAIC-4			P/RP-4		
NAIC-5			P/RP-5		
NAIC-6			P/RP-6		

(4) There were no admitted assets held in foreign investments and unhedged foreign currency exposure.

(5) - (11) There were no admitted assets held in Canadian investments, no unhedged Canadian currency exposure, nor any Canadian-currency-denominated investments, which support Canadian-denominated insurance liabilities.

(12) There were no admitted assets held in investments with contractual sales restrictions.

(13) There were no admitted assets held in equity interests.

(14) There were no privately placed equities.

(15) There were no admitted assets held in general partnership interests.

(16) - (17) There were no admitted assets held in mortgage loans.

(18) - (19) There were no assets held in real estate.

(20) There were no admitted assets subject to securities lending, repurchase, reverse repurchase, dollar repurchase, or dollar reverse repurchase agreements.

(21) There were no warrants.

(22) There was no potential exposure for collars, swaps, and forwards.

(23) There was no potential exposure for future contracts.

See accompanying independent auditors' report.

EXHIBIT 4

Receiver's Status Report on Chartered Health Plan Inc.

Dec. 3, 2012

Chartered's receiver is negotiating a transaction with health-insurer AmeriHealth Mercy headquartered in Philadelphia and has entered into a letter of intent which has the potential to best achieve value for Chartered and to best serve its members and providers and the District. Amerihealth has filed a proposal today to service the District's Medicaid and Allied clients.

Here are some questions and answers from the receiver on Chartered's status:

Is the independent audit of Chartered's 2011 annual statement which was due November 30 completed?

Unfortunately, no. Chartered requested an extension of time to December 20 for the outside auditors to complete their work on the 2011 financial statement.

Chartered has been working diligently to provide the auditors with the necessary information and the auditors are performing appropriate tests of that data and reviewing the company's schedules and comments.

This process has taken more time than anticipated but it should be completed soon, and the audited statement will be made public when it is filed with the Department of Insurance, Securities and Banking.

Can Chartered pay its claims and perform on its current contract with the District?

Yes, Chartered is paying provider claims and continues to meet its obligations under its Medicaid contract with the District. That agreement runs to April 30, 2013. The Rehabilitator continues to seek a way forward that achieves the best value and utilization of Chartered's assets and which can help provide the best results for its members, providers and the District. We will take a plan to the Court with details of how this would be done when definitive terms for a plan are finalized.

Did Chartered file a response to the RFP for a new five year Medicaid contract?

No. Chartered entered a letter of intent with AmeriHealth Mercy regarding a potential transaction and AmeriHealth Mercy responded to the RFP.

How did Chartered determine not to bid on the RFP?

The Rehabilitator engaged an investment banking firm to conduct a process seeking a strategic partner with sufficient financial and operational resources to serve the District's Medicaid enrollees and their medical providers. In a very compressed timeframe, Chartered and its advisors are seeking a way forward that can realize value for Chartered's assets and best provide model services and improved health outcomes for District enrollees. We are negotiating a transaction with AmeriHealth Mercy to accomplish both of those goals.

Is there any agreement with the holding company or the holding company's stockholder?

There are no agreements with the holding company or its shareholder regarding any potential transaction or proceeds from such a transaction.

For more information, contact Michael Flagg at the Department of Insurance, Securities and Banking: Michael.flagg@dc.gov, 202 442-7756.

EXHIBIT 10

JOINT OVERSIGHT ROUNTABLE ON

THE DC CHARTERED HEALTH PLAN, INC. RECEIVERSHIP

OF THE

COMMITTEE ON PUBLIC SERVICES AND CONSUMER AFFAIRS

YVETTE ALEXANDER, CHAIRPERSON

AND THE

COMMITTEE ON HEALTH

DAVID CATANIA, CHAIRPERSON

TESTIMONY OF WILLIAM P. WHITE

COMMISSIONER OF THE DEPARTMENT OF INSURANCE, SECURITIES AND BANKING

ROOM 500

WILSON BUILDING

1350 PENNSYLVANIA AVENUE, N.W.

OCTOBER 25, 2012

11:00 A.M.

Chairwoman Alexander, Chairman Catania, council members and staff:

Thank you for the opportunity to appear and talk to you about the Department of Insurance, Securities and Banking's (DISB) actions last week regarding D.C. Chartered Health Plan Inc.

Last Friday afternoon the Superior Court of the District of Columbia entered an order putting Chartered into receivership and appointed me to take control of the company and, if possible, strengthen its finances through a sale or otherwise.

Finding a qualified buyer and completing a purchase agreement within the timeline to allow Chartered to effectively compete for a new contract will be challenging, but we are going to do our best.

Working closely with DHCF, our primary goal throughout this process was to ensure the company's 110,000 Medicaid and D.C. Alliance enrollees – some of our city's most vulnerable citizens – continue to get health care and that their providers continue to be paid.

That remains our goal now that the company is in receivership. Chartered's Board and the sole shareholder of its parent company, D.C. Healthcare Systems Inc., unanimously consented to receivership and the legal process went smoothly. The company continues to pay hospitals, doctors and other service-providers without interruption. And more importantly, the city's Medicaid and D.C. Alliance

enrollees will continue to receive health care. I am overseeing the company with help from a deputy rehabilitator and the company's management.

This is a prime example of how good, firm, sensible regulation works. Let me explain how it went and what exactly we did in supervising the company over the last two years.

In its annual financial statements for 2009, the capital levels reported by the company had reached a level of concern to my department. We increased our financial oversight of the company accordingly. In 2010, Chartered again filed an annual financial statement that showed its capital at a level that concerned us. At the company's request, my department granted Chartered an extension to file its 2011 statement, normally due March 1, 2012. In April, the company reported a $15 million loss for 2011. That weakened the company's finances to the point that I was worried about whether it had sufficient capital to keep operating.

My staff and I started consulting even more closely and often with the board of directors and management to help Chartered improve its financial strength so it could keep providing services to the city's Medicaid and D.C. Alliance enrollees.

Not only were we extremely worried about continuing to provide care to 110,000 Medicaid and D.C. Alliance enrollees; we were also trying to keep the more than 160 Chartered employees in the District from losing their jobs.

We also knew the District was trying to increase the number of competitors in the city's Medicaid market to lower prices and increase quality. There are only three managed-care companies with city Medicaid contracts right now, the others are smaller than Chartered. And one, MedStar Family Choice, only got a contract this summer. Federal rules require state governments have at least two Medicaid contractors.

Meanwhile problems at Chartered persisted through the summer and into the fall. There were three big ones:

- First, the owner's legal problems hurt the company's ability to keep its Medicaid contract, its only business and sole source of revenue.
- Second, the company's original auditors, KPMG, resigned in May and the company had to hire a new auditor, Brown Smith Wallace. In fact, the audit still continues. We hope a final audit will be available soon.
- Third, several interested buyers couldn't reach a deal with the company that would have infused capital and addressed its financial problems.

There are several significant issues with the audit that are still unresolved, including one the auditors may not be able to resolve; and because of some potential irregularities, it remains unclear how much surplus the auditors will find. I wish I could be more specific, but I can't until the auditor ties up all the loose ends and we have a completely accurate version of the company's books and how they got into this shape.

Recently it became clear from our careful half-year of intensive supervision that the department would have to step in and assume a larger role to ensure health care for Medicaid and Alliance enrollees would continue. I then decided on a rehabilitation of the company under receivership. That means I control the company and have final say over its actions, including supervising the identification and selecting a potential buyer.

A week ago Tuesday, DHCF Director Wayne Turnage and I and our staffs met with Chartered's board and laid out what we proposed to do and how it would benefit everyone if the company did not contest our petition for receivership. As I mentioned, Chartered's board agreed, as did the sole shareholder of Chartered's parent company, Mr. Jeff Thompson, who is no longer in Chartered management after resigning as chairman of the board this spring. We are working closely with the remaining managers, including Maynard G. McAlpin, president and CEO.

At this point we think a sale and change of ownership, if feasible, is the best and safest outcome for everyone. Several interested buyers have approached the company, some of them reported in the local press. I'm not prepared now to say that a sale will occur, who will buy the company or when, because I simply don't know. But I do believe that Chartered is a far more attractive prospect in rehabilitation as it now has a far better chance to get its all-important city Medicaid contract renewed.

I hope you'll bear with me as the auditors finish their report and we get this company into shape to be sold while keeping our Medicaid system – so important to the city's Medicaid and Alliance participants – working without interruption.

Let's be clear: At no time did these possible financial irregularities found by the ongoing audit affect the quality of care or payment to providers. To our knowledge, patients are being seen and medical providers are being paid. Chartered will pay all the costs of the receivership, as is typical with a rehabilitation.

I have hired Daniel L. Watkins, an experienced insurance executive, as special deputy rehabilitator and retained the law firm of Faegre Baker Daniels as counsel. The company will continue to operate as a private company – it will never become a city agency or otherwise change its status as a private corporation.

Several members of the Council have already asked where to direct people interested in purchasing part or all of Chartered. Mr. Watkins, as special deputy rehabilitator, will identify and evaluate potential buyers, and I ask that you direct them to him so he can conduct an orderly, fair, and open process of evaluating the many, well capitalized, experienced companies and people who appear to see value in Chartered as an ongoing concern.

Of course, Mr. Watkins' chief concern is identifying the best suitor to assure minimum disruption for the City's Medicaid and Alliance participants and to

protect the jobs of the more than 160 Chartered employees who work hard every day to provide the best possible care and service to the most vulnerable of District residents.

The best outcome here is that the enrollees continue to get their health care, the providers continue to be paid and Chartered be sold to become strong financially again and remain a private company so we can have vibrant competition in the Medicaid market.

EXHIBIT 11

DANIEL B. ABRAHAMS
direct dial: (202) 536-1751
fax: (617) 289-0773
dabrahams@brownrudnick.com

601
Thirteenth
Street NW
Suite 600
Washington DC
20005
tel 202.536.1700
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December 17, 2012

VIA ELECTRONIC FILING

District of Columbia Contract Appeals Board
One Judiciary Square
441 4th Street NW, Suite 350 North
Washington, DC 20001

RE: Protest of DC Healthcare Systems, Inc.
Under Request for Proposals No. DHCF-2013-R-0003

Dear Sir/Madam:

DC Healthcare Systems, Inc. ("the Company" or "Protestor"), through the undersigned counsel, respectfully submits this protest against the award of a contract to provide managed care under the District of Columbia Medicaid program. The Company's mailing address is 1920 N Street, NW, Suite 800, Washington, D.C. 20036. The telephone number of the Company is (202) 667-4366. The Company asks that all facsimiles be sent to Brown Rudnick LLP at (617) 289-0773. We are special counsel to the Company and will be representing the Company in this protest. Our contact information is contained on the letterhead above. Please direct all communications regarding this protest to our attention.

The identity of the contracting agency that issued the solicitation is the Office of Contracting and Procurement ("OCP"), on behalf of the Department of Health Care Finance ("DHCF"). The Solicitation is designated as number DHCF-2013-R-0003 and the copy we possess is undated (henceforth referred to as "Solicitation" or "RFP"). We have been told that initial proposals were due on December 3, 2012. As far as we know, no contract has been awarded.

The factual and legal grounds for the protest are as follows:

STATEMENT OF FACTS

Sometime in the fall of 2012, OCP, on behalf of DHCF, (henceforth referred to as the "District") issued a Request for Proposals ("RFP") to Managed Care Organizations "to join the District's

current Managed Care program in providing healthcare services to its Medicaid eligible population enrolled in the District of Columbia Healthy Families Program (the "DCHFP") and to its DC Health Care Alliance (i.e., the "Alliance" program) from the date of award through April 30, 2018."[1] The RFP contemplated an award of up to award three (3)[2] contracts to top qualified offerors to provide healthcare services in its Medicaid eligible population enrolled in DCHFP and Alliance.

DC Chartered Health Plan, Inc. ("Chartered") is an incumbent contractor currently performing such work. Chartered is a wholly-owned subsidiary of DC Health Care Systems, Inc. (*i.e.*, "the Company"). Chartered is currently being supervised by an appointed "Rehabilitator" pursuant to D.C. Code § 31-1311 (2001 ed.) and an Emergency Consent Order of Rehabilitation issued by the District of Columbia Superior Court. The Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("DISB") designated the Rehabilitator who is the agent of the District. DC Code § 31-1312(c) empowers the Rehabilitator to "take such action as deemed necessary or appropriate to reform and revitalize the insurer." By law and agreement, the Rehabilitator is supposed to be working to reform and revitalize Chartered.

The protest here arises from the actions of the Rehabilitator and two other potential offerors under the Solicitation, as well as the failure of the District to take appropriate corrective action when notified of the ethical conflicts and the interlocking and collusive relationships of the offerors, the Rehabilitator, and the Rehabilitator's legal counsel.

On or about June 5, 2012, reserving all its rights,[3] the Company and its subsidiary, Chartered, wrote the District and noted two important ethical matters relating to the actions of the District and the Rehabilitator:

> The first conflict involves Daniel L. Watkins, the lawyer who DISB has recently hired, at Chartered's expense, to assist DISB with its examination and analysis of Chartered. Specifically, although it was not disclosed to us by DISB (or by Mr. Daniel Watkins), we have learned that Daniel Watkins' brother, Robert Watkins, was the Chief Operating Officer of Chartered from December of 2007 to September of 2011. Mr. Robert Watkins only left Chartered last September, 2011. Moreover, Robert Watkins was actively involved in rate-setting, contract negotiations (including the 2010-2011 rates), and pharmacy management while he was Chartered's COO. As you are aware, several of these practices and decisions are being reviewed by DISB and Mr. Watkins as part of the current examination of Chartered.

---

1 RFP § B.1.

2 *Id*. However, § C.1.1 states that the District is seeking four (4) Managed Care Organizations.

3 Which it did in almost every single communication on this subject.

> Second, we have recently learned that Faegre Baker Daniels, LLP, the second consultant DISB has retained, at Chartered's expense, to examine and analyze Chartered in this matter currently represents United Health Care, a direct competitor of Chartered that has expressed interest in acquiring Chartered and would gain a significant advantage should Chartered no longer be able to continue to service the D.C. market. This actual or potential conflict also was not disclosed to Chartered before (or after) DISB retained Faegre Baker Daniels, LLP in this matter.
>
> The retention by DISB of Mr. Daniel Watkins and Faegre Baker Daniels, LLP to examine and analyze Chartered in this matter concerning Chartered's business raise actual or potential conflict of interest and potential bias issues that we believe should have been disclosed to, and discussed with, Chartered before Chartered agreed to Mr. Watkins' or Faegre Baker Daniels, LLP's retention by DISB in this matter. Indeed, D.C. Code § 31-1405[,] Conflict of interest, specifically provides that "No examiner may be appointed by the Mayor if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter." Furthermore, as a lawyer, Mr. Watkins has his own obligation to analyze and disclose his actual or potential conflicts of interest pursuant to D.C. Rules of Professional Conduct Rule 1.7.

The District replied on June 9, 2012, in pertinent part as follows:

> Mr. Watkins --- Prior to formally engaging Mr. Watkins and initiating the mandatory conflicts-check procedures imposed by the OAG for retaining outside counsel, Mr. Watkins voluntarily disclosed the fact that his brother had been employed by Chartered as recently as six-months ago. In response to questions posed by DISB lawyers, Mr. Watkins assured us that his brother was no longer affiliated with the company.
>
> In further vetting Mr. Watkins with the OAG Ethics Officer, we disclosed this fact and explained that his work regarding the examination of Chartered's RBC Plan would involve the review of proposed corrective actions that would be prospective in nature. We also made clear that if an occasion arose where the work performed by his brother was called into question, we would direct Mr. Watkins to recuse himself. To this end, the OAG Ethics Officer informed us that the Commissioner's engagement of Mr. Watkins would not pose a conflict.

> Faegre Baker Daniels (FBD) --- In vetting the FBD proposed engagement with the Department, the mandatory conflicts-check procedures required prospective outside counsels to disclose those clients which may have interests adverse to the District. In this regard, FBD, particularly in light of what they have now shared with us, were under no obligation to disclose their firm's representation of United Health Care ("UHC"). Consequently, the Department does not believe that the Commissioner's engagement of FBD poses either an actual or potential conflict.
>
> Please note however, as it relates to both outside firms, each firm has an on-going duty to disclose any matters for new or existing clients whose interests may be adverse to the District. Further, and in light of the concerns you have expressed, we have also asked that they disclose any matters that could pose a potential conflict. Going forward, if and when any such disclosures are made to the Department by either firm, I will personally, where and when appropriate, be sure to share such information with Chartered.[4]

The Company was not satisfied with the District's response and, on June 13, 2012, the Company and Chartered wrote to the District as follows:

> First, with respect to the family conflict regarding Mr. Daniel L. Watkins, the lawyer who DISB hired to examine and analyze Chartered, you merely responded that Mr. Daniel Watkins "voluntarily disclosed the fact that his brother had been employed by Chartered as recently as six-months ago." You further stated that DISB disclosed this fact to the OAG Ethics Officer before he was retained by DISB. Your response failed, however, to explain why DISB decided not to disclose this conflict to Chartered before retaining Mr. Watkins as specifically requested in my June 5th email. Although you stated that the OAG Ethics Officer believed that fact that Mr. Watkins' brother recently was Chartered's former COO would not pose a conflict, this presumably was based upon the representation to OAG repeated in your email response that Mr. Watkins' review would involve "proposed corrective actions that would be prospective in nature." You fail to mention, however, that part of Mr. Watkins' review necessarily would involve the reasons for Chartered's Corrective Action Plan, reasons which directly involved the decisions made by Mr. Daniel Watkins' brother, Robert Watkins, who recently was actively involved in rate-setting, contract negotiations (including the 2010-2011 rates) and pharmacy management for Chartered. Unless you are

[4] Email from Thomas M. Glassic (DC Department of Insurance, Securities and Banking) to A. Scott Bolden dated June 9, 2012.

conceding and are willing to confirm in writing that Mr. Daniel Watkins absolutely will not review, evaluate or opine, in any way, on any of Chartered's past history or past decision-making, as part of his examination and analysis in this matter, then DISB must direct Mr. Watkins to recuse himself immediately as you suggest.

Chartered continues to believe that DISB's retention of Mr. Watkins should have been disclosed to, and discussed with, Chartered before Chartered agreed to his retention by DISB in this matter. Your June 9th response does not change our strong belief that DISB's retention of Mr. Watkins violates D.C. Code § 31-1405. To more completely evaluate your position, however, we ask that DISB provide us promptly with a copy or inspection of the OAG's conflicts evaluation file of Mr. Watkins which you have represented was conducted prior to DISB's retention of Mr. Watkins.

Second, with respect to the conflict of interest relating DISB's retention of Faegre Baker Daniels, LLP ("Faegre") to examine and analyze Chartered in this matter while also currently representing United Health Care, you responded that: i) DISB required Faegre "to disclose those clients which may have interests adverse to the District" and ii) DISB concluded that Faegre was "under no obligation to disclose their firm's representation of United Health Care." This is an incomplete and unacceptable conflicts analysis. Before retaining Faegre to examine Chartered in this matter, DISB was required, but apparently failed, to determine whether Faegre may have interests adverse to Chartered--not only to the District. D.C. Code § 31-1405 specifically provides that "No examiner may be appointed by the Mayor if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter." D.C. Code § 31-1405 is not limited only to conflicts of interest with the District as you suggest in your response. Rather, pursuant to § 31-1405's Conflict of Interest provision, DISB was required to ensure that the consultants it retained to examine Chartered were free from direct or indirect conflicts of interest with Chartered--the entity which is "subject to examination." As I explained in my June 5th email, Faegre's current client, United Health Care, is a direct competitor of Chartered that has expressed interest in acquiring Chartered and would gain a significant advantage should Chartered no longer be able to continue to service the D.C. market. Your response completely fails to address this fact. Moreover, Scott M. Kosnoff, one of the Faegre partners assigned to to [sic] work on Chartered's examination in this matter, states in his current firm bio that he

"Recently... advised...UnitedHealth Group," which is United Health Care's corporate parent. Further, as with the conflict with Mr. Watkins, DISB has neglected in its response to explain why Faegre's United Health Care conflict was not disclosed to Chartered before (or after) DISB retained Faegre in this matter.

Chartered continues to believe that Faegre's conflict involving its representation of United Health Care should have been disclosed to, and discussed with, Chartered before Chartered agreed to Faegre's retention by DISB in this matter. Your June 9th response does not change our strong belief that DISB's retention of Faegre in this matter violates D.C. Code § 31-1405.

With respect to both conflicts of interest, Chartered expects that DISB will answer the questions we have repeated herein, provide us with access to any pre-retention conflicts of interest vetting or an opinion that was done by OAG and/or DISB, and advise us if DISB will recuse Watkins and Faegre, and if not, explain in detail how DISB's plans to address these two conflicts of interest going forward to ensure that DISB's examination is credible, impartial, non-biased and conducted without even the appearance of impropriety. We would also be willing to allow a D.C. bar ethics panel independently opine as to the conflicts issues created by DISB in this matter. Indeed, without providing this requested conflicts information, DISB will be and would be significantly challenged in defending its position before any reviewing court before any reviewing court.

On June 22, 2012, the District replied to the Company and Chartered, noting, *inter alia*, that:

Mr. Watkins

Dan Watkins disclosed his family relationship with Bob Watkins in his first interview with DISB. We discussed the matter with the OAG ethics officer, who concluded that the family relationship does not cause a conflict in Mr. Watkins performing his duties in DISB's exam.

Moreover, Dan introduced himself to Joe Lowry as Bob's brother at the May 17th meeting with Chartered. This was before Chartered executed the letter confirming its acceptance of the terms of Mr. Watkins' engagement. Thus, Chartered executives knew who Mr. Watkins was and did not raise a timely objection.

> As previously communicated, if work performed by Mr. Watkins' brother becomes the subject of the DISB's review, we will direct Dan to recuse himself from that facet of the examination.
>
> Faegre Baker Daniels
>
> DISB has conferred with FaegreBD regarding the firm's representation of UnitedHealth Group, which is mentioned in Scott Kosnoff's bio on the firm's website. For all of the reasons described in the e-mail from Charlie Richardson (see attached), the firm's representation of UnitedHealth does not pose a conflict with respect to the examination of Chartered.

The Company and Chartered quickly replied on June 23, 2012 that the District had not allayed their concerns:

> Unfortunately, your June 22nd response, like your June 9th response, does not allay the serious concerns Chartered has raised regarding these conflicts of interest. Your response also fails to respond to a number of the specific questions and requests for documents and information posed in my June 5th email and again in my June 13th email.
>
> First, with respect to the retention of Mr. Daniel Watkins and Faegre Baker Daniels ("Faegre"), we, as Chartered's counsel, were not aware of the conflicts of interest because neither had been disclosed to us by DISB. If they had been disclosed by DISB, we obviously would have raised the conflict issues with you before we confirmed the engagement letters you presented to us. The fact that Daniel Watkins may have informally told Mr. Lowry about his family relationship with Chartered's former COO during the May 17th meeting does not change the fact that DISB completely failed to advise us--Chartered's legal counsel in this matter--of a conflict about which you have conceded you were aware and internally evaluated--without any prior disclosure to us. We timely objected and advised your office of this conflict as soon as we learned of it. Chartered continues to believe that DISB's retention of Mr. Watkins should have been disclosed to, and discussed with, us *before* Chartered agreed to his retention by DISB in this matter.
>
> Your June 22nd email again offers to recuse Mr. Watkins "if work performed by Mr. Watkins' brother becomes the subject of the DISB's review," however, you once again have failed to address the fact that Mr. Watkins' review necessarily will involve the reasons for Chartered's Corrective Action Plan, reasons which directly involved the decisions made by Mr. Daniel Watkins' brother, Robert Watkins, who recently was actively involved in rate-setting,

contract negotiations (including the 2010-2011 rates) and pharmacy management for Chartered. Again, unless DISB is concedes and is willing to confirm in writing that Mr. Daniel Watkins absolutely will not review, evaluate or opine, in any way, on any of Chartered's past history or past decision-making as part of his examination and analysis in this matter, then DISB must direct Mr. Watkins to recuse himself immediately as you have suggested. You completely failed to respond to this request made previously in my June 13th email. We renew it again here. You also failed to respond to our June 13th request that DISB provide us promptly with a copy or inspection of the OAG's conflicts evaluation file of Mr. Watkins which you have represented was conducted prior to DISB's retention of Mr. Watkins. We also renew this request again here.

Second, with respect to the conflict of interest relating to DISB's retention of Faegre to examine and analyze Chartered in this matter while also currently representing United Health Care, Mr. Richardson's June 22nd email (which you attached to your June 22 email) does not allay the conflict concerns we have raised or address our prior information requests. Mr. Richardson's own opinion that his own representation and examination in this matter does not pose a conflict for him or his law firm is hardly an independent, objective or unbiased opinion, but more importantly, it is wrong. Mr. Richardson asserts that "FaegreBD's client in this matter is the DISB, not Chartered. Thus, the only relevant inquiry under the rules is the possible impact of our representations of United Health (the "United Work") on our representation of DISB." This is legally incorrect as it is directly contradicted by the express language of D.C. Code § 31-1405 which specifically provides that "No examiner may be appointed by the Mayor if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this chapter." (emphasis supplied). As we previously advised you on June 13th, D.C. Code § 31-1405 is *not* limited only to conflicts of interest with the District as Mr. Watkins claims in his June 22nd email. Rather, pursuant to § 31-1405's Conflict of Interest provision, DISB was required to ensure that the consultants it retained to examine Chartered were free from direct or indirect conflicts of interest with Chartered--the entity which is "subject to examination." Not surprisingly, although Mr. Richardson cites D.C. Code § 31-1405 in his June 22nd email, he neglects to mention, address or acknowledge that conflicts of interest with the entity which is "subject to examination" must be evaluated, not just conflicts with DISB. Neither you or Mr. Richardson address in your June 22nd emails, the fact, raised in my June

5th and June 13th emails, that Faegre's current client, United Health Care, is a direct competitor of Chartered that already has expressed interest in acquiring Chartered and would gain a significant advantage should Chartered no longer be able to continue to service the D.C. market. These facts take this conflict out of the realm of mere "competing insurers in disparate matters" as Mr. Richardson blithely suggests in his June 22nd email. Mr. Richardson's after-the-fact assurance that Faegre's "representations of United Health do not give rise to a conflict of interest with respect to DISB or Chartered" is self-serving and unacceptable without more information and independent analysis. For example, Mr. Richardson does not disclose on what issues his partner Scott M. Kosnoff working on Chartered's examination in this matter "[r]ecently… advised...United Health Group," United Health Care's corporate parent. This information must be shared with us. Further, as with the conflict with Mr. Watkins, DISB and Mr. Richardson have failed to explain why Faegre's United Health Care conflict was not disclosed to Chartered before (or after) DISB retained Faegre in this matter.

Finally, you failed to address our request that these conflict issues be jointly submitted for an independent conflicts evaluation by the D.C. Bar ethics panel. Although you offer in your June 22nd email that "in the event DISB determines that some aspect of the exam precludes either of their participation on an issue due to a conflict, DISB will take steps to ensure that occurs," (i) because you have not addressed our existing conflicts concerns described above and (ii) because we would have no way of ascertaining or monitoring when such potential conflict arises, this one-sided, non-independent, non-transparent conflicts monitoring proposal is not acceptable. Your proposal does not explain or even address how DISB proposes to ensure that DISB's examination is credible, impartial, non-biased and conducted without even the appearance of impropriety.

We repeat our prior requests that with respect to both conflicts of interest, DISB answer the questions we have repeated herein and provide us with access to any pre-retention conflicts of interest vetting or an opinion that was done by OAG and/or DISB. As we stated in our June 13th email, without providing this requested conflicts information, DISB will be significantly challenged in defending its position before any reviewing court or a DC Bar ethics panel. This is our third request for this information regarding these conflict of interest issues. Clearly, you are unwilling or incapable of proving this information to us for our consideration. That being said, in order to protect my client's interests and the integrity of the DISB review process, I am

> recommending the matter be referred to the DC Bar for an independent analysis and opinion. Perhaps, you and the consultants will provide them with the information we have requested.
>
> By making this reply to your June 22nd email response, Chartered does not intend to waive or otherwise prejudice any of its rights, including, but not limited to, any judicial review of this matter.

Notwithstanding this back and forth and notice to the District, no resolution of this matter was ever proposed by the District and no corrective action was ever taken. Meanwhile, there is close-at-hand, public information that the Faegre firm is hopelessly conflicted here. Faegre has admitted it represents United Healthcare.[5] And, that is confirmed by news articles.[6] Faegre also represents Blue Cross Shield entities, one of which is a parent company of AmeriHealth Mercy.[7] Likewise, public records show that Faegre is a registered lobbyist for AmeriHealth Mercy of Indiana.[8]

Subsequently, the District issued the subject RFP. Chartered, as part of its rehabilitation plan, was in the process of preparing a proposal in response to the Solicitation. At least that is what the Company was told was the case, since if Chartered was to be "reformed and revitalized", then it had to seek award of the substantive contract that formed the sole source of operating revenue for the business. On information and belief, proposals were due to be submitted the District on December 3, 2012.

However, on December 3, 2012, the Company first learned from a DISB news release that Chartered had not submitted a response to the Solicitation. Specifically, in a DISB document entitled, Receiver's Status Report on Chartered Health Plan Inc. and dated "Dec. 3, 2002 [sic],"[9] the Company was told in writing that:

> **Did Chartered file a response to the RFP for a new five year Medicaid contract?**
>
> No. Chartered entered a letter of intent with AmeriHealth Mercy regarding a potential transaction and AmeriHealth Mercy responded to the RFP.

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[5] *See* June 9, 2012 Email from Glassic to Bolden (quoted above).

[6] *See, e.g.,* http://online.wsj.com/article/SB10001424052970203914304576627071487867628.html.

[7] *See* http://www.ibx.com/company_info/news/press_releases/2011/08_09_IBC_and_BCBS_of_Michigan.html.

[8] *See* www.in.gov/ilrc/files/2012_employer.pdf (noting that the Faegre law firm is the registered lobbyist for Mercy in Indiana). The significance of this fact will become clear below.

[9] This document was received for the first time by outside counsel on December 3, 2012.

How did Chartered determine not to bid on the RFP?

The Rehabilitator engaged an investment banking firm to conduct a process seeking a strategic partner with sufficient financial and operational resources to serve the District's Medicaid enrollees and their medical providers. In a very compressed timeframe, Chartered and its advisors are seeking a way forward that can realize value for Chartered's assets and best provide model services and improved health outcomes for District enrollees. We are negotiating a transaction with AmeriHealth Mercy to accomplish both of those goals.

Is there any agreement with the holding company or the holding company's stockholder?

There are no agreements with the holding company or its shareholder regarding any potential transaction or proceeds from such a transaction.

The Company was shocked by the news release from the DISB and its conflicted agent that Chartered had not submitted a proposal in response to the RFP. The Company understands that these decisions were influenced by and even made by Dan Watkins and the Faegre law firm. The Company further understands that perhaps two clients of the Faegre law firm may have submitted proposals in response to the RFP. Those clients apparently are United Healthcare and AmeriHealth Mercy. And, thus, the Company learned that the fruits of it decades of work might be awarded to its two competitors, and that the decision for the Company's subsidiary to "no bid" was made by individuals whom the District had been advised had incurable ethical issues, conflicts of interest and interlocking relationships with Chartered's competitors.

PROTEST GROUNDS

I. The RFP should be cancelled and resolicited due to violations of ethics and conflict of interest laws and regulations

The purpose of the District's procurement laws is to guarantee the integrity of the procurement process and to ensure fair and equitable treatment of all persons who deal with the procurement system of the District government.[10] Here, the Company respectfully submits that, the only way to guarantee that these statutory goals are met is to cancel the procurement, or at least, to re-opened the Solicitation and receive new bids. The procurement is full of ethical lapses, omissions, personal conflicts of interest, and organizational conflicts of interest which preclude full and open competition and a fair award.

[10] *Protest Of Urban Alliance Foundation etc.*, DCCAB No. P-0087, et al., 2012 WL 4775002 (citing D.C. Code § 2-351.01(b)(4) (2010)).

First, there is the fact of Dan Watkins' family relationship to his blood brother Bob Watkins, the former Chief Operating Officer ("COO") of Chartered, whose management decisions still affect Chartered today. This relationship precluded Dan Watkins from exercising independent and unbiased judgment in deciding whether Chartered should bid in response to the RFP, thus depriving the District of full and fair competition. This was the most basic personal conflict of interest. DCHF and DISB knew that Chartered was controlled by a Rehabilitator who could not make an unbiased decision whether to bid on this procurement. DISB had an obligation to notify DHCF of this relationship. Dan Watkins is an agent of the District government. In the discharge of his agency functions, he did not devote himself to the reform and revitalization of Chartered; he thereby depriving the District of the "top qualified" firms that the RFP sought.

Similarly, the District knew or should have known that the Faegre law firm, which has become counsel to the Rehabilitator, and which has apparently justified the no bid, has an inherent organizational conflict of interest. It also represents the two principal competitors (United Healthcare and AmeriHealth Mercy). It is a registered lobbyist for AmeriHealth Mercy. Representation of Chartered too, accordingly, would appear to violate the rules of professional responsibility of the District of Columbia Bar association. The District knew all of this. And, even if the District did not know, it is fundamentally wrong and an inexorable stain on the integrity of the procurement process.[11]

The District has regulations relating to ethics and conflicts of interest which are intended to protect the procurement system and the people that the District's agencies serve. For example, the Procurement Code requires that contractors have "satisfactory records of integrity and business ethics."[12] The RFP further said at section H.14.3: "In accordance with 42 C.F.R. § 438.58, as a condition of contracting with MCOs, the District will have in effect safeguards against conflict of interest on the part of the District and local officers, employees, and agents of the District who have responsibilities relating to the MCO or PIHP, contracts, or the default enrollment process specified in 42 C.F.R. § 438.50(f)." As a DISB retained appointee, and the court-appointed Rehabilitator, Mr. Watkins (as well as the Faegre law firm) is an agent of the District. The RFP also incorporates federal anti-conflict of interest regulations such as 42 C.F.R. § 438.58. Accordingly, this procurement is tainted by the violation of the letter, or at least the spirit, of numerous local and Federal legislative and regulatory requirements.

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[11] Make no mistake about it; these are not merely the private affairs of a private company that decided not to compete for its own business reasons. The District took control of Chartered under the guise of reforming and revitalizing it; yet it turned the instruments of its control over to agents who had another agenda, and then sat by blindly while they pursued that contrary agenda, all to the detriment of the procurement system and the participants of the DCHFP and Alliance programs

[12] DC Code § 2-353.01(4) (2001).

II. The RFP should be cancelled and resolicited because it is tainted by an illegal restraint of trade

District of Columbia Municipal Regulations § 2225 requires the District to prevent anti-trust violations in connection with procurements. Agreements in restraint of trade are illegal in the District.[13] By allowing a Rehabilitator (with ethical conflicts) and a law firm (also with ethical conflicts) to decide to "no bid" a public contract, the District has condoned a restraint of trade. The goal of our procurement world is usually full and open competition by responsible, responsive offerors. When private or public parties act in concert to restrain trade, that reduces competition, and that causes a public harm. Here, the restraint of trade, caused one competitor to no-bid and that can cause the other competitors, who are free from the competitive threat, to raise their prices. Thus, the evil of restraining trade, and the anti-trust concepts, present valid bid protest considerations.

Indeed, here the RFP contemplates up to three[14] awards. We don't know how many offers the District actually received. But we do know it received one less than it should have. If there were only two proposals in hand as a result of this restraint of trade, for example, the District would not get adequate competition and would not get "top qualified Offerors to provide healthcare services in its Medicaid eligible population enrolled in" DCHFP and Alliance.

III. The RFP should be cancelled and resolicited because it is tainted by illegal collusive bidding

The District of Columbia Procurement Code prohibits collusion in bidding.[15]. Here, the District has knowingly condoned collusive bidding because it looked the other way while the same individuals controlled or advised three potential bidders (Chartered, United Healthcare and AmeriHealth Mercy), while at the same time causing one of the three (Chartered) to "no bid" the Solicitation. At the same time, the Company was deprived of the opportunity to bid. This is really no different, and, indeed even worse than, the classic arrangement where contractors "no bid" in order to decrease competition and proceed to rotate the award of lucrative government contracts. It just is an even more sophisticated plan to limit competition. However, one thing is certain--there is nothing more collusive then deciding not to bid when the decision is being made by the conflicted agents of the District who also work for the competitors. How can that promote the integrity of or public faith in the procurement system? It cannot be. Rather, this procurement is fatally tainted.

As noted by the DC Contract Appeals Board ("Board"), collusive bidding and a restraint of trade are grounds cancel a solicitation and reject all bids. Specifically, the Board has held that:

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[13] *See* District Unfair Trade Practices Act, DC Code §28-4508.

[14] Or four; *see* footnote 2.

[15] DC Code § 2-354.15.

> [The regulation] provides that a contracting agency may cancel a solicitation and reject all bids when the CPO determines in writing that cancellation is in the best interests of the District for reasons including that the "bids were not independently arrived at in open competition, were collusive, or were submitted in bad faith." If there is evidence of collusion, or other anti-trust violations among businesses in connection with a solicitation, the contracting officer is ***required*** by 27 DCMR § 1007.2 to report such evidence to the CPO. The CPO in turn "shall consult with the Corporation Counsel within ten (10) days of the report to ascertain whether a reasonable basis exists for believing that collusion has occurred among any businesses for purposes of defrauding the District." If the CPO in consultation with the Corporation Counsel concludes that there is a reasonable basis to believe that an anti-trust violation has occurred, the CPO would then be required to consider the issues of cancellation and contractor responsibility, among others. Section 1007.3 of 27 DCMR sets forth practices and events that may evidence violations of antitrust laws, including "[a]ssertions . . . by competitors of offerors[] that an agreement to restrain trade exists."[16]

Given the evidence of collusion here, the District should cancel the RFP and resolicit.

TIMELINESS OF PROTEST

This protest is timely because it is being filed within ten business days of when the Company knew or should have known of the grounds for protest. Specifically, on December 3, 2012, the Company learned for the first time from DISB and the conflicted agents, and to its surprise, that Chartered had not submitted a bid in response to the subject solicitation. That factual knowledge gave rise to the knowledge that the District had done nothing to resolve the conflict of interest and ethics problems that have tainted this procurement. The Company was not prejudiced and could not file a protest until the conflicts produced its subsidiary's decision to "no bid"; only then did the Company have a viable protest.

PROTESTOR IS AN AGGRIEVED PARTY

The Company is an "aggrieved party" with standing to protest because it has a direct economic interest that would be affected by the award of a contract or by the failure to award a contract and it is aggrieved in connection with the solicitation of a contract.

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[16] *Protest of Hood's Institutional Foods, Inc.*, DCCAB No. P-572, 1999 WL 292734 (emphasis added). In that case the Board found no evidence of either and dismissed the protest. Here, the evidence is overwhelming.

Specifically, the Company did not submit a proposal on December 3rd because it was told that Chartered would be doing so. However, the conflicted Rehabilitator and its conflicted legal counsel supervise the day-to-day affairs of Chartered. They made the decision to no-bid, but never communicated that decision to the Company until it was too late. Accordingly, the Company was aggrieved at the hands of conflicted agents for the District, for all the reasons noted above.

Thus, the fact that neither the Company nor Chartered is an actual bidder should not affect the Company's standing since that is the very competitive harm which is being protested here. But for the improprieties protested here, the Company could have taken appropriate steps to compete or submit an offer. While we do not know the number of actual offerors, it is foreseeable that the Company-owned subsidiary would have been in line for one of the three contemplated awards. Accordingly, the company was prejudiced.[17]

REQUEST FOR A HEARING

The Company requests a hearing before the Board due to the fact-intensive nature of the conflicts of interest, ethical concerns, restraint of trade and collusion.

REQUEST FOR DOCUMENTS

The Company requests the production of the following documents by the District (including DISB and DCHF):

1. All documents possessed by the District related to the alleged conflict of interest or ethical issues involving Daniel L. Watkins, Robert Watkins and/or Chartered Health Plan.

2. All documents possessed by the District related to the alleged conflict of interest or ethical issues involving Faegre Baker Daniels, LLP and/or Charlie Ritchson, and Chartered Health Plan.

3. All documents possessed by the District related to the relationship between Daniel L. Watkins, Faegre Baker Daniel, LLP, and/or Charlie Ritchson and United Healthcare or any of its affiliates.

4. All documents possessed by the District related to the relationship between Daniel L. Watkins, Faegre Baker Daniel, LLP, and AmeriHealth Mercy or any of its affiliates.

5. All documents possessed by the District related to the relationship between Daniel L. Watkins, Faegre Baker Daniel, LLP, and Mercy or any of its affiliates.

6. All documents possessed by the District related to the relationship between Daniel L. Watkins, Faegre Baker Daniel, LLP, and AmeriHealth or any of its affiliates.

[17] *See also* footnote 11 *supra*.

7. All documents possessed by the District related to the relationship between Daniel L. Watkins, Faegre Baker Daniel, LLP, and/or any Blue Cross Blue Shield of Pennsylvania or Independence Blue Cross Blue Shield affiliate.

8. All documents related to the "mandatory conflicts-check procedures imposed by the OAG for retaining outside counsel" as identified by the District in an email dated June 9, 2012.

9. All voluntary disclosures made by Mr. Watkins to the OAG Ethics Officer or others in the District.

10. All communications between the Rehabilitator and management of Chartered and/or AmeriHealth Mercy and/or Blue Cross Blue Shield of Pennsylvania or Independence Blue Cross Blue Shield affiliate.

11. All supplemental disclosures or communications made to the OAG Ethics Officer or any other District employee by:

    a. Daniel L. Watkins;
    b. Faegre Baker Daniels, LLP;
    c. United Healthcare; and/or
    d. AmeriHealth Mercy.

11. All communications between the OAG Ethics Officer and any other employee of the District related to:

    a. Daniel L. Watkins;
    b. Faegre Baker Daniels; LLP;
    c. United Healthcare; and/or
    d. AmeriHealth Mercy.

12. All disclosures made to Chartered Health Plan and/or DC Healthcare Systems, Inc. relating to any potential conflict of interest or ethical concern involving:

    a. Daniel L. Watkins;
    b. Faegre Baker Daniels; LLP
    c. United Healthcare; and/or
    d. AmeriHealth Mercy.

REQUEST FOR RELIEF

The Company specifically requests the following relief: (1) The District should not make award, and, instead, should stay performance of any contract pending the decision on the protest; (2) the District should cancel the solicitation; (3) the Solicitation should be re-opened and the Company should be permitted to submit a proposal; (4) the Company should be awarded its costs (including attorney fees) for preparing and prosecuting this protest, to the extent allowed by law; and (5) any other legal and equitable relief within the power of the Board and warranted by the facts.

Respectfully submitted,

BROWN RUDNICK LLP

Daniel B. Abrahams
Shlomo D. Katz

cc: O'Linda Fuller, MBA, CASA
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EXHIBIT 12

GOVERNMENT OF THE DISTRICT OF COLUMBIA
CONTRACT APPEALS BOARD

PROTEST OF:	)	
	)	
D.C. Healthcare Systems, Inc.	)	
1920 N Street, NW – Suite 800	)	**CAB No. P-0930**
Washington, DC 20036	)	
	)	
Under Solicitation	)	
No. Doc70947/DHCF-2013-R-0003 (MCO)	)	

DISTRICT OF COLUMBIA'S
MOTION TO DISMISS FOR LACK OF
SUBJECT MATTER JURISDICTION AND STANDING
IN RESPONSE TO PROTEST OF D.C. HEALTHCARE SYSTEMS, INC.

Pursuant to Rule 306 of the Rules of the District of Columbia Contract Appeals Board, 27 DCMR § 306, the District of Columbia respectfully moves the Board to dismiss with prejudice the protest in CAB No. P-0930 that D.C. Healthcare Systems, Inc., filed with the Board on December 17, 2012. By sustaining this Motion to Dismiss, the Board would fully dispose of all of the issues raised by D.C. Healthcare Systems, Inc., in the Protest.

As authorized by Board Rule 306.1, 27 DCMR § 306.1, the District is submitting to the Board this dispositive motion in lieu of filing its Agency Report. By the Protest, D.C. Healthcare Systems, Inc. ("D.C. Healthcare"), presents to the Board issues relating quite peripherally, if at all, to the District's activities in furtherance of the new Managed Care Organization procurement by Solicitation No. Doc70947/DHCF-2013-R-0003 (the "Solicitation" or "RFP"). The District submits that Protester is attempting to circumvent the exclusive jurisdiction of the District of Columbia Superior Court, pursuant to Title 31, Chapter 13 of the D.C. Official Code, over all of the matters raised in the Protest and that the Board has no jurisdiction over the subject matter of the protest. Alternatively, on the facts presented in the Protest, the Board should conclude that it

has no jurisdiction of the Protest because Protester, D.C. Healthcare, has no standing in this matter.

In support of this Motion, the District responds, and proves below, that D.C. Healthcare has not established that the protested matters are subject to the Board's jurisdiction nor that D.C. Healthcare, which is not an offeror or prospective offeror pursuant to the above-captioned solicitation, is an aggrieved party in the sense required by D.C. Official Code §§ 2-360.03(a)(1) and 2-360.08(a) and is therefore lacking in standing. On these bases, the District moves this Board to dismiss the Protest with prejudice.

I. STATEMENT OF FACTS

A. The RFP and Closing for Proposals

1. On November 1, 2012, on behalf of the District of Columbia Department of Health Care Finance ("DHCF"), the District's Office of Contracting and Procurement ("OCP") issued RFP No. Doc70947/DHCF-2013-R-0003 (District of Columbia Motion to Dismiss Exhibit No. ("Exhibit") 1, page 1).[1] OCP issued this RFP electronically, in its E-Sourcing system, by posting Doc70947 (Exhibit 1a) on the OCP website. Document DHCF-2013-R-0003 (Exhibit 1b), which contains the specifications, contract clauses, and proposal and evaluation criteria for the RFP, is an attachment to the Doc70947 E-Sourcing document (as identified in section 1.1 of Doc70947 as the "STATEMENT OF WORK MCO RFP 110112(2).pdf"). [Exhibit 4, Declaration of Helena Barbour, Contract Specialist, ¶ 5].

[1] RFP No. Doc70947/DHCF-2013-R-0003 is the correct designation of the solicitation according to the Office of Contracting and Procurement E-Sourcing (electronic) System. [See Exhibit 4, ¶ 5].

2. By the RFP, the District is seeking Managed Care Organizations ("MCOs") to join the District's current Managed Care program as contractors in providing healthcare services to its Medicaid eligible population enrolled in the District of Columbia Healthy Families Program and to its DC Health Care Alliance program). [Exhibits 4 (¶ 8) and 1.b (Sec. B.1)].
3. Pending award of new MCO contracts, D.C. Chartered Health Plan, Inc. (D.C. Chartered), is performing its current MCO Contract, No. DCHC-2006-D-5052. Recently, the District extended the term of this predecessor contract to April 30, 2013 and D.C. Chartered currently is performing this predecessor contract. [Exhibit 3, Modification No. M023, (which extend the term of predecessor contract) and Exhibit 4 (¶ 4)]. D.C. Chartered is wholly owned by Protester. [Protest, page 2].
4. At the same time that OCP/DHCF issued the RFP by posting on the E-Sourcing system, through this system, they also communicated directly with some forty-three prospective offerors, inviting them to participate in the procurement. The invited firms included the three current MCO contractors, D.C. Chartered, MedStar Family Choice, and United Health Care. Among the invited firms was also AmeriHealth Mercy. [Exhibit 4 (¶ 6); see gen. Protest, pages 10-12].
5. Prospective offerors were required to register in the District's E-Sourcing system in order to submit proposals pursuant to the new MCO RFP. Neither D.C. Healthcare Systems, Inc. nor D.C. Chartered Health Plan, Inc. registered to submit proposals for this new MCO RFP. [Exhibit 4 (¶ 7)].
6. The Contracting Officer issued eleven amendments to the RFP. By RFP Amendment 0006, on November 15, 2012, the Contracting Officer revised the period of performance to clarify

that, in RFP sections B.4 and F.1, the period of performance of the awarded Contract shall be for a one-year base period with four one-year option periods. [Exhibit 4 (¶ 9)].

7. OCP/DHCF held a Pre-Proposal Conference on November 8, 2012, as provided in RFP Amendment 0001 issued November 2, 2012. In Amendments 0004 and 0005, both dated November 13, 2012, DHCF/OCP distributed written answers to questions by prospective offerors resulting from their reviews of the RFP and from the Pre-Proposal Conference. In Amendment 0004, the District stated that, by the RFP, the District was seeking to make awards to three MCO contractors, as indicated in original sections B.1.1 and L.1.1 of RFP DHCF-2013-R-0003 (Exhibit 1b, pages 2 and 262) and, to avoid a conflict on this issue, accordingly would revise RFP section C.1.1 (Exhibit 1b, page 7) . [Exhibit 4 (¶ 10)].
8. By RFP Amendment 0009, issued November 29, 2012 (Exhibit 2), the Contracting Officer revised the closing date for submission of proposals. By this revision, the Contracting Officer returned the closing date to the original, final closing date of December 3, 2012. [Exhibit 4 (¶ 11)].
9. By the closing date of December 3, 2012, several offerors submitted proposals pursuant to MCO RFP No. Doc70947/DHCF-2013-R-0003. Protester, D.C. Healthcare Systems, Inc., did not submit a proposal in its own name and neither did the current MCO contractor, D.C. Chartered Health Plan, Inc. [Exhibit 4 (¶ 12)].
10. The District has not made any awards under MCO RFP No. Doc70947/DHCF-2013-R-0003. [Exhibit 4 (¶ 13)].
11. Currently, the District is evaluating the proposals under this RFP and expects to solicit best and final offers from appropriate offerors. [Exhibit 4 (¶ 13)].

12. In connection with the District's administration of performance of the predecessor MCO contract with D.C. Chartered Health Plan, the District's Contract Specialist was aware that D.C. Chartered has been under the control of the Commissioner of the D.C. Department of Insurance, Securities, and Banking ("DISB" or "Rehabilitator"). However, OCP/DHCF contract administration of the predecessor contract has not involved any contact with DISB by the Contract Specialist. Neither has the Contract Specialist had any contact with DISB concerning the solicitation of offerors under the New MCO RFP. [Exhibit 4 (¶ 14)].

B. D.C. Healthcare Systems' Protest Allegations

13. In its statement of facts, Protester has quoted from a series of e-mail communications in June 2012 between Counsel for D.C. Chartered and the General Counsel, D.C. Department of Insurance, Securities, and Banking. [Protest, pages 2-10].

14. Protester describes the relationship of these two parties as pertaining to the Commissioner's control of Chartered "by an appointed 'Rehabilitator' pursuant to D.C. Code 31-1311 … and an *Emergency Consent Order of Rehabilitation* issued by the District of Columbia Superior Court." [Protest, page 2]. DISB examination and oversight of Chartered utilizing consultants had been ongoing since about May 2012 well prior to the *Emergency Consent Order of Rehabilitation*. [See Exhibits 5, 6, 16].

15. Protester acknowledges that the Court-designated *Rehabilitator*, the DISB Commissioner, is empowered by D.C. Official Code 31-1312(c) to "take such action as deemed necessary or appropriate to reform and revitalize the insurer [D.C. Chartered]." [Protest, page 2]. Protester must also acknowledge that D.C. Chartered, by its sole shareholder and Board of Directors, consented to the jurisdiction of the Rehabilitator and the Court overseeing the rehabilitation. [Exhibit 13; see District's Statement of Facts ("SOF"), ¶ 26, below].

16. In the above-described e-mail communications, sent significantly prior to Chartered entering rehabilitation, the identified parties discussed the allegations that Protester characterizes here as violations of ethics and conflict of interest laws and regulations in connection with the ongoing examination by DISB of the financial condition of D.C. Chartered. In these communications, the DISB representative informed the Chartered representative essentially that no conflicts were apparent to DISB and that DISB would monitor the situation to prevent conflicts. [Protest, pages 2-10].[2] Protester does not contend that these communications involved any other non-DISB District personnel, *e.g.*, personnel from the OCP.[3] These communications do not identify Protester as a participant in this dialogue about possible conflicts.

17. Protester further contends that the RFP is tainted by illegal collusive bidding. [Protest, pages 1-14]. This allegation is based upon Protester's alleged expectation that D.C. Chartered would submit a proposal pursuant to the RFP and its discovery on the proposal submission date of December 3, 2012, that D.C. Chartered had not done so – Protester alleges that its discovery occurred when its unidentified outside counsel received a DISB document, the *Receiver's Status Report on Chartered Health Plan Inc*. (Exhibit 20) on that date. [Protest, page 10].[4] As Protester contends, that Status Report did state that D.C. Chartered did not file

[2] The communications from which these quotations in the Protest were extracted are included as Exhibits 7-12 to this Motion to Dismiss.

[3] The DISB General Counsel did mention that DISB had "discussed the matter with the OAG ethics officer." [Exhibit 11 (page 1)].

[4] If Protester truly discovered that D.C. Chartered would not submit a proposal only on December, 3, 2012, it was not paying much attention to public postings by the Commissioner on the DISB web site. [See the documents cited at SOF ¶ 20, 30, and 31].

a proposal but instead "entered a letter of intent with AmeriHealth Mercy regarding a potential transaction and AmeriHealth Mercy responded to the RFP."

18. Protester contends that its allegations of illegal collusive bidding are supported by its assumptions that actions of Dan Watkins and the Faegre law firm, allegedly conflicted representatives of the *Rehabilitator*, the DISB Commissioner, were collusive rather than appropriate actions pursuant to the Rehabilitator' performance of its statutory duties. [Protest, pages 11, 13-14]. As shown in the District's SOF, at Part C, below, Mr. Watkins and the Faegre law firm were authorized representatives of the *Rehabilitator* who were engaged, with the consent of D.C. Chartered, to facilitate the examination and rehabilitation of D.C. Chartered.

19. Protester has not alleged that the District procurement authorities were involved in any way with the actions of the *Rehabilitator* or his authorized agents and, in fact, they were not. The District's Contract Specialist was aware that D.C. Chartered has been under control of the Commissioner of DISB, as Rehabilitator. However, administration of the predecessor contract by OCP/DHCF has not involved any contact with DISB or the Rehabilitator by the Contract Specialist. Neither has the Contract Specialist had any contacts with the Rehabilitator or DISB concerning the solicitation of offerors under the RFP. [SOF, ¶ 12].

C. Rehabilitation of D.C. Chartered by the Commissioner, Department of Insurance, Securities, and Banking, Pursuant to Title 31, Chapter 13 of the D.C. Official Code

20. As elaborated below, for some time, at least from early in 2012, the Commissioner, D.C. Department of Insurance, Securities, and Banking ("DISB") has been engaged in examination, pre-rehabilitation and rehabilitation activities for D.C. Chartered, resulting in a court-

ordered receivership. [See gen. Exhibit 17, DISB FAQ, Frequently Asked Questions on Rehabilitation of D. C. Chartered Health Plan, Inc.].

21. Rehabilitation proceedings are conducted in accordance with District law, specifically Title 31, Chapter 13, *Insurers Rehabilitation and Liquidation Procedures*, of the D.C. Official Code (2001).

22. The Rehabilitator has "[a]ll powers of the directors, officers and managers of Chartered, whose authority is suspended except as may be re-delegated by the Rehabilitator." He also has "[a]uthority to take such action as deemed necessary or appropriate to reform and revitalize Chartered." [D.C. Official Code § 31-1312(c); Exhibit 16, *Emergency Consent Order of Rehabilitation*, page 2].

23. All rehabilitation proceedings must be commenced in the Superior Court of the District of Columbia, and the Superior Court has exclusive jurisdiction to entertain, hear or determine any complaint seeking any relief relating to such proceedings. [D.C. Official Code § 31-1303(a), (b) & (e)]. As addressed in SOF paragraphs 28 and 29, below, the Superior Court appointed the Commissioner as Rehabilitator of D.C. Chartered and retains jurisdiction over the Rehabilitator's work in this matter.

24. The Superior Court granted the Rehabilitator "[a]uthority to take possession and control of Chartered's assets and administer them under the general supervision of the Court." [Exhibit 16, *Emergency Consent Order of Rehabilitation*, page 2; D.C. Official Code § 31-1311(a)].

25. On May 24, 2012, Maynard McAlpin, President and CEO of D.C. Chartered accepted terms of engagement for Daniel L. Watkins and the law firm Faegre Baker Daniels LLP ("FBD"). [Exhibits 5 and 6]. By accepting these terms, D.C. Chartered recognized, *inter alia*, that Mr. Watkins and FBD were engaged to represent the Commissioner in all matters pertaining to

the examination of Chartered, pursuant to District of Columbia law on insurance, as determined by the Commissioner. D.C. Chartered also agreed to pay the fees and expenses authorized by the Commissioner in the examination of Chartered. [See, *e.g*., D.C. Official Code § 31-1402, *Authority, scope, and scheduling of examinations*].

26. On October 18, 2012, D.C. Chartered, through its Sole Shareholder, Jeffrey Thompson, and its Board of Directors, consented in writing to the commencement of rehabilitation proceedings and the filing of a *Consent Petition for an Order of Rehabilitation* and entry of an *Order of Rehabilitation* by the Superior Court of the District of Columbia. [Exhibit 13].
27. On October 19, 2012, on behalf of the Commissioner, the District filed in the D.C. Superior Court an *Emergency Consent Petition for an Expedited Order of Rehabilitation* in District of Columbia v. DC Chartered Health Plan, Inc., Civil Action No. 2012 CA 8227. [Exhibit 15].
28. On October 19, 2012, the D.C. Superior Court filed its *Emergency Consent Order of Rehabilitation* in District of Columbia v. DC Chartered Health Plan, Inc., Civil Action No. 2012 CA 8227 (Exhibit 16). In this Consent Order, the Superior Court granted the above *Emergency Consent Petition* and, pursuant to D.C. Official Code § 31-1311, appointed the Commissioner the Rehabilitator of Chartered, with "all powers of the directors, officers and managers of Chartered, whose authority is suspended except as may be re-delegated by the Rehabilitator" and authority to take other enumerated actions necessary to manage and administer the affairs of Chartered.
29. As provided in D.C. Official Code § 31-1311(a), in its above *Emergency Consent Order*, the Superior Court granted the Rehabilitator "[a]uthority to take possession and control of Chartered's assets and administer them under the general supervision of the Court." As provided in D.C. Official Code § 31-1312(c), the Court has also retained 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." [Exhibit 16].

30. Effective *nunc pro tunc* October 19, 2012, the Commissioner appointed Daniel L. Watkins Special Deputy to the Rehabilitator, with all the powers of the Rehabilitator under the Order and, *inter alia*, Title 31, Chapter 13 of the D.C. Official Code, for purposes of rehabilitating D.C. Chartered and for any related actions. This Order was executed November 2, 2012 and is posted to the DISB web site. [Exhibit 19, *Order Appointing A Special Deputy*].

31. On October 25, 2012, Commissioner William P. White testified at the Joint Oversight Roundtable on DC Chartered Receivership, before the D.C. Council Committee on Public Services and Consumer Affairs and the Committee on Health. Apropos of Protester's contention that it did not know that Chartered would not submit a proposal pursuant to the RFP in its own name, Commissioner White noted that "(f)inding a qualified buyer and completing a purchase agreement within the timeline to allow Chartered to effectively compete for a new contract will be challenging. He also explained how the financial condition of the company dictated his approach to this rehabilitation. [Exhibit 18].[5]

[5] This testimony, in the record at Exhibit 18, is posted at http://disb.dc.gov/node/363252 on the DISB web site.

II. ARGUMENT

The District submits the following arguments in support of its two-part Motion to Dismiss. In deciding these motions, the Board need not evaluate the truth of the Protester's allegations but only determine their sufficiency when measured against the jurisdictional requirements that we address in following arguments. The District contends that as a matter of law the Protest must be dismissed with prejudice on either of these grounds. [6]

A. The Board's Subject Matter Jurisdiction and the D.C. Code's Requirements for Standing to Protest

The Board's jurisdiction to hear protest cases is set forth in D.C. Official Code 2-360.03(a)(1)[7] and the requirements are substantially matched in the Board Rules as set forth in D.C. Municipal Regulations, Title 27, § 300.1 (2002). Code 2-360.03(a)(1) provides that:

> (a) The Board shall be the exclusive hearing tribunal for, and shall review and determine de novo:
>
> (1) Any protest of a solicitation or award of a contract addressed to the Board by any actual or prospective bidder, offeror, or the contractor who is aggrieved in connection with the solicitation or award of a contract.

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[6] Protester's contention that this protest is timely is also suspect. If Protester was truly paying attention, it should have discovered that D.C. Chartered would not submit a proposal well before its asserted discovery date of December, 3, 2012 – several public postings on the DISB web site in October and November 2012, Exhibits 17-19, so indicated. [See the documents cited at SOF ¶ 20, 30, and 31 and several other documents on that site – the links to the documents are included in the District's Index to Exhibits].

[7] The Procurement Practices Reform Act ("PPRA"), District of Columbia Code §2-360.03(a)(1) is the controlling statute with respect to the Board's jurisdiction. The Board has held that the current Code §2-360.03(a)(1) is identical to the former §2-309.03(a)(1)." *Lorenz Lawn & Landscape, Inc.*, CAB No. P-0869, September 29, 2011, note 7 [2011 WL 7402964]. With respect to the Board's protest jurisdiction, the terms of the PPRA do not differ at all from the PPA and the PPA cases cited below are equally applicable to this matter governed by the PPRA.

Thus, D.C. Official Code 2-360.03(a)(1) identifies the basic subject matter necessary to the Board's protest jurisdiction as "a solicitation or award of a contract" and also identifies the entities or persons who may have standing to protest the solicitation or award of a contract. As defined in Board Rule 100.2, 27 DCMR § 100.2, and relevant to this protest, to have standing, a protester must be an *aggrieved person*, namely "an actual or prospective bidder or offeror (i) whose direct economic interest would be affected by the award of a contract or by the failure to award a contract, or (ii) who is aggrieved in connection with the solicitation of a contract."

The Board thus has jurisdiction only if the protester has satisfied both of the above elements, namely that its protest relates to a District procurement and that the protesting entity is an actual or prospective offeror and is aggrieved. As is elaborated below, Protester has not met either of the required elements.

B. The Board Has No Jurisdiction Over the Subject Matter of This Protest

The allegations in this Protest by D.C. Healthcare Systems, Inc. do not relate directly to the solicitation or award of a District contract. This is made clear in the District's Statement of Facts, at paragraphs 13–19, supra.

D.C. Healthcare's allegations all relate to actions by authorized representatives of the Court-appointed Rehabilitator, and its agents that were performed in furtherance of the Rehabilitator's non-procurement mission of working to rehabilitate, and make economically viable, D.C. Chartered pursuant to Title 31, Chapter 13, *Insurers Rehabilitation and Liquidation Procedures*, of the D.C. Official Code and the *Rehabilitation Order* thereunder (Exhibit 16) issued by the D.C. Superior Court. In its own allegations, Protester has not attributed any of these actions to the procurement or program officials of the Office of

Contracting and Procurement or the Department of Health Care Finance in furtherance of the procurement process undertaken through the RFP. The authority and actions of the Commissioner of DISB, as the Court-appointed Rehabilitator of D.C. Chartered ("Rehabilitator"), are not connected by Protester with the procurement process leading to the and involving the RFP to procure the services of Managed Care Organizations for District residents. [SOF, ¶¶ 20-31].

Because the Protester's allegations all relate to the actions of the Rehabilitator, they do not relate to the solicitation or award of a District contract in the sense of the jurisdictional requirement for protest cases in D.C. Official Code 2-360.03(a)(1). As this Board has held, "the Contract Appeals Board is an administrative agency created by the Procurement Practices Act … with only those powers conferred either expressly or by necessary implication." Black Entertainment Television, CAB No. P-436, October 2, 1995, 1995 WL 817330 ("BET protest").

Thus, in the BET protest, the Board held that it did not have jurisdiction to address the merits of the protester's complaints under the following circumstances:

> The Board concludes that the [Redevelopment Land Agency Board] did not use nor was it required to use the statutory and regulatory framework of the PPA in deciding which unsolicited proposal it would recommend to the Council in leasing this RLA-owned land. We further conclude that the PPA by itself does not authorize or empower us [to] hear protests arising under D.C. Code §§5-801 to 5-820.

Therefore the Board dismissed the BET protest for lack of subject matter jurisdiction.[8] Black Entertainment Television, supra; see Metropolitan Service & Maintenance Corp., CAB No. P-388, Feb. 7, 1995, 1995 WL 214778 at 8 (Board lacked subject matter jurisdiction over the

[8] In its BET Opinion, the Board recognized that the D.C. Council's legislative history of the PPA stated that: "The bill does not apply to agencies that have been granted statutory authority to enter into contracts." The Board also found that the RLA was one of those agencies that had been granted statutory authority to enter into contracts prior to the enactment of the PPA.

renewal of a contract issued pursuant to the *Bus Shelter Act*, D.C. Law 3-67, which law was passed prior to the PPA and not amended or repealed by the PPA).

On the above authorities, the instant case should be considered to be outside the protest jurisdiction of the Board. The inapplicability of the PPRA to the rehabilitation activities under the above insurance laws is more clear and certain than the subject-matter-jurisdiction issues in the cited cases and other similar Board cases. In those cases, the protests related to contracts of the District or independent District agencies that were specifically exempted from the PPA, and now PPRA, according to its terms.

Here, the protested actions of the Rehabilitator and his agents were taken pursuant to a part of the D.C. Code that does not relate to procurement actions, but rather is designed to protect the District and its citizens from failures of insurance firms that operate in the District. These actions were taken after the informed consent of D.C. Chartered's sole owner and Board of Directors to enter rehabilitation (SOF ¶¶ 25-26). [See gen. SOF ¶¶ 20-31; see, e.g., Exhibits 18 and 20].

Furthermore, it is not only the authority of the Rehabilitator that the Protester here seeks to circumvent, but also the authority of the D.C. Superior Court. In its *Emergency Consent Order of Rehabilitation for Chartered*, the Superior Court made clear that it "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." [Exhibit 16 and SOF ¶ ; see D.C. Official Code § 31-1312(c)]. Protester has not informed us whether it has sought relief for its plaints from the Superior Court or, if not, why not.

The essence of this Protest is that D.C. Healthcare, the sole owner of D.C. Chartered, is dissatisfied with the rehabilitation actions taken by the Commissioner with respect to D.C.

Chartered. By closing its eyes and pretending to the Board that the statutory rehabilitation process is a contract action, Protester seeks improperly to circumvent the Rehabilitator's authority and that of the Superior Court under the District's insurance laws. Protester's dissatisfaction is remediable, if at all, by the Superior Court in its retained jurisdiction over the Chartered matter.

The Board must see this ploy for what it is and deny the protest for lack of subject matter jurisdiction.

C. Protester, D.C. Healthcare Systems, Inc., is Not an Aggrieved Party Because It Did Not Submit a Proposal and Because It Is Not Authorized to Pursue a Protest on Behalf of D.C. Chartered Health Plan, Inc. – Therefore Protester Has No Standing to Protest the RFP

On this record, there is no question that Protester did not submit a proposal in response to the RFP. In a variety of factual situations, the Board has held that a protester that did not submit a bid or proposal was not an aggrieved party and thereupon dismissed the protests.

1. Protester, D.C. Healthcare Systems, lacks standing because it did not submit a proposal pursuant to the RFP and does not otherwise possess the direct economic interest required by the PPRA

The record is clear that Protester did not submit a proposal in its own name. The Board previously and on many occasions has held that a protester which did not submit an offer and did not show that it had the capacity to participate in the procurement or that it was aggrieved by agency action is not an interested party or aggrieved person. In one such case, finding that the protester could not "be considered a prospective bidder or offeror for the purpose of our jurisdiction," the Board dismissed the protest for lack of standing in the protester. Tyrone F. General, CAB No. P-357, Feb. 19, 1993, 40 D.C. Reg. 4996, 4999 [1993 WL 763604]. In another such case,, the Board held that, "(h)aving failed to submit a bid or establish itself as a prospective bidder, protester cannot be considered to have a sufficient economic interest in the outcome of

the procurement." 24/7 Computer Doctors, LLC, CAB No. P-0909 (*Order on Motion to Dismiss*), September 17, 2012 [2012 WL 4753873 at 3]. Protester does not explain why this failure to submit a proposal is not fatal to its standing, as by showing that it is a prospective offeror.

Plaintiff asserts that it has standing because it is an aggrieved part with a direct economic interest in the contracting process for the MCO RFP. [Protest, page 14]. Protester does not further explain this statement which is otherwise unsupported by the Board's decision on standing. Below we show why Protester's purported showing of standing is insufficient in law and fact.

The District concedes, as it must, that D.C. Healthcare Systems has some economic interest in the award of a contract to its subsidiary. See Integral Systems, Inc., B-405303.1 (Comp. Gen.), 2011 CPD ¶ 161 [2011 WL 3796660 at 4]; Eagle Eyes Security Company, LLC, CAB No. P-0908, June 12, 2012 [2012 WL 4753872 at 3]. However, under the Board's rulings, the economic interest of D.C. Healthcare Systems is not the same as, or equivalent to, the direct economic interest of an actual or prospective bidder that is contemplated and required by the PPRA for the Board's protest jurisdiction to attach.

The Board often has emphasized that the protester must have a direct economic interest in the procurement regardless of the nature of the issues raised. Recently the Board held that:

> Whether or not a protester is an interest [*sic*, interested] party is determined by the nature of the issues raised, the protester's status in relation to the procurement, and the direct or indirect benefit or relief sought.

Virginia E. Durbin, CAB No. P-0591, 46 D.C. Reg. 8693, 8694 [1999 WL 770211]. In Durbin, the Board then held that it had no jurisdiction over a protest of terms of a solicitation lodged by a potential subcontractor because its economic interest was not the direct economic interest of

an actual or prospective offeror contemplated by the then-current Procurement Practices Act. Accord, Mid-Atlantic Tennis Courts & Supplies, CAB No. P-0849, August 3, 2010 [2010 WL 3947586].

In Eagle Eyes Security, the protester had not submitted a bid, but instead had sought to establish a subcontracting relationship with a prime contractor that would submit a bid in response to the Solicitation. The Board first recognized that, as a potential subcontractor, Eagle Eyes Security had some economic interest in offering services to a prime contractor. But the Board held that Eagle Eyes Security was not aggrieved and had no standing to protest because its economic interest was not the same as the direct economic interest of an actual or prospective bidder contemplated by the PPRA. Eagle Eyes Security, supra.

The Integral Systems protest is close to the instant Protest on its facts and the reasoning for the Comptroller General's denial of standing in that case is persuasive and we contend that it should control the result here. In Integral Systems, the Comptroller General addressed standing in the context of a protest by the parent of an incorporated, wholly owned subsidiary that had submitted a proposal but, during evaluation, had been excluded from the competitive range by the government.

The Comptroller General found in Integral Systems that the proposal was submitted by the incorporated, wholly owned subsidiary and that the government would have contracted with that subsidiary because the protester had not shown the subsidiary to be other than a separate and distinct legal entity from the protester. Integral Systems, Inc., supra [2011 WL 3796660 at 4]. Finally, rejecting the protester's contention that it was an interested party because it would benefit from award of the contract, the Comptroller General stated that it had "no doubt that [protester] has an economic interest in the award of a contract to its

subsidiary… but that "[s]uch interest … is not the direct economic interest of an actual or prospective offeror contemplated by CICA."[9] Integral Systems, Inc., supra.

2. Protester, D.C. Healthcare Systems, lacks standing because it has not demonstrated that it is capable of performing to the RFP requirements

Protester, D.C. Healthcare Systems, has not shown that it has the capacity to submit a proposal and or to perform a contract pursuant to the MCO RFP. As shown above, Protester does not currently control its subsidiary, D.C. Chartered Health Plan, Inc., because, by order of the Superior Court, D.C. Chartered is under the control of the Rehabilitator. Therefore D.C. Healthcare Systems could not propose to perform the District's new MCO contract using D.C. Chartered, an experienced and current MCO contractor. On this basis alone, the Board should dismiss the protest for lack of standing in the Protester.

The Board has held that a protester which did not submit an offer and did not show that it had the capacity to participate in the procurement or that it was aggrieved by agency action is not an interested party or aggrieved person. In one such case, the Board stated:

> … we are constrained to find from the facts extant that protestor has shown that he, in any way, was a potential competitor with sufficient economic interest in the procurements at issue. He certainly did not participate in the procurements, and he has not shown that he had the capacity to do so.

Therefore, finding that the protester could not "be considered a prospective bidder or offeror for the purpose of our jurisdiction," the Board dismissed the protest for lack of standing in the protester. Tyrone F. General, CAB No. P-357, Feb. 19, 1993, 40 D.C. Reg. 4996, 4999 [1993

[9] Similarly to the PPRA, CICA (the federal Competition in Contracting Act of 1984) provides that the Comptroller General "only may decide a protest filed by an interested party, which the statute defines as an actual or prospective bidder or offeror whose direct economic interest would be affected by the award of the contract or by the failure to award the contract." 31 U.S.C. § 3551(2) (2010); 4 C.F.R. § 21.0 (2011).

WL 763604 at 3]. Accord, Schwing America, Inc., CAB No. P-0156, 38 D.C. Reg. 2963, 2967 (Sept. 11, 1989) (Held that the protester was "neither an actual or prospective bidder because it does not have the capability to perform the prime contract at issue.") (1989 WL 508677).

Similarly, in 24/7 Computer Doctors, LLC, supra, the Board held as follows:

> Lacking the capability to perform as a prospective prime contractor, protester cannot be considered a prospective bidder within the meaning of the statute.

The Board concluded that, having failed to submit a bid or establish itself as a prospective bidder or to establish a sufficient economic interest in the outcome of the procurement, the protester, *Computer Doctors* did not have standing to pursue the protest.

The instant Protester did not submit a proposal pursuant to the RFP and has not attempted to show that it considered submitting a proposal in its own name or had the capacity to participate in the procurement. Therefore, D.C. Healthcare Systems should fare no better than *Computer Doctors* and should be found to have no standing here.

3. Protester, D.C. Healthcare Systems, lacks standing to represent the interests in this RFP, if any, of D.C. Chartered

D.C. Healthcare Systems has lodged the protest in its own name and has requested relief that would provide it an opportunity to submit a proposal pursuant to a new solicitation by the District. However, it seems that, on the current record, Protester is not capable of performing the MCO contract contemplated by the RFP and perforce would need to use D.C. Chartered for most of that work. To the extent that Protester has such an intent, D.C. Healthcare Systems seems to be representing D.C. Chartered in the protest. However, in Integral Systems, Inc., the Comptroller General held that a parent corporation was not an actual or prospective bidder or offeror and therefore did not qualify as an interested party under CICA

when its wholly-owned and incorporated subsidiary had submitted the proposal involved in the putative protest and would be the entity in privity with the government if its proposal were chosen for award. Integral Systems, Inc., supra, at 4.

We submit that, on the authorities addressed above, Protester lacks standing to represent the interests in this RFP, if any, of D.C. Chartered.

III. PROTESTER"S REQUESTS FOR HEARING AND DOCUMENTS

In the Protest, at pages 15-16, D.C. Healthcare Systems requests a hearing before the Board and requests production of many designated categories of documents. The District submits that both requests are premature and should be addressed, if still appropriate, after the Board decides the District's Motion to Dismiss. The request for documents is subject to Board Rule 309 which provides that discovery in protest cases is available to Protester "only with approval by the Board." We propose that, if the Board denies the District's Motion to Dismiss, the issue of discovery by Protester be addressed if necessary after the District has filed its agency report pursuant to Rules 305 and 306.

IV. DISTRICT'S REQUEST FOR RELIEF

For all of the above reasons, Protester has failed to establish that the subject matter of its protest may properly be brought before this Board and also has failed to establish, under the facts herein, that D.C. Healthcare Systems, Inc., is an aggrieved person in the sense required by the PPRA. On this record, therefore, there is no basis for finding that D.C. Healthcare Systems, Inc., has this standing. For either of these reasons, the Board should dismiss the Protest with prejudice.

Accordingly, on the premises and facts set forth in this Motion to Dismiss, the District respectfully requests that the Board dismiss with prejudice the Protest of DC Healthcare Systems, Inc., in CAB No. P-0930.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the filing date for this Motion, January 10, 2013, for reasons stated herein, the District served on Protester through listed counsel, by File & Serve, a copy of the foregoing *District of Columbia's Motion to Dismiss for Lack of Subject Matter Jurisdiction and Standing in Response to the Protest of D.C. Healthcare Systems, Inc.* in CAB No. P-0930.

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/s/
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CD:PS:JNK:TSC/jnk
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EXHIBIT 13

DISTRICT OF COLUMBIA CONTRACT APPEALS BOARD

PROTEST OF:	)	
	)	
D.C. HEALTHCARE SYSTEMS, INC.	)	CAB No. P-0930
	)	
Solicitation No: DHCF2013R0003	)	

OPPOSITION OF PROTESTOR D.C. HEALTHCARE SYSTEMS, INC. TO THE DISTRICT OF COLUMBIA'S MOTION TO DISMISS

Protestor, D.C. Healthcare Systems, Inc. ("D.C. Healthcare"), through its undersigned counsel, respectfully submits this Opposition to the Motion to Dismiss filed by the District of Columbia ("the District") in the above-referenced matter. Contrary to the District's arguments, the Contract Appeals Board ("CAB" or "Board") does have jurisdiction over the subject matter of this protest, D.C. Healthcare does have standing as an "aggrieved party," and D.C. Healthcare's protest is timely. Therefore, and for the reasons set forth more fully below, the District's motion should be denied.

Introduction

The District's jurisdictional arguments arise from a fundamental misunderstanding or mischaracterization of D.C. Healthcare's protest. D.C. Healthcare's argument is simple: It was deprived of an opportunity to bid. This happened because DC Chartered Health Plan, Inc. ("Chartered") was under control of the District and its appointed agent, the Rehabilitator.[1] As a result of anti-competitive behavior by District and its conflicted agents, and other bidders, Chartered failed to submit a bid, and the District was deprived of adequate competition for the services covered by the District's request for proposals ("RFP" or "solicitation"), in violation of the Procurement Practices Act's mandate to obtain competition. Had D.C. Healthcare known in advance that potential bidders and their District agents would engage in anti-competitive

[1] This filing presumes familiarity with the protest and the District's motion and therefore does not reintroduce the players.

behavior, D.C. Healthcare would have marshaled its resources and submitted a bid itself, thus providing the District with adequate competition and placing itself in line for award. Instead, D.C. Healthcare was misled by the agents of the District and in effect induced to sit on the sidelines because its subsidiary, now controlled by the District's agents, was going to bid for the work. The law is well-established that contracting officers have a duty to watch for and mitigate the effects of anti-competitive behavior; especially behavior orchestrated by the Department of Health Care Finance ("DHCF") and the Department of Securities, Insurance and Banking ("DISB"). Accordingly, this procurement should be re-opened to allow D.C. Healthcare and others to submit new bids.

The essence of the District's Motion to Dismiss is that D.C. Healthcare is not an aggrieved party because it did not bid and allegedly could not perform the contract. But in this case, the District denied D.C. Healthcare the opportunity to compete. The District induced D.C. Healthcare not to submit a bid, and misled it as to the course of action of its wholly-owned subsidiary, which had come under the control of the District. Chartered was known to be actively working to prepare a bid, attended a pre-bid conference, and on information and belief, participated in the solicitation process, as well as drafted a proposal in response to the RFP. D.C. Healthcare was a prospective bidder who was dissuaded from bidding by the actions of the District. What the District is arguing now to D.C. Healthcare is that although we misled you and induced you into not bidding, you can't protest the collusive conduct since you aren't an actual bidder. That is just plain wrong.

As for the argument that D.C. Healthcare could not perform the work, that is just a naked unsupported supposition by the District, and it has no basis in the record they presented in their motion. D.C. Healthcare has been in this business since the year 2000. In its protest, D.C.

Healthcare asserted that it could have submitted a stand-alone proposal. It knows the MCO business inside and out. The company oversaw, managed, and supervised its subsidiary, and through that oversight it had all the corporate experience that Chartered possessed. (Chartered has been performing this work for 25 years.) It was a direct service provider to Chartered, and performed some of the Medicaid Managed Care Organization ("MCO") work. It has intimate technical knowledge of and proven experience in the performance of this kind of work. It is not just some corporate shell. It could have used its own and accessed other resources, and submitted its own bid. And it could have teamed with other potential bidders as well.[2]

So why didn't D.C. Healthcare submit a proposal? The answer is self-evident. It understood that its wholly owned subsidiary was bidding for the work. D.C. Healthcare has certain duties it owed to Chartered. It could hardly have coveted and usurped the corporate opportunities of its subsidiary without raising the ire of Chartered creditors and regulators. There are creditors who are owed millions of dollars by Chartered. Moreover, this contract work is Chartered's life blood. Chartered has one customer, one contract, and basically one revenue source. It is one of three incumbent contractors and it has been performing the work for 25 years. For Chartered not to go after and compete for the work is almost like asking why we bother to breathe; it is inconceivable that Chartered would voluntarily suffocate itself and no bid the procurement. There are also more than 160 District of Columbia jobs at stake. *See* Commissioner White written testimony at the District's Motion to Dismiss, Exhibit 18 at 2.

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[2] If D.C. Healthcare had known that the District intended to pull the plug on Chartered's bidding effort, abandon its creditors, and desert more than 160 employees, then it would have taken immediate steps to incorporate those subsidiary resources in a bid and try to save them from the executioner's ax. It is a hornbook rule of procurement law, that the experiences of affiliated corporations are considered in evaluating the proposals of a related entity. *See, e.g.*, discussion *supra*. at 14.

DHCF Director Wayne Turnage also submitted written testimony at the City Council Roundtable and noted that Chartered was the City's largest Medicaid contractor, covering 110,000 members at annual cost of more than $359 million, with contracts with 5,387 health care providers (most of whom are District employers). *See* Protester Exhibit 1 at 2. (This procurement thus impacts approximately one out every six District residents.) And Chartered's intention to compete was further confirmed in written testimony by the Insurance Commissioner White of the DISB, who also noted that he wanted to "to keep more than 160 Chartered employees from losing their jobs." Motion to Dismiss, Exhibit 18 at 2. He noted in his written testimony that allowing "Chartered to effectively compete for a new contract would be challenging, but we are going to do our best." *Id.* at 1. Commissioner White further represented that with Chartered in rehabilitation "it now has a far better chance to get its all-important city Medicaid contract renewed." *Id.* at 4. And Commissioner White finally stated in writing that the City wanted Chartered to "remain a private company so we can have competition in the Medicaid market." *Id.* at 6.

This written testimony is backstopped by the oral testimony offered at the October 25, 2012 City Council Committee Roundtable hearing. That oral testimony was recorded on video and is found at:

http://oct.dc.gov/services/on_demand_video/on_demand_October_2012_week_4.shtm
(10/25/2012, 11 AM Public Hearing, Committee on the Health, David Catania, Chairperson).

At the hearing the following public statements were made:

- 27:30 minutes: [Catania] "Will your receiver be submitting a proposal? "[White] "We do expect that Chartered's receivership will be submitting a bid."
- 54:20 minutes: [White] "Chartered in receivership can respond to the RFP."
- 54:50 minutes: [White] "Chartered in receivership will be able to make a bid, will be able to go forward with the RFP."
- 55:08 minutes: [White] "While it is in receivership, I anticipate that Chartered will bid on the RFP."

At the hearing, both Council Members Alexander and Barry prophetically suggested that the District needed to be flexible to attract buyers for Chartered, and to protect the employees and other interested parties, and expressed some dismay about the District's actions to date.

Accordingly, and contrary the District's motion, based on this record, D.C. Healthcare had every reason to think Chartered was going to bid and it knew Chartered was working to prepare a bid.

The District makes much of the fact that Chartered was invited to submit a proposal, but allegedly didn't register for the solicitation as a bidder, and thus chose not to compete. *See* Motion to Dismiss, Exhibit 4 at ¶¶ 6 and 7. D.C. Healthcare, however, thinks the timeline suggests something more complicated.[3] Contrary to the District's Declaration, the solicitation

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[3] The solicitation was completed with relative haste, including an amendment on November 29, 2012 suddenly requiring the submission of bids two working days later on an accelerated schedule by Monday, December 3, 2012. The old adage is that haste makes waste is borne out here. The RFP includes a special clause (H.2) applying the Service Contract Act ("SCA"). *See* Motion to Dismiss Exhibit 1 at 223. The SCA is a prevailing wage and fringe benefit law. It specifies wage levels by job category, vacation benefits, holidays, and health and welfare benefits (which are currently $3.71 an hour) which are specified in a wage determination also incorporated into the RFP. *Id.* at Attachment J-2. Every year a new wage determination is added to the contract and the rates must be equitably adjusted. *See id.* at 223. The problem is that the SCA is not applicable to Medicaid contracts. Specifically, the SCA regulations provide that:

> [S]ervice contracts entered into by the State or local bodies with purveyors of services are not deemed to be entered into by the United States merely because such services are paid for with the funds of the public body which have been received from the Federal Government as a grant under a Federal program. ...Similarly, contracts let under the Medicaid program which are financed by federally assisted grants to the States, and contracts which provide for insurance benefits to a third party under the Medicare program are not subject to the Act.

29 C.F.R. 4.107(b). It would appear that in its haste to procure the work, the District has ladled on extra wage and fringe benefit requirements not otherwise required by law. This will obviously impact the cost to perform the work and the level of benefits that can be given to the

had been circulated to prospective offerors since the middle of 2012. A revised RFP was issued November 12, 2012, and there were 11 amendments resulting in bid submission deadline of December 3, 2012. Yet on October 24, 2012, presumably near the date for registration of bidders, DISB Commissioner White testified in writing before the District of Columbia City Council at a Joint Oversight Roundtable that "we are going to do our best" to allow Chartered to effectively compete for a new contract. *See id.* at Exhibit 18, page 1. Since this testimony came rather late in the procurement process, it would suggests that the Commissioner should have known then that Chartered wasn't bidding, but for some reason he testified otherwise before the City Council, represented otherwise to the public, and thus misled D.C. Healthcare.[4]

In addition, D.C. Healthcare respectfully submits that, as between D.C. Healthcare—an innocent potential bidder—and the District, any anticompetitive behavior by agents of the District (*i.e.*, the Rehabilitator and DISB) must be ascribed to the District as a whole. The District has given a carefully worded Declaration of Helena Barbour which states in pertinent part "Neither have we had any contact with DISB concerning the solicitation of offerors under the New MCO RFP." *See* District Exhibit 4 at p. 3 ¶ 14. Notice, however, that the District Declarant doesn't deny that there may have been ample contact between DHCF, whom she works for, and DISB regarding Chartered's status and its non-participation in the solicitation. It strains credulity to think that the District officials didn't notice or discuss the fact that the largest

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District's Medicaid recipients. It alone, from the cost perspective, is a reason enough for the District to pull back, re-open the RFP, fix the problem and take new bids using the proper living wages required by these types of city contracts. Otherwise, this contract will presumably cost possibly millions of dollars more over the next five years than would be required by law to be incurred.

[4] While the DISB Commissioner and the DHCF Director testified that the procurement timelines are short here, it is a fact that in the past the District has always extended performance of the existing MCO contractors to accommodate the pace of their procurements, and can do the same in this procurement.

of the MCO contractors performing services for more than 100,000 enrollees was not going to be bidding. Indeed, in its carefully crafted Motion to Dismiss, the District simply says "Neither has the Contract Specialist had any contact with DISB concerning the solicitation of offerors under the New MCO RFP." *Id.* at 5. Suffice it to say, that doesn't mean much, since it doesn't prove that others in the District procurement office or DHCF had no such contact. The problem here is the non-participation of Chartered and the misleading conduct toward D.C. Healthcare. The supposed lack of contact concerning the solicitation is not the same as saying everyone at DHCF was in the dark about the lack of a bid by D.C Healthcare or Chartered, or the other facts alleged in the protest.[5] Indeed, as the District emphasizes repeatedly in its Motion to Dismiss, D.C. Healthcare does not control Chartered. Rather, the Commissioner of DISB and the Rehabilitator he appointed, both of whom are agents of the District of Columbia itself, control Chartered and have used that control to affect the outcome of the procurement to the detriment of other actual or prospective competitors, including D.C. Healthcare, as well as the District and Medicaid beneficiaries.[6]

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[5] Indeed, the District's Declaration clearly suggests otherwise, noting that Chartered was invited to bid, District Exhibit 4 at 2, ¶6, and neither Chartered nor D.C. Healthcare registered to submit proposals, *id.* at 2, ¶7. It strains credulity to suggest that DHCF, the procuring entity, was unaware of the events at Chartered since it was the largest of the incumbent contractors performing the work. In fact, Wayne Turnage, Director of DHCF provided written testimony on October 25, 2012, at the Joint Oversight Roundtable before the City Council regarding the intense, close oversight his agency was performing on Chartered. *See* Protester Exhibit 1 at 2-5. Nor does the District try to suggest that no one at DISB had contact with DHCF regarding these events. Of course, the content and scope of that contact, and what actually went on, awaits an agency report and a substantive response to the protest.

[6] The District's contracting officials cannot avoid the knowledge imputed to the District of Columbia agency for which the procurement is being conducted, DHCF, nor the information that D.C. Healthcare provided to DISB. All these players are part of a single entity, the Government of the District of Columbia. Even the Rehabilitator, his appointees, and his law firm are mere agents of the District of Columbia. Thus, an affidavit from the contracting officer's representative that she didn't know about some fact doesn't mean the knowledge of the

D.C. Healthcare is *not* asserting rights on behalf of Chartered, nor is it asserting rights under the District's insurance laws. Thus, the District's characterization of the protest as attempting to circumvent the authority of the Rehabilitator and the Superior Court simply misses the point. D.C. Healthcare's protest also does not require the CAB to rule directly on the propriety or impropriety of the acts of the Rehabilitator, Mr. Watkins or the Faegre law firm. Rather, it would suffice for the procurement to be cancelled and the potential conflicts, ethical issues and anti-trust matters to be remanded to the contracting agency for investigation, review and a determination. Meanwhile, the procurement could be re-opened for new bids. The protest argues that the contracting officer may not proceed with the procurement in the face of unresolved allegations of collusive bidding and other potential anti-trust violations. There is no dispute that the procuring agency was aware that Chartered was under the control of a Rehabilitator (District's Statement of Facts ("DSOF") ¶ 12), whose actions, inactions, and conflicts form the basis for D.C. Healthcare's allegations of anti-competitive practices. In addition, the protest also concerns the relationships between the District's agents and other bidders – including Chartered, United Health Plan, and AmeriHealth Mercy. And, as discussed in the protest and below, it is well-established that procurement authorities *should be* concerned about the potential for such anti-competitive practices. As such, those practices also are a proper subject of inquiry for the CAB to the extent they impact the integrity of the procurement process, as they do here.

D.C. Healthcare is an "aggrieved party" with standing to bring and maintain this protest. The District admits that Chartered was invited to submit a bid (DSOF") ¶ 4), but that Chartered

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collusion, anti-competitive behavior, and conflicts was not found within the four corners of the District government—or even in the possession of other procurement officials.

neither registered to submit a bid[7] (DSOF ¶ 5) nor submitted a bid (DSOF ¶ 9). The District also admits that D.C. Healthcare has an economic interest in the award of a contract to its subsidiary, Chartered (Motion to Dismiss at 16). Obviously, then, D.C. Healthcare also has an economic interest in an award to itself, which will be a possibility if the relief sought by D.C. Healthcare is granted. Because D.C. Healthcare has a direct economic interest that would be affected by the award of a contract or by the failure to award a contract and it is aggrieved in connection with the solicitation of a contract.

Lastly, D.C. Healthcare's protest is timely. Sadly, the statement by the DISB Commissioner on which the District bases its timeliness argument is incompletely quoted by the District and therefore misleading.

For these reasons, as discussed in detail below, D.C. Healthcare's protest should not be dismissed.

Discussion

I. D.C. Healthcare's Protest is Timely

The District argues that D.C. Healthcare's protest is untimely because D.C. Healthcare allegedly should have known on October 25, 2012 that Chartered would not submit a proposal. The District asserts this to be true because DISB Commissioner William P. White purportedly testified before the D.C. Council on that date that finding a qualified buyer and completing a purchase agreement within the timeline to allow Chartered to effectively compete for a new contract will be challenging. Motion to Dismiss, at 10, ¶ 31.

However, that is not what Commissioner White actually said, as reflected by Exhibit 18 to the District's motion. What Commissioner White actually said was:

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[7] Chartered's failure to even register to submit a bid should have raised red flags for the contracting officer about the likelihood of anti-competitive behavior taking place.

> Finding a qualified buyer and completing a purchase agreement within the time to allow Chartered to effectively compete for a new contract will be challenging, ***but we are going to do our best.***

District Motion to Dismiss, Exhibit 18, at 1 (emphasis added). Commissioner White further said:

- "[W]e were also trying to keep the more than 160 Chartered employees in the District from losing their jobs." [*Id.* at 2]
- "We also knew the District was trying to increase the number of competitors in the city's Medicaid market to lower prices and increase quality." [*Id.* at 3]
- "The best outcome here is that . . . Chartered be sold to become strong financially again and remain a private company ***so we can have vibrant competition in the Medicaid market.***" [*Id.* at 6 (emphasis added)]

Commissioner White's statements were not indications that Chartered would not be bidding. Indeed, they were representations to the contrary. *See also* citations to the video of the public hearing at set forth at page 4 of this Opposition. The quoted statements clearly indicated the Commissioner's intent that Chartered would be a bidder.

Thus, as of October 25, 2012, D.C. Healthcare was justified in believing that the Rehabilitator was doing his best to submit a bid in Chartered's name. As indicated in the protest, D.C. Healthcare did not know, and had no reason to know, until December 3, 2012, (timed to be posted after the proposal submission was due) that Chartered had not submitted a bid. Thus, this protest is timely because it was filed within ten business days of when the Company knew or should have known of the grounds for protest.

II. D.C. Healthcare Is an "Aggrieved Party" and Is Properly Pursuing This Protest in its Own Name.

A. D.C. Healthcare does not need to have submitted a proposal in order to have standing where the whole basis of its protest is that the anti-competitive acts complained of prevented it from submitting a proposal.

Predictably, the District argues that D.C. Healthcare does not have a direct economic interest in the procurement and is not an aggrieved party because D.C. Healthcare did not submit a proposal in response to the Solicitation. As set forth below, that argument disregards the facts, twists the law, and is incorrect.

In order for the Board to have jurisdiction over a protest, a protestor must be an aggrieved party, *i.e.*, the protestor must have a direct economic interest in the procurement. Whether such an interest exists is not as simple as whether the protestor submitted a proposal or whether the protestor is second-in-line for award. Rather, this Board has held that whether a party is sufficiently interested to be considered aggrieved "depends on the party's status in relation to the procurement and the issues involved and how these circumstances show the existence of a direct or a substantial economic interest on the part of the protester." *Cup Temporaries, Inc.*, CAB No. P-474, July 3, 1997, 1997 WL 383070.

This Board has stated that: "Sufficient injury can be found, for example, in an adverse agency action which denies a person the right to be considered for contract award, denies the person the opportunity to compete, or precludes the person's product or services from being considered due to defects in the government's specifications." *M.C. Dean, Inc.*, CAB No. P-528, April 16, 1998, 1998 WL 198901. That is one of the arguments that D.C. Healthcare is making here—that due to the improper behavior of the District's agents, the DISB Commissioner and the Rehabilitator for Chartered, D.C. Healthcare was denied the opportunity to compete.

In *B&B Security Consultants, Inc.*, CAB No. P-630, March 7, 2001, 2001 WL 433425, the protestor challenged the District's decision to restrict competition to holders of Federal Supply Schedule ("FSS") contracts. Not being an FSS contract holder, B&B Security Consultants ("B&B Security") had not submitted an offer in response to the solicitation. The

District argued that B&B Security was not an aggrieved party, since it had not submitted an offer, but the Board disagreed, saying:

> Were the Board to decide that the District's use of the FSS was illegal, the District would have to procure its service needs either by exercising its option with B&B Security or resoliciting the contract in the open market. In either case, B&B Security would have a possibility of receiving the award.[8]

See also McRae Industries, Inc., B- 287609.2, 2001 CPD ¶ 127 (Protester is an interested party to challenge contracting agency's alleged waiver of solicitation testing requirements notwithstanding that it did not submit a proposal where, if protest were sustained, the protester would have an opportunity to compete under a revised solicitation); *Courtney Contracting Corp.*, B- 242945, 91-1 CPD ¶ 593 (same).

Here, too, were the Board to sustain D.C. Healthcare's protest, D.C. Healthcare would have a possibility of submitting a bid and, thereafter, be eligible for award. Thus, D.C. Healthcare is an aggrieved party.

The cases cited by the District to argue that D.C. Healthcare is not an aggrieved party are readily distinguishable. For example, in *Eagle Eyes*, the protestor was merely a prospective or "wannabe" subcontractor, which is not the case here. And, in *Integral Systems*, the primary case on which the District relies, the protestor was arguing *on behalf of* its subsidiary. That is not the case here, where D.C. Healthcare is arguing that it, D.C. Healthcare, was deprived of the opportunity to bid.

In any case, the District "concedes, as it must, that D.C. Healthcare has some economic interest in the award of the contract...." Motion to Dismiss at 16. But the District persists in

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[8] Ultimately, the Board dismissed B&B Security's protest as untimely for reasons not present here.

minimizing the direct economic interest that D.C. Healthcare has in its own right in this procurement. D.C. Healthcare has twelve years of intimate technical involvement, knowledge and experience in this Medicaid work. As noted above it has its own independent interest in the procurement. Yes, it is the parent company of Chartered. But that is not the only basis for its interest. D.C. Healthcare has been supervising, managing and overseeing the operations of this Medicaid contract for a dozen years. It has an intimate knowledge of the Medicaid business and has the corporate and technical experience to perform the work. As they had done for Chartered in the prior procurement process in the past, D.C. Healthcare could have bundled its own resources, and that of other potential team members, and submitted a proposal, but for the anti-competitive and misleading actions of the District and its agents.

B. **D.C. Healthcare has the capacity to perform the RFP's requirements.**

The District argues, citing the *Tyrone F. General* and *24/7 Computer Doctors* cases, that D.C. Healthcare has no standing because it has not shown that it has the capacity to perform the RFP's requirements. The District's legal argument lacks merit and it has provided no facts to back up its contentions.

In *Tyrone F. General*, the Board found that the protestor failed to demonstrate aggrieved party status where he asserted only that he was "an 'enterprising businessman' who has desired an opportunity to compete since 1990." In *24/7 Computer Doctors* case, the protestor was initially involved in a team to bid, but then abandoned that effort. Moreover, the protestor in *24/7 Computer Doctors* did not allege that the District had violated any procurement law. These cases are a far cry from the present case, where the protestor, D.C. Healthcare, is itself in the Medicaid MCO business; has participated in *this* procurement in the past; and where the District has failed to fulfill its duty to obtain competition and to prevent or mitigate anti-competitive

bidding practices by the district's own agents. While the District argues that D.C. Healthcare does not control Chartered, the fact is that, were Chartered to lose the Medicaid contract, its resources would no longer be necessary for that purpose and the rehabilitation proceeding would presumably end. In that event, D.C. Healthcare, as the sole owner of Chartered, would again have access to those resources.[9] While those resources were not a necessary prerequisite for D.C. Healthcare's bid, they would augment it. And, it is well established that an agency may properly attribute the experience or past performance of an affiliated company to an offeror where the firm's proposal demonstrates that resources of the affiliate will affect the performance of the offeror. *See, e.g., Ecompex, Inc.*, B-292865, 2004 CPD ¶ 149 at 5; *Perini/Jones, Joint Venture*, B-285906, 2002 CPD ¶ 68 at 4. Here, of course, D.C. Healthcare never received a chance to make that showing, since it was deprived of the opportunity to submit a bid by the actions of agents of the District.

And, in any case, D.C. Healthcare emphatically submits that it does have the capacity to bid on and successfully perform this contract. D.C. Healthcare has been in this business since the year 2000. In its protest, D.C. Healthcare affirmatively asserted that it could have submitted a stand-alone proposal, and for motion to dismiss purposes, the facts asserted to be true must be so conceded. In any case, D.C. Healthcare knows the MCO business inside and out. The company supervised and managed its subsidiary, and through that oversight it had all the experience that Chartered possessed. It was a direct service provider to Chartered, and had performed services on this same MCO contract. D.C. Healthcare has intricate technical and working knowledge of and experience in the performance of this kind of work. Again, it is not just some corporate shell. The company has independent resources that it could organize and marshal to submit its own bid.

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[9] Obviously, this is not a decision for the CAB to make. At this stage, the only question is whether D.C. Healthcare has standing to protest.

D.C. Healthcare had done this very same proposal work for Chartered in the past, including managing and drafting the Chartered proposal which won the award of a contract on the prior procurement cycle. And, given this wealth of experience, and the solicitation provisions offering special evaluative credit to local offerors, it was particularly well-situated to team with other potential bidders as well.

Accordingly, the case law is squarely in D.C Healthcare's corner; the Company alleged in its protest filing that it was capable of bidding; under the ordinary legal rules for a motion to dismiss, the allegation must be accepted as true. For the foregoing reasons, D.C. Healthcare is an "aggrieved party."

III. D.C. Healthcare's Protest Is within the Subject Matter Jurisdiction of the Board

The District's Motion to Dismiss wrongly characterizes D.C. Healthcare's protest as attempting to circumvent the authority of the Rehabilitator and the Superior Court.[10] As noted, D.C. Healthcare is not asserting any rights under the insurance laws of the District of Columbia. Rather, as stated in D.C. Healthcare's protest, ***and not addressed at all in the District's motion***,

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[10] The District suggests that "Protester's dissatisfaction is remediable, if at all, by the Superior Court...." District Motion to Dismiss at 15. (Emphasis added). But this claim ignores the fact that this dispute is a bid protest initiated to correct alleged violation of the D.C. procurement code. As the District knows, it cannot bestow initial jurisdiction over that bid protest in the Superior Court, at least until this Board has exhausted its statutory jurisdiction. This Board has initial and **exclusive and independent** jurisdiction over the procurement process, and not the Superior Court, whose protest role is only appellate in nature. If D.C. Healthcare had run to the Superior Court with a request to cancel the District's solicitation, the District would have argued that D.C. Healthcare had failed to exhaust its administrative remedies at the Board. Only the Board has at least the initial and exclusive jurisdiction over the allegations concerning collusive bidding and other procurement irregularities. What the District is really arguing is that these allegations have no remedy (*i.e.*, hence, in the District's words "remedial, if at all") and there is no forum for the protest. D.C. Healthcare, on the other hand, urges the Board to defend its jurisdiction – the role of the Board and the courts are not in conflict. The Superior Court's continued jurisdiction over the Rehabilitator is concurrent (and complementary to) the Board's jurisdiction over the procurement process and this protest.

this protest is brought under the District of Columbia Procurement Code, which prohibits collusion in bidding as well as the other acts complained of. D.C. Code § 2-354.15. D.C. Healthcare argued, *inter alia,* in its protest that the District has knowingly condoned collusive bidding because it looked the other way while the same individuals (again, agents of the District, no less!) controlled or advised three potential bidders (Chartered, United Healthcare and AmeriHealth Mercy) and caused one of the three (the incumbent, Chartered) to "no bid" the Solicitation. As alleged in the bid protest, this decision not to bid benefitted the conflicted agents and other competitors, who knew that the largest and most experienced competitor was out of the picture. The District admits that the incumbent, Chartered, did not even register to submit bid. DSOF ¶ 5. This should have been a giant red flag, given Chartered status as the largest of the MCO incumbent contractors engaged by DCHF. But the District's procurement officials apparently did nothing to ensure that adequate competition would take place. Instead, officials of the District publicly assured all that they would do their "best" to make sure Chartered submitted a bid and more than 160 jobs would be protected. When the District controlled Chartered decided no bid, the District defaulted on that representation and actively misled D.C. Healthcare by continuing to withhold that information until the deadline for submission of proposals had past.

As stated in D.C. Healthcare's protest, this Board has held that collusive bidding and a restraint of trade are grounds to cancel a solicitation and reject all bids. Unlike the non-procurement-related statutes at issue in the *Black Entertainment Television* and *Metropolitan Service & Maintenance Corp.* cases cited on page 13 of the District's Motion to Dismiss, laws against anti-competitive behavior are very much the business of the District's procurement

authorities. As just noted, the District's ***Procurement*** Code prohibits collusion in bidding. D.C. Code § 2-354.15. Moreover, this Board has held that:

> [The regulation] provides that a contracting agency may cancel a solicitation and reject all bids when the CPO determines in writing that cancellation is in the best interests of the District for reasons including that the "bids were not independently arrived at in open competition, were collusive, or were submitted in bad faith." If there is evidence of collusion, or other anti-trust violations among businesses in connection with a solicitation, the contracting officer is required by 27 DCMR § 1007.2 to report such evidence to the CPO. The CPO in turn "shall consult with the Corporation Counsel within ten (10) days of the report to ascertain whether a reasonable basis exists for believing that collusion has occurred among any businesses for purposes of defrauding the District." If the CPO in consultation with the Corporation Counsel concludes that there is a reasonable basis to believe that an anti-trust violation has occurred, the CPO would then be required to consider the issues of cancellation and contractor responsibility, among others. Section 1007.3 of 27 DCMR sets forth practices and events that may evidence violations of antitrust laws, including "[a]ssertions . . . by competitors of offerors[] that an agreement to restrain trade exists."

The question of whether the Board has jurisdiction and whether a protestor is an aggrieved party must be viewed in the context of the procurement error being alleged. Here the procurement involves turning a blind eye to collusive bidding, anti-competitive behavior and conflicts of interest. If an aggrieved party, including a party that was induced to not bid, cannot challenge such violations of the Procurement Code at the CAB, then the Procurement Code itself becomes toothless. That's why the conduct here, which denied D.C. Healthcare the opportunity to compete, and which compromised the public interest in competition, suffices to bestow standing and to give the Board jurisdiction.[11]

[11] Similarly, it renders D.C. Healthcare's protest timely. It is inevitable that anti-competitive behavior will become apparent only after bids have been submitted.

Conclusion

As demonstrated above, D.C. Healthcare's protest was timely filed because it was filed within ten business days of when D.C. Healthcare learned that collusive bidding behavior had caused its subsidiary to "no-bid" the procurement. D.C. Healthcare is an aggrieved party because it has a direct economic interest in the outcome of the procurement; it is a prospect bidder, capable of bidding, and aggrieved by the District's actions. And this Board does have jurisdiction over D.C. Healthcare's challenge to a violation of the D.C. Procurement Code.

The protest alleges anti-competitive practices in violation of the D.C. Procurement Code that go to the heart of the integrity of the procurement process. The District says nothing in response to the substance of the allegations. If the protest allegations are correct, and for a motion to dismiss purposes they should be so deemed, they describe serious procurement-related irregularities. This Board is charged with resolving that protest.

From our vantage point, the District's Motion to Dismiss is a finely calibrated dagger aimed at the jurisdiction of this Board to hear and resolve important issues of procurement integrity. Granting of this motion would undermine the Board's jurisdiction, and leave the procurement community without a forum to address serious procurement irregularities. That serves no public good. For these reasons, the District's Motion to Dismiss should be denied.

Accordingly, D.C. Healthcare respectfully requests that the Board enter an order:

1. Denying the Motion to Dismiss;
2. Directing the District to submit on an expedited basis an agency report and record responsive to the protest; and
3. Directing the District to include in that record all the documents specifically requested by D.C. Healthcare in it protest filing.

Respectfully submitted,

BROWN RUDNICK LLP

/s/

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Certificate of Service

I hereby certify that on the filing date for this Opposition, January 25, 2013, the Protestor served on the District, through listed counsel, by File & Serve, a copy of the foregoing OPPOSITION OF PROTESTOR D.C. HEALTHCARE SYSTEMS, INC. TO THE DISTRICT OF COLUMBIA'S MOTION TO DISMISS in CAB No. P-0930 to:

Jon N. Kulish, Esquire
Talia Sassoon Cohen, Esquire
441 4th Street, N.W., Suite 700 South
Washington, D.C. 20001

/s/
Michael D. Maloney

EXHIBIT 14

DISTRICT OF COLUMBIA CONTRACT APPEALS BOARD

PROTEST OF:

DC HEALTHCARE SYSTEMS, INC.	)	
	)	CAB No. P-0930
Solicitation No: DHCF-2013-R-0003	)	

For the Protester: Daniel B. Abrahams, Esq., Shlomo B. Katz, Esq., Brown Rudnick LLP. For the District of Columbia Government: Jon N. Kulish, Esq., Talia S. Cohen, Esq., Office of the Attorney General.

Opinion by Administrative Judge Monica C. Parchment, with Chief Administrative Judge Marc D. Loud, Sr. and Administrative Judge Maxine E. McBean, concurring.

ORDER DISMISSING PROTEST

Filing ID #49821131

This protest arises in connection with the District's solicitation for managed care organizations to provide healthcare services to the District's Medicaid eligible population. The protester, DC Healthcare Systems, Inc., alleges collusion and various other improprieties in the District's management of protester's wholly-owned subsidiary, DC Chartered Health Plan, Inc., which it alleges caused both the protester and the subsidiary to not respond to the solicitation. The Board finds that (1) we lack jurisdiction over the subject matter of protester's allegations; and (2) the protester lacks standing to bring the protest. Accordingly, we dismiss the protest.

FACTUAL BACKGROUND

DC Chartered Health Plan, Inc. ("Chartered"), a wholly-owned subsidiary of the protester, is an incumbent contractor providing healthcare services to those enrolled in the District of Columbia Healthy Families Program. (Protest 1-2.) The provision of these services, on behalf of the District of Columbia Department of Health Care Finance ("DHCF"), serves as Chartered's sole source of operating revenue. (*Id.* at 10.) Chartered's current contract with DHCF expires on April 30, 2013. (Dist. Ex. 3.)

On November 1, 2012, the District of Columbia Office of Contracting and Procurement ("OCP"), on behalf of DHCF, issued Request for Proposals No. DHCF-2013-R-0003 (the "Solicitation"). (Dist. Ex. 1.) The Solicitation sought offerors to provide healthcare services to the District's Medicaid eligible population under the District of Columbia Healthy Families Program through April 30, 2018. (Dist. Ex. 1 ¶ B.1.) The Solicitation anticipated making awards to up to three offerors for such services. (*Id.*) Under Amendment 9 to the Solicitation, proposals were due on December 3, 2012. (Dist. Ex. 2.) Neither the protester nor Chartered submitted a proposal in response to the Solicitation, or otherwise challenged the terms of the Solicitation before proposals were due. (Protest 10, 15.)

The District of Columbia Department of Insurance, Securities & Banking ("DISB"), pursuant to a Superior Court Order of Rehabilitation, is the court-appointed Rehabilitator of Chartered's affairs. (Dist. Ex. 16.) As Rehabilitator, DISB is empowered to "take such action as deemed necessary or appropriate to reform and revitalize" Chartered. D.C. CODE § 31-1312(c) (2001). To assist it in managing the affairs of Chartered, DISB hired Daniel L. Watkins and Faegre Baker Daniels, LLP ("Faegre"), as examiners pursuant to D.C. CODE § 31-1401 *et seq.* (Protest 2-3.) On December 3, 2012, DISB issued a status report in which it explained why Chartered had not submitted an offer in response to the Solicitation. (Dist. Ex. 20.) This report from DISB indicated that AmeriHealth Mercy and Chartered had established some type of partnering arrangement, but that only AmeriHealth Mercy was directly responding to the RFP as the prime contractor. (*Id.* at 2.)

The protester submits that if it had known that Chartered was not submitting an offer, it would have prepared its own response to the Solicitation. (Protest 15.) The protester filed the present protest on December 17, 2012, raising three related protest grounds and requesting that the Board cancel the Solicitation.

Protest Allegations

The protester first alleges that various conflicts of interest have tainted the present procurement. (Protest 11-12.) In its protest, the protester quotes, at length, its June 2012 communications with DISB in which the protester and Chartered alleged that DISB's examiners, Watkins and Faegre, had impermissible conflicts of interest in violation of D.C. CODE § 31-1405 (2001). (*Id.* at 2-10.) Protester alleges that Watkins is the brother of Chartered's former Chief Operating Officer. (*Id.* at 2.) The protester also alleges that, in addition to its work with Chartered, Faegre also (1) represents various Blue Cross Shield entities, including AmeriHealth Mercy; (2) is a registered lobbyist for AmeriHealth Mercy of Indiana; and (3) represents United Healthcare, another bidder and competitor, which had also expressed an interest in acquiring Chartered. (*Id.* at 3, 10.) The protester alleges that these "conflicts of interest […] preclude full and open competition and a fair award." (*Id.* at 11.)

Second, the protester alleges that the conflicts of interest described above resulted in collusive bidding when DISB decided that Chartered would not respond to the Solicitation, but would instead partner with AmeriHealth Mercy. (*Id.* at 13.) Finally, the protester argues that DISB's decision not to have Chartered submit a proposal in response to the Solicitation constituted an illegal restraint on trade in violation of D.C. CODE § 28-4501 *et seq.* (*Id.*)

Motion to Dismiss

The District moved to dismiss the protest on January 10, 2013, arguing that the Board lacks jurisdiction to hear the protest, and that the protester lacks standing. More specifically, the District argues that the Board lacks jurisdiction because the protester's allegations do not directly relate to the solicitation or award of a contract. (Dist. Mot. to Dismiss 12.) Rather, the District argues that the protest arises from the protester's dissatisfaction with the Rehabilitator's actions as they relate to Chartered. (*Id.* at 14-15.) The District further argues that the protester lacks standing to bring the present protest because the protester did not submit an offer in its own name, and the protester has not demonstrated that it has the capacity to perform as a prime

contractor. As such, the District argues that the protester lacks a direct economic interest in the outcome of the procurement, which is necessary to establish standing before the Board. (*Id.* at 15-19.) Finally, citing *Integral Systems, Inc.*, B-405303.1, 2011 CPD ¶ 161 (Aug. 16, 2011), the District argues that the protester lacks standing to represent the interests of its subsidiary, Chartered, in this protest before the Board.[1] (*Id.* at 19-20.)

The protester filed its opposition to the District's motion to dismiss on January 25, 2013. The protester argues, broadly, that the actions protested violate the anti-collusion provisions in "the District of Columbia Procurement Code," and therefore that the Board has jurisdiction over its protest. (Protester's Opp'n to Mot. to Dismiss 15-17 (citing DC CODE § 2-354.15 (2011)).) The protester further argues that it has standing to bring the protest in its own right as a prospective offeror denied an opportunity to compete for the underlying contract and asserts that it has the capability to perform the disputed contract. (*Id.* at 11-15.)

After the Board's review of this matter, and the underlying record, we find that the Board lacks jurisdiction over the present protest for the reasons discussed below.

DISCUSSION

Before considering the merits of protester's allegations, the Board must first determine (1) whether it has subject matter jurisdiction over the claims raised in the instant protest; and (2) whether protester has standing to bring this protest—that is, whether protester is an "aggrieved person," as defined in D.C. MUN. REGS. tit. 27, § 100.2(a) (2002).

Jurisdiction

The Board has exclusive jurisdiction over any "protest of a solicitation or award of a contract…by any actual or prospective bidder, offeror, or the contractor who is aggrieved in connection with the solicitation or award of a contract." D.C. CODE § 2-360.03(a)(1) (2011). The Board's statutory protest jurisdiction, however, is limited to deciding whether a solicitation or award of a contract was made in accordance with applicable procurement law and regulations, and the terms of the solicitation. D.C. CODE § 2-360.08(d). In this regard, the District asserts that the present protest is not a "protest of a solicitation or award of a contract," but instead consists of a series of allegations by the protester concerning conduct by District officials (and agents) that were not responsible for issuing the solicitation, evaluating offers, or awarding the resulting contract in this procurement. (Dist. Mot. to Dismiss 12-13.)

While the District asserts that this is a protest against the actions of the Rehabilitator, and not against the actions of procurement officials, the protester, on the other hand, argues that its protest "does not require the [Board] to rule directly on the propriety or impropriety of the acts of the Rehabilitator." (Protester's Opp'n to Mot. to Dismiss 8.) However, the Board notes that all of the protester's protest allegations center on actions taken by DISB and its agents acting as

[1] The District filed its Motion for Leave to File Reply to Protester's Opposition to the District of Columbia's Motion to Dismiss ("Reply") on February 5, 2013, which the Board grants. In its Reply, the District reiterated many of the arguments contained in its initial brief, and included with its Reply separate Declarations by the Rehabilitator and by the Contracting Officer, which effectively state that, contrary to Protester's allegations, said individuals acted independently and without collusion. (*See generally* Reply Ex. A, Ex. B.)

Rehabilitator for Chartered, which the protester effectively admits in its opposition. (*Id.*) Specifically, as set forth above, the thrust of the protest alleges that DISB's decision that Chartered would not submit an offer in response to the Solicitation was improper because it resulted from the influence of agents who had conflicts of interest including, specifically, Mr. Watkins and Faegre, that unduly influenced Chartered not to bid for the contract. Accordingly, the Board finds that the protest, in fact, largely challenges the propriety of the conduct of the Rehabilitator, and its agents, and not that of the procuring agency – OCP on behalf of DHCF – that issued the Solicitation.

Nevertheless, while the protester does not allege any improper acts directly on the part of OCP or the contracting agency, DHCF,[2] the protester still argues that any anti-competitive behavior by the Rehabilitator and its agents must be ascribed to the District as a whole, presumably to include the procuring agencies OCP and DHCF. (*Id.* at 6.) Although the Board has, on occasion, held that knowledge of the actions of one District official can be imputed to another, such imputation would require evidence of close cooperation between said officials. *See Fort Myer Constr. Corp.*, CAB No. D-859, 40 D.C. Reg. 4655, 4677 (Nov. 3, 1992) (holding that the District project manager's knowledge of contractor's performance must be imputed to the contracting officer, because the project manager "had a duty to report matters concerning performance of work" to the contracting officer). Here, on the other hand, there is no evidence of an ongoing communication line between DISB and its agents and OCP and DHCF that would require that the Board impute any knowledge to OCP and DHCF regarding the Rehabilitator's conduct in managing Chartered, or to find that collusion occurred between these agencies that tainted the protested Solicitation.

In addition to the fact that this protest is not directly related to the Solicitation, the protester also seeks to have the Board adjudicate statutory provisions unrelated to the procurement matters within the statutorily-prescribed jurisdiction of the Board, because the protester is effectively challenging the actions of the Rehabilitator's deputies appointed under D.C. CODE § 31-1312(a) (2001). Indeed, the Board would be required to interpret the conflict of interest provision at D.C. CODE § 31-1405 (2001), enacted under a statutory scheme regulating the insurance industry, in connection with the protester's allegation that the Rehabilitator's agents had unmitigated organizational and personal conflicts of interest. Further, as set forth in the statutory provisions concerning antitrust violations, the protester's allegations that Watkins and Faegre illegally restrained trade through their involvement with Chartered's no-bid decision are matters for the District of Columbia Attorney General to review in enforcing the District's antitrust laws, and for individuals who wish to seek civil remedies through the courts. *See* D.C. CODE §§ 2-354.15, 28-4506, 28-4507, 28-4508; *see also Great South Bay Marina*, B-296335, 2005 CPD ¶ 135 at 6 (July 13, 2005) (holding that allegations of antitrust violations are not reviewable under GAO's bid protest function); *Shel-Ken Props., Inc.; McSwain & Assocs., Inc.*, B-261443, B-216443.2, 95-2 CPD ¶ 139 at 3 (Sept. 18, 1995) ("If the contracting officer suspects collusion, the matter should be referred to the Attorney General.").

[2] At most, the protest asserts that DHCF had knowledge of Chartered's rehabilitation. (*See* Protest 12.) In its opposition to the District's motion, the Protester further asserts that DHCF had knowledge that Chartered would not submit an offer prior to the submission deadline. (*See* Protester's Opp'n to Mot. to Dismiss 7, 16.) However, this still does not establish that DHCF acted improperly in relation to this procurement, as there is nothing inherently unusual or improper in an incumbent not bidding on a follow-on contract.

Therefore, based upon these factors, we find that the nature of the protester's allegations do not constitute a challenge against a solicitation or award of a contract as contemplated by D.C. CODE § 2-360.08 and, moreover, concern matters beyond the jurisdiction of this Board.

Standing

In response to the District's allegation that the Protestor lacks standing, the Board finds that protester is not an "aggrieved person," as defined in D.C. MUN. REGS. tit. 27, § 100.2(a), and therefore has no standing to bring the instant protest. This Board has repeatedly held that "[i]n order to have standing an actual or prospective bidder or offeror must show that it has suffered, or will suffer, a direct economic injury as a result of the alleged adverse agency action. *M.C. Dean, Inc.*, CAB No. P-528, 45 D.C. Reg. 8746, 8749-50 (Apr. 16, 1998) (citing *District of Columbia v. Grp. Ins. Admin.*, 633 A.2d 2, 18-19 (D.C. 1993)); *accord MorphoTrust USA, Inc.*, CAB No. P-924, 2012 WL 6929398 (Nov. 28, 2012).

In *MorphoTrust*, the protester was excluded from competition due to the rigorous specifications included with the solicitation. CAB No. P-924, 2012 WL 6929398. The Board held that despite that protester's inability to submit a responsive proposal, the protester nonetheless had standing because it could allege that it had been denied the opportunity to compete, and/or had been excluded from consideration "due to defects in the government's specifications." *Id.* (citing *Recycling Solutions, Inc.*, CAB No. P-0377, 42 D.C. Reg. 4550, 4575 (Apr. 15, 1992)). In the instant case, and under the same rationale, the facts reflect that neither OCP nor DHCF (the District agencies responsible for the procurement) have denied the protester the opportunity to compete. Nor has the protester been excluded from consideration due to defects in the solicitation, or other acts by procurement officials that could have precluded this protester from submitting a responsive proposal. Essentially, it appears to the Board that the protester learned too late that Chartered was not going to bid for the contract, and once it learned this fact, the District' deadline for submission of proposals had passed. In short, these facts indicate that the protester was not an actual, or a prospective, offeror in this procurement given that the protester clearly had no original intention to bid on the contract before it later learned that Chartered had not submitted a proposal.

Finally, the Board notes that the protester's status as the parent company of Chartered would not, by itself, give the protester the direct economic interest in the procurement that is required to show standing. In *Integral Systems, Inc.*, the parent company of an offeror protested the exclusion of its wholly-owned subsidiary from the competitive range. *Integral Systems, Inc.*, B-405303.1, 2011 CPD ¶ 161 (Aug. 16, 2011). Although the Government Accountability Office ("GAO") agreed that the protester, as the offeror's corporate parent, had an economic interest in the procurement, GAO held that the protester did not have standing because this interest was not the direct economic interest required by federal statute. *Id.* at 5 (citing *Allied Tube & Conduit*, B-252371, 93-1 CPD ¶ 345 at 2 (Apr. 27, 1993)). Similarly, in the instant case, while the protester has an economic interest in Chartered's future as a contractor for the District, this interest is not a direct one. Thus, the protester cannot demonstrate standing solely by virtue of its status as the parent company of Chartered.

CONCLUSION

For the foregoing reasons, the Board holds that the present protest is not a protest of a solicitation or award of a contract as defined by statute and, therefore, is beyond the scope of our protest jurisdiction. D.C. CODE § 2-360.03(a)(1). We also hold that the protester is not an "aggrieved person," as defined in D.C. MUN. REGS. tit. 27, § 100.2(a), and therefore has no standing to bring the instant protest. Accordingly, the protest is hereby DISMISSED with prejudice.

SO ORDERED.

Date: February 27, 2013

/s/ Monica C. Parchment
MONICA C. PARCHMENT
Administrative Judge

CONCURRING:

/s/ Marc D. Loud, Sr.
MARC D. LOUD, SR.
Chief Administrative Judge

/s/ Maxine E. McBean
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EXHIBIT 15

QUESTIONS AND ANSWERS ABOUT D.C. CHARTERED HEALTH PLAN INC.
February 22, 2013

The special deputy rehabilitator for the company, Daniel L. Watkins, answers questions about Chartered's recent status report and petition to approve the sale of certain Chartered assets to AmeriHealth, a national leader in government-sponsored managed-care health services.

What is AmeriHealth purchasing from Chartered?

AmeriHealth is purchasing certain assets of Chartered, not its stock or liabilities (except those specifically identified in the Asset Purchase Agreement). AmeriHealth is seeking a new Medicaid contract with the District. If it is successful in securing the contract, it would hire most of Chartered's employees and utilize Chartered's provider network.

What happens if AmeriHealth does not secure a Medicaid contract with the District?

AmeriHealth is not required to close on the Asset Purchase Agreement if it is not successful in securing the Medicaid contract with the District. In that case, the rehabilitator would continue to marshal Chartered's assets, resolve Chartered's liabilities and wind down Chartered's affairs after the expiration of its current Medicaid contract April 30.

How much is AmeriHealth paying for Chartered's assets?

AmeriHealth has agreed to pay $5 million and provide significant services for the rehabilitation at no cost to Chartered after Chartered's contract ends. AmeriHealth will also capitalize its new company in an amount expected to be in excess of $30 million.

In addition, if the transaction is approved and closes, most of Chartered's employees will have jobs with AmeriHealth.

Chartered's financial advisor, Keefe, Bruyette & Woods, believes the transaction represents a reasonable reflection of any inherent value in Chartered's business operations in its current state, given the significant challenges—legal and financial—described in the first report to the court.

What are the premium-claims assets which Chartered is keeping?

Chartered has filed claims with the District for retrospective adjustments owed for costs Chartered incurred due to contract changes the District made in 2010.

The increased costs are primarily due to expensive HIV medications heavily utilized by enrollees in the city's own health-care program for the poor, D.C. Healthcare Alliance, who were shifted onto Medicaid coverage with expanded pharmacy benefits.

Chartered's contract with the Department of Health Care Finance provides for an equitable adjustment to pay for losses when there is a change to the contract, such as the switch to Medicaid coverage for certain Alliance members.

The rehabilitator is seeking an expedited review and, hopefully, resolution of these claims with the District. The claims represent a substantial portion of Chartered's assets, and Chartered needs to realize fair value on the claims to meet its liabilities under its current Medicaid contract.

Has Chartered's holding company or its shareholder responded to Chartered's demand to provide satisfactory documentation for transactions with Chartered Family Health Center or repayment of the amounts in question? What about federal income tax refunds due Chartered by the holding company?

DC Health Systems Inc., Chartered's parent company, has asked for additional information and documentation regarding amounts claimed by Chartered from the parent company and/or its shareholder. Chartered is providing the parent company updated documentation and reconciliations on related party accounts. The rehabilitator will continue to seek satisfactory documentation and recovery of income-tax refunds and other related party payments determined to be due from the parent company and its shareholder.

Will providers be paid for the services currently being provided to Chartered enrollees?

Chartered intends to marshal and utilize all available assets to pay provider claims. A significant portion of Chartered's assets are illiquid and currently not available—over $60 million in retrospective premium claims filed with the Department of Health Care Finance and approximately $12 million in assets pledged to Cardinal Bank.

The rehabilitator is seeking an expedited review, and, hopefully, timely resolution of those claims with the District so that providers can be paid in full.

EXHIBIT 16

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District of Columbia Department of Health Care Finance
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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	$ 146.27	$ 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	$ 508.78	$ 614.03	$ 614.03	$ 607.89	$ 607.89	$ 614.03
Infant Month of Birth	$ 4,285.43	$ 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	$ 14,566,618
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	87,296	$ 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.

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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-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
MEMBERMONTHS OR DELIVERIES	53,962	478,264	115,046	101,428	211,844	37,727	108,383	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	$ 6,345.22	$ 77.35	$ 48.63	$ 5,390.06
Inpatient Hospital - Mental Health	$ -	$ 2.43	$ 9.20	$ 11.02	$ 2.01	$ 0.75	$ 2.42	$ 0.84	$ 3.68	$ 23.34	$ 37.32	$ 3.77	$ 3.61	$ 30.35
Outpatient Hospital - Physical Health	$ 37.02	$ 22.37	$ 22.31	$ 16.20	$ 35.69	$ 17.50	$ 66.47	$ 47.21	$ 112.74	$ 141.03	$ 716.47	$ 33.39	$ 31.10	$ 429.58
Outpatient Hospital - Mental Health	$ 0.02	$ 0.27	$ 0.30	$ 0.36	$ 0.21	$ 0.24	$ 0.24	$ 0.14	$ 1.42	$ 1.67	$ 2.66	$ 0.29	$ 0.27	$ 2.17
Emergency Room	$ 28.41	$ 16.81	$ 17.52	$ 13.13	$ 32.49	$ 14.45	$ 33.74	$ 17.46	$ 19.85	$ 87.43	$ 249.77	$ 22.48	$ 21.58	$ 168.83
Physician - Physical Health	$ 57.45	$ 21.35	$ 21.46	$ 13.08	$ 43.35	$ 14.03	$ 62.27	$ 41.67	$ 54.69	$ 137.57	$ 337.54	$ 32.26	$ 30.99	$ 237.84
Physician - Mental Health	$ 0.02	$ 1.60	$ 1.45	$ 3.58	$ 1.02	$ 0.46	$ 1.52	$ 0.61	$ 1.66	$ 3.60	$ 6.84	$ 1.55	$ 1.52	$ 5.22
Pharmacy	$ 13.64	$ 10.07	$ 11.55	$ 11.77	$ 27.32	$ 10.44	$ 60.27	$ 36.39	$ 166.10	$ 2.28	$ 0.23	$ 21.86	$ 21.85	$ 1.25
Transportation	$ 2.82	$ 1.67	$ 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	$ 25.61	$ 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	$ 42.86	$ 118.70	$ 7.77	$ 7.34	$ 80.89
TOTAL MEDICAL EXPENSES	$ 291.81	$ 123.81	$ 141.06	$ 120.98	$ 214.72	$ 125.06	$ 370.07	$ 264.96	$ 545.29	$ 4,869.69	$ 7,817.62	$ 217.45	$ 183.62	$ 6,347.87

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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	438,995	113,054	99,968	209,268	35,521	109,426	22,545	15,958	3,071	3,011	1,152,945	1,152,945	6,082
PMPM MEDICAL EXPENSES														
Inpatient Hospital - Physical Health	$ 144.91	$ 18.65	$ 19.90	$ 22.22	$ 46.22	$ 55.40	$ 118.24	$ 112.19	$ 134.84	$ 3,466.18	$ 5,420.81	$ 67.87	$ 44.48	$ 4,433.85
Inpatient Hospital - Mental Health	$ -	$ 1.99	$ 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	$ 40.96	$ 19.50	$ 18.21	$ 14.11	$ 29.15	$ 15.78	$ 26.54	$ 16.75	$ 29.12	$ 13.05	$ 36.74	$ 22.51	$ 22.38	$ 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	$ 14.39	$ 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	$ 21.66	$ 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	$ 99.48	$ 130.26	$ 104.69	$ 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	6.9%	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%	1.6%	-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%	-2.0%	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	$ 167.69
37 - 49 Years, Female	$ 366.12	5.9%	2.9%	-2.3%	-8.0%	10.0%	2.0%	2.0%	$ 435.93	$ 415.85	$ 453.86
37 - 49 Years, Male	$ 271.37	5.7%	3.0%	-2.1%	-20.0%	10.0%	2.0%	2.0%	$ 281.08	$ 268.38	$ 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	$ 736.83
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%	-3.8%	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%	$ 8,669.25	$ 8,328.04	$ 9,068.03
Overall	**$ 218.79**	**5.6%**	**2.2%**	**-3.6%**	**0.4%**	**9.3%**	**2.0%**	**2.0%**	**$ 275.04**	**$ 259.41**	**$ 283.88**

*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)

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%	$ -	$ 282.33	$ 300.80	$ 18.06	$ 19.39	$ 244.27	$ 281.41	$ -	$ -	$ -
1 - 12 Years, Male and Female	$ 112.14	$ 9.93	$ 102.20	0.0%	$ 0.01	$ 116.31	$ 130.01	$ 10.76	$ 11.57	$ 105.54	$ 118.44	$ 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	$ 13.37	$ 129.76	$ 143.98	$ 1.63	$ 1.64	$ 1.61
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	$ 251.85	$ 29.90	$ 32.10	$ 199.54	$ 219.75	$ 4.03	$ 4.27	$ 4.44
19 - 36 Years, Male	$ 121.65	$ 9.84	$ 111.81	0.0%	$ 0.05	$ 126.14	$ 144.02	$ 10.67	$ 11.46	$ 115.47	$ 133.16	$ 0.06	$ 0.06	$ 0.06
37 - 49 Years, Female	$ 366.12	$ 62.03	$ 304.09	0.5%	$ 1.43	$ 358.63	$ 391.41	$ 61.91	$ 66.47	$ 296.71	$ 324.94	$ 1.40	$ 1.47	$ 1.53
37 - 49 Years, Male	$ 271.37	$ 39.94	$ 231.43	0.1%	$ 0.16	$ 231.45	$ 252.21	$ 34.66	$ 37.21	$ 196.79	$ 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	$ 529.54	$ 94.35	$ 151.95	$ 344.42	$ 377.59	$ 0.01	$ 0.02	$ 0.02
Infant Month of Birth	$ 3,970.26	$ 1.27	$ 3,968.99	0.0%	$ 0.03	$ 3,863.74	$ 4,208.24	$ 1.38	$ 1.48	$ 3,862.36	$ 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	$ 99.62	$ 100.23	$ 108.69
Overall	$ 218.79	$ 21.78	$ 197.01	0.7%	$ 1.37	$ 225.54	$ 251.12	$ 23.17	$ 27.13	$ 202.37	$ 223.99	$ 1.39	$ 1.45	$ 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.

EXHIBIT 17

MERCER

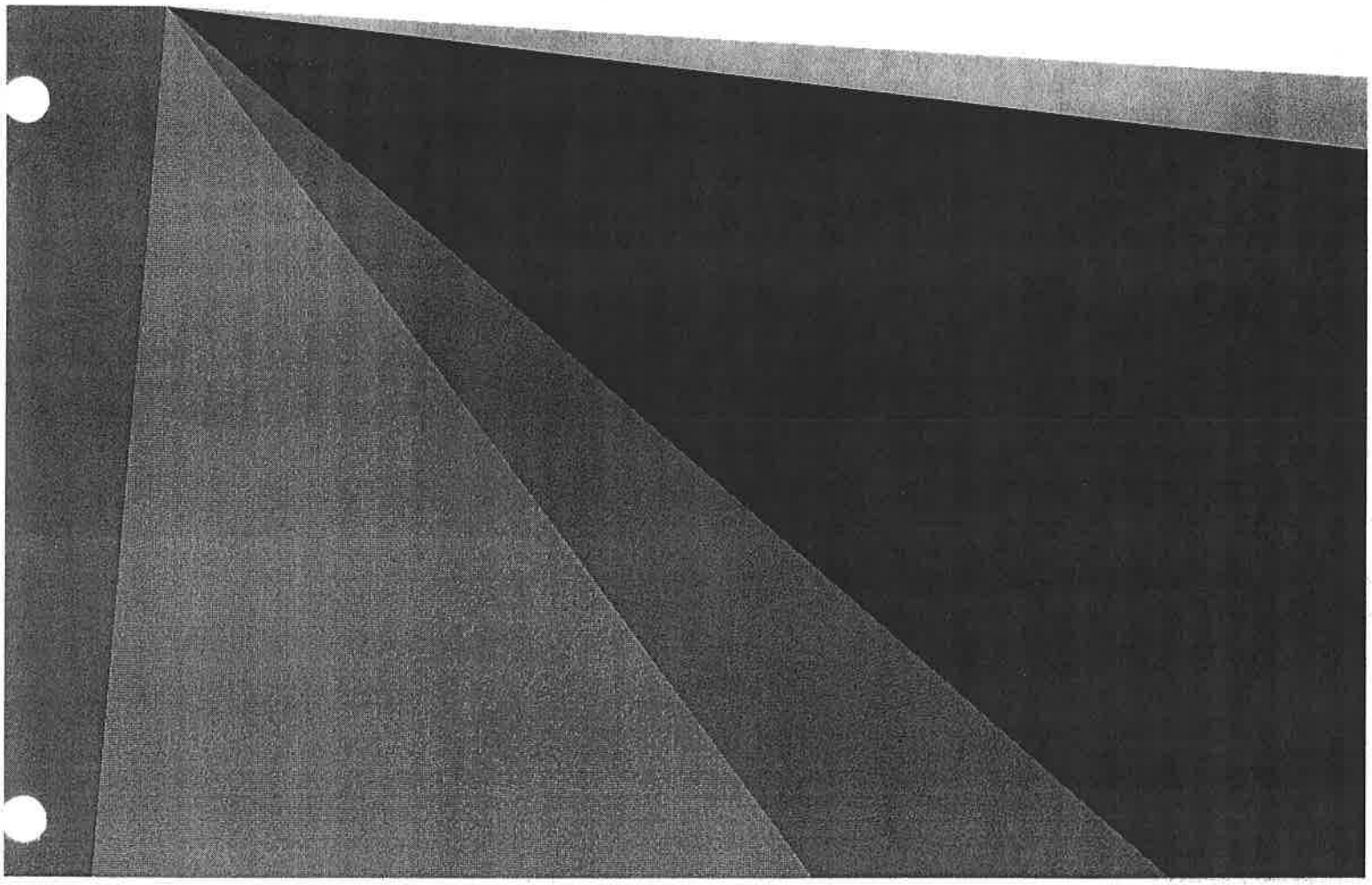
CONSULTING. OUTSOURCING. INVESTMENTS.

DCHFP DATA BOOK FOR RATES EFFECTIVE MAY 1, 2012

DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH CARE FINANCE

JANUARY 6, 2012

Government Human Services Consulting



MARSH & McLENNAN COMPANIES

CONTENTS

1

Introduction

Purpose of this Data Book

The intent of this Data Book is to summarize historical data on the cost and utilization patterns of Medicaid eligibles in the District of Columbia's (District's) Healthy Families Program (DCHFP). This Data Book has been produced by the State's actuarial contractor, Mercer Government Human Services Consulting (Mercer), as part of Mercer Health & Benefits LLC.

Contents of this Data Book

This Data Book contains demographic, cost and utilization data related to DCHFP covered services only. The managed care data summarized in this Data Book was submitted by contracted managed care organizations (MCOs) and includes encounter data and reported financial information for Medicaid eligible individuals in the DCHFP managed care program.

- The encounter data is submitted by the MCOs to the District's fiscal agent, ACS. ACS provided an extract of the encounter data to Mercer in December 2011.
- Pharmacy data was submitted by the MCOs directly to Mercer during September 2011.
- The financial data is submitted by the MCOs directly to Mercer based on specifications outlined in a data request.
- The eligibility information used in the encounter data analysis is summarized from the District's eligibility file provided by ACS which outlines the MCO enrollment segments for each member.

The users of this Data Book are cautioned that direct comparisons cannot be made between the information in this Data Book and raw encounter data or financial data. Mercer applied adjustments to the raw data, which are described in Section 3.

The encounter information in this Data Book is summarized for the following years (based on date of service):

- August 1, 2009 through July 31, 2010, paid through September 2011
- August 1, 2010 through July 31, 2011, paid through September 2011

The pharmacy claims information in this Data Book is summarized for the following years (based on date of service):

- August 1, 2009 through July 31, 2010, paid through August 2011
- August 1, 2010 through July 31, 2011, paid through August 2011

The financial information in this Data Book is summarized for the following years (based on date of service):

- August 1, 2009 through July 31, 2010, paid through September 2011
- August 1, 2010 through July 31, 2011, paid through September 2011

Additionally, completion factors were applied to reflect claims not yet adjudicated in the encounter or financial data. Please see Section 4 for more detail.

This Data Book summarizes information provided by each of the following MCOs:

- Chartered Health Plan — Contract for the entire period of the Data Book
- Health Right, Incorporated — Contract through April 2010
- Unison Health Plan — Contract for the entire period of the Data Book

The users of this Data Book are cautioned against relying solely on the data contained herein. The District and Mercer provide no guarantee, either written or implied, that this book is 100% accurate or error-free.

2

Covered Populations and Services

This section describes the covered populations and services of the DCHFP contract as they are reflected in this Data Book.

Covered Populations

The DCHFP program covers individuals who meet the eligibility requirements for the District's Temporary Assistance for Needy Families 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. Program code 775 is associated with childless adults with incomes between 134% and 200% of the FPL who were enrolled in the MCOs effective December 2010. These adults are funded out of the District's Disproportionate Share Hospital (DSH) funding.

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 twelve 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)

Covered Services

The DCHFP contract specifies the services covered under the managed care contract in Sections C.8.2. The historical service costs are summarized into the following major service categories in this Data Book.

Service Category	Description	Units of Service
Inpatient Hospital — Physical Health	Acute Care Hospital Services	Days
Inpatient Hospital — Mental Health	Behavioral Health Inpatient	Days
Outpatient Hospital — Physical Health	Outpatient Hospital Services	Visits
Outpatient Hospital — Mental Health	Day Treatment and Outpatient Mental Health	Visits
Emergency Room	Emergency Room Services	Visits
Physician — Physical Health	Primary Care + Specialist Services	Visits
Physician — Mental Health	Professional Mental Health Claims	Visits
Pharmacy	Prescription Drugs	Scripts
Transportation	Ambulance and Non-emergent	Trips
Dental	Dental Services	Units
Residential Treatment Center	Residential Treatment Center	Days
Long Term Care	Skilled Nursing and Intermediate Care Facilities	Days
Other Services	DME, Home Health, Independent Lab, Vision	Units

For a complete list of covered and excluded services, please refer to Section C.8.2 of the DCHFP contract.

The following table outlines the logic used in the summarization of the encounter data to map the encounters into the categories of service (COS).

Service Category	Category of Service
Inpatient Hospital — Physical Health	01 + unknown COS with inpatient claim type
Inpatient Hospital — Mental Health	20, 26 + inpatient hospital claims meeting the mental health indicator (see note below)
Outpatient Hospital — Physical Health	02,29,30,34 + 03 for lab claims with an outpatient claim type + unknown COS with outpatient claim type
Outpatient Hospital — Mental Health	14 + outpatient hospital claims meeting the mental health indicator (see note below)
Emergency Room	02,29,30,34 (see note below)

Service Category	Category of Service
Physician — Physical Health	05,10,11,22,23,25,28,32,35,42 + unknown COS with professional claim type
Physician — Mental Health	09 + Physician claims meeting the mental health indicator (see note below)
Pharmacy	Based on pharmacy claims submitted directly by MCOs
Transportation	37,38,39,43,56
Dental	12
Residential Treatment Center	21
Long Term Care	04,08,19
Other Services	06,07,13,16-18,24,31,33 + 03 for lab claims with a professional claim type

Mental Health Codes and Descriptions

Mercer also categorized any claims with a primary diagnosis of mental health into the corresponding mental health category. The diagnosis codes and Diagnosis Related Group (DRG) codes are identified in the tables below. For example, if an inpatient hospital claim with category '01' was identified as being primary mental health, the claim was summarized as Inpatient Hospital — Mental Health rather than Inpatient Hospital — Physical Health.

ICD-9 Diagnosis Codes	
V11	PERSONAL HISTORY OF MENTAL DISORDER
V40	MENTAL AND BEHAVIORAL PROBLEMS
V61	OTHER FAMILY CIRCUMSTANCES
V62	OTHER PSYCHOSOCIAL CIRCUMSTANCES
290-294	ORGANIC PSYCHOTIC CONDITIONS
295-299	OTHER PSYCHOSES
300-316	NEUROTIC DISORDERS, PERSONALITY DISORDERS, AND OTHER NONPSYCHOTIC MENTAL DISORDERS
317-319	MENTAL RETARDATION

DRG Codes	
424	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS
425	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION
426	DEPRESSIVE NEUROSES
427	NEUROSES EXCEPT DEPRESSIVE
428	DISORDERS OF PERSONALITY & IMPULSE CONTROL

DRG Codes	
429	ORGANIC DISTURBANCES & MENTAL RETARDATION
430	PSYCHOSES
431	CHILDHOOD MENTAL DISORDERS
432	OTHER MENTAL DISORDER DIAGNOSES
433	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA
521	ALCOHOL/DRUG ABUSE OR DEPENDENCE W CC
522	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY W/O CC

Emergency Room Logic

Mercer separated emergency room services from other outpatient hospital encounters using the following logic.

- Physician Component: HIPAA Place of Service Code "23" and Procedure Code 99281-99285
- Facility Component: Revenue Code 450-459 and Procedure Code 99281-99285

3

Adjustments Reflected in this Data Book

This Section lists the adjustments Mercer made to the encounter and financial data sources. These adjustments are reflected in the summaries shown in Sections 4 and 5.

Encounter Data

To support the rate range setting efforts, Mercer summarized the District's encounter and MCO pharmacy claims data from August 1, 2009 through July 31, 2010 (fiscal year [FY] 2010) and August 1, 2010 through July 31, 2011 (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 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 89% of the financial expenses are reflected in the encounter data for FY 2011.

A subset of encounter records were initially denied due to differing payment arrangements between the MCOs and the fee-for-service program. Mercer's encounter data team confirmed these are valid encounters ('non-repairable' denials) for covered services, which must be included in the analysis. In addition, for this rate-setting exercise, the District and Mercer incorporated 'repairable' denials that were present in the encounter data that had not yet been repaired. Mercer adjusted the status of these encounters to include in the final rate-setting analysis. This adjustment increased the FY 2010 data by 8.6% and the FY 2011 data by 3.5%.

Mercer cross-referenced the encounter data to the District's eligibility file to confirm Medicaid eligibility. Mercer excluded any encounters without a matching Medicaid eligibility segment. This reduced the FY 2010 data by 0.2% and the FY 2011 data by 0.2%.

Completion Factors

The encounter data in this Data Book includes claims for dates of service from August 1, 2009 to July 31, 2011. Mercer developed completion factors to estimate Incurred But Not Reported (IBNR) claims (those claims not yet adjudicated).

Due to dating conventions within the encounter data, Mercer relied on the financial lags as the source of the completion factors. To estimate the completion factors, Mercer estimated the

incurred claims for each time period in the financial data and compared it to the total paid claims for each period through September 2011. 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 service category separately for each MCO's data.

Completion factors were developed and applied by month of service. Due to the December 2010 effective date for the program code 775 population, the overall factors have been provided separately for that population reflecting the estimated completion factors for that more recent data period.

The following factors are applied to both dollars and utilization.

Category of Service	August 2009–July 2010	August 2010–July 2011	December 2010–July 2011 775 Population
Inpatient Hospital — PH	1.0084	1.1368	1.2068
Outpatient Hospital — PH	1.0000	1.0144	1.0238
Physician — PH	1.0002	1.0298	1.0434
Pharmacy	0.9996	0.9997	1.0007
Mental Health	1.0050	1.1284	1.1129
Other Services	1.0002	1.0298	1.0434
Total	1.0023	1.0460	1.0694

Adjustments for Other Covered Expenses

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 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, Mercer calculated a ratio of the MCO paid amount to the Medicaid proxy amount (ACS_Paid_Amount) for the paid encounters by procedure code 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%.

Net Reinsurance Costs

To the extent 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 per member per month (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 Medicaid Management Information Systems to OMNICAID. 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.

The following adjustments were applied by COS.

Category of Service	FY 2010 Underreporting Adjustment
Inpatient Hospital — PH	1.0111
Outpatient Hospital — PH	1.0362
Physician — PH	1.0341
Pharmacy	1.0000
Mental Health	1.0173
Other Services	1.0341
Overall Adjustment	1.0276

Financial Data

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 2010
- Assurance that pharmacy rebates were reasonable and deducted from the data
- Assurance that reinsurance premiums and recoveries were accurately reflected in the financial data
- Assurance that administrative services only contract payments were excluded from medical costs
- 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.

Completion Factors

Mercer reviewed the remaining liability associated with IBNR claims individually for each of the MCOs. Adjustments were applied to the expenses reflected in Report #1 for each fiscal year separately for each MCO. The overall adjustment for FY 2010 and FY 2011 using paid claims data through September 2011 is reflected by major service category in the following table. Based on the monthly completion factors, Mercer calculated specific completion factors for the program code 775 rate cells due to the December 2010 effective date of coverage.

Category of Service	August 2009–July 2010	August 2010–July 2011	December 2010–July 2011 775 Population
Inpatient Hospital — PH	1.0100	1.0812	1.1088
Outpatient Hospital — PH	0.9999	1.0122	1.0177
Physician — PH	1.0002	1.0183	1.0274
Pharmacy	0.9996	0.9996	1.0021
Mental Health	1.0037	1.0658	1.0410
Other Services	1.0003	1.0127	1.0127
Total	1.0032	1.0326	1.0407

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.

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 or 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. The major PMPM difference between Health Right data and the other MCOs was in the Outpatient Hospital — Physical Health category, which required an adjustment. Based on these comparisons, the following adjustments were applied to the financial data by service category.

Category of Service	FY 2010 Health Right Adjustment
Outpatient Hospital — Physical Health	1.085
Overall Adjustment	1.009

After applying these factors, the PMPMs from the financial data reflect the adjustment for the missing Health Right data. To put the total dollars and member months (MMs) on a comparable basis, Mercer recalculated the total units and expenses on the financial data exhibits based on the encounter MMs. The member months are then consistent between the two data sources, which allows for comparison of the total expenses between the two data sources on a comparable enrollment basis. This has no impact on the rate cell PMPMs or the utilization per 1,000 or unit cost statistics.

4

DCHFP Encounter Data

Encounter Summaries

At the top of each page, the fiscal year and rate cell are listed. Below this information is the MMs associated with each rate cell. The MMs listed on the encounter data pages are based on the MCO enrollment information for each month as represented in the District's eligibility file provided by ACS.

Note the Data Book pages are arranged by first delineating the experience for the twelve Medicaid rate cells followed by an overall Medicaid summary. Following those pages are the experience for the six program code 775 rate cells followed by a 775-specific subtotal and finally an overall DCHFP summary.

The remaining columns on each page are described below:

- **COS** — As described in Section 2, each of the covered services is listed
- **Units** — Utilization for each service line item. This represents the number of visits, days or services for each category (see chart in Section 3) as reported in the encounter data
- **Expenses**— MCO_Paid_Amount as reflected on the encounter. For subcapitated encounters, a ratio was applied to the ACS_Paid_Amount to proxy the MCO_Paid Amount. As stated previously, these amounts are based on date of service.
- **Utilization Per 1,000** — Annual utilization for each service divided by total MMs multiplied by 12,000
- **Unit Cost** — Average cost of each service line item; expenses divided by the utilization of services delivered
- **PMPM** — Expenses divided by total MMs

Rate Cell: Medicaid: Less Than 1 Male and Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	57,568					57,393				
Category of Service	Units	Expenses	Util/1,000	Unit Cost	PMPM	Units	Expenses	Util/1,000	Unit Cost	PMPM
Inpatient Hospital - Physical Health	2,960	$ 7,559,911	617	$ 2,554.38	$ 131.32	2,805	$ 6,018,512	586	$ 2,145.88	$ 104.86
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Outpatient Hospital - Physical Health (ER Excluded)	3,878	$ 2,190,544	808	$ 564.87	$ 38.05	3,125	$ 2,114,914	653	$ 676.87	$ 36.85
Outpatient Hospital - Mental Health	16	$ 17,583	3	$ 1,090.42	$ 0.31	12	$ 13,472	3	$ 1,095.95	$ 0.23
Emergency Room	8,946	$ 2,409,592	1,865	$ 269.36	$ 41.86	13,274	$ 3,381,974	2,775	$ 254.79	$ 58.93
Physician - Physical Health	32,896	$ 2,601,670	6,857	$ 79.09	$ 45.19	36,893	$ 2,824,507	7,714	$ 76.56	$ 49.21
Physician - Mental Health	170	$ 37,148	35	$ 218.40	$ 0.65	310	$ 67,255	65	$ 217.04	$ 1.17
Pharmacy	17,614	$ 726,550	3,672	$ 41.25	$ 12.62	17,145	$ 863,167	3,585	$ 50.34	$ 15.04
Transportation	3,022	$ 215,896	630	$ 71.45	$ 3.75	3,678	$ 323,650	769	$ 88.00	$ 5.64
Dental	102	$ 11,795	21	$ 115.18	$ 0.20	172	$ 16,067	36	$ 93.31	$ 0.28
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	4,594	$ 251,853	958	$ 54.83	$ 4.37	4,673	$ 291,387	977	$ 62.35	$ 5.08
Subtotal **		**$ 16,022,543**			**$ 278.32**		**$ 15,914,905**			**$ 277.30**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 1-12 Male and Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	508,697					529,258				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	3,605	$ 9,404,119	85	$ 2,608.42	$ 18.49	4,136	$ 10,254,187	94	$ 2,479.44	$ 19.37
Inpatient Hospital - Mental Health	647	$ 890,710	15	$ 1,377.19	$ 1.75	428	$ 616,530	10	$ 1,440.53	$ 1.16
Outpatient Hospital - Physical Health (ER Excluded)	17,786	$ 10,422,398	420	$ 585.99	$ 20.49	15,623	$ 10,279,553	354	$ 657.98	$ 18.42
Outpatient Hospital - Mental Health	330	$ 357,717	8	$ 1,084.15	$ 0.70	222	$ 183,345	5	$ 827.66	$ 0.35
Emergency Room	34,122	$ 9,692,557	805	$ 284.05	$ 19.05	54,567	$ 15,035,170	1,237	$ 275.54	$ 28.41
Physician - Physical Health	97,192	$ 7,427,416	2,293	$ 76.42	$ 14.60	109,992	$ 8,337,731	2,494	$ 75.80	$ 15.75
Physician - Mental Health	11,041	$ 1,457,286	260	$ 131.99	$ 2.86	17,981	$ 2,425,995	408	$ 134.92	$ 4.58
Pharmacy	127,913	$ 5,657,119	3,017	$ 44.23	$ 11.12	130,446	$ 5,890,747	2,958	$ 45.16	$ 11.13
Transportation	25,656	$ 1,002,533	605	$ 39.08	$ 1.97	26,099	$ 1,386,972	592	$ 53.14	$ 2.62
Dental	50,392	$ 9,531,386	1,189	$ 189.15	$ 18.74	61,282	$ 9,793,406	1,389	$ 159.81	$ 18.50
Residential Treatment Center	29	$ 13,600	1	$ 468.97	$ 0.03	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	36,362	$ 1,674,361	858	$ 46.05	$ 3.29	43,662	$ 2,194,576	990	$ 50.26	$ 4.15
Subtotal **		**$ 57,531,203**			**$ 113.10**		**$ 66,398,212**			**$ 125.46**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 13-18 Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	113,492					112,089				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	856	$ 1,778,383	90	$ 2,077.75	$ 15.67	845	$ 1,979,951	90	$ 2,344.41	$ 17.66
Inpatient Hospital - Mental Health	850	$ 1,329,820	90	$ 1,564.47	$ 11.72	704	$ 983,585	75	$ 1,396.41	$ 8.78
Outpatient Hospital - Physical Health (ER Excluded)	7,432	$ 3,794,341	786	$ 510.54	$ 33.43	6,733	$ 4,244,333	721	$ 630.40	$ 37.87
Outpatient Hospital - Mental Health	112	$ 37,384	12	$ 335.02	$ 0.33	76	$ 59,484	8	$ 778.38	$ 0.53
Emergency Room	7,031	$ 1,944,651	743	$ 276.59	$ 17.13	9,692	$ 2,702,068	1,038	$ 278.78	$ 24.11
Physician - Physical Health	22,756	$ 1,917,801	2,406	$ 84.27	$ 16.90	23,947	$ 2,119,395	2,564	$ 88.50	$ 18.91
Physician - Mental Health	2,491	$ 274,708	263	$ 110.26	$ 2.42	4,620	$ 436,573	495	$ 94.49	$ 3.89
Pharmacy	36,181	$ 1,453,337	3,826	$ 40.17	$ 12.81	35,363	$ 1,381,554	3,786	$ 39.07	$ 12.33
Transportation	6,188	$ 328,421	654	$ 53.08	$ 2.89	7,673	$ 446,912	821	$ 58.25	$ 3.99
Dental	12,526	$ 3,116,767	1,324	$ 248.82	$ 27.46	15,238	$ 3,339,940	1,631	$ 219.18	$ 29.80
Residential Treatment Center	66	$ 77,760	7	$ 1,174.69	$ 0.69	32	$ 14,107	3	$ 443.33	$ 0.13
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	18,134	$ 1,327,337	1,917	$ 73.20	$ 11.70	19,955	$ 1,384,012	2,136	$ 69.36	$ 12.35
Subtotal **		**$ 17,380,709**			**$ 153.14**		**$ 19,091,913**			**$ 170.33**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 13-18 Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	101,370					99,948				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	668	$ 1,990,886	79	$ 2,980.41	$ 19.64	776	$ 2,245,197	93	$ 2,893.74	$ 22.46
Inpatient Hospital - Mental Health	818	$ 1,211,602	97	$ 1,481.69	$ 11.95	726	$ 1,179,493	87	$ 1,624.44	$ 11.80
Outpatient Hospital - Physical Health (ER Excluded)	3,086	$ 2,001,383	365	$ 648.53	$ 19.74	2,852	$ 1,906,812	342	$ 668.70	$ 19.08
Outpatient Hospital - Mental Health	50	$ 24,265	6	$ 487.92	$ 0.24	53	$ 29,937	6	$ 561.31	$ 0.30
Emergency Room	4,560	$ 1,381,051	540	$ 302.86	$ 13.62	6,049	$ 1,895,221	726	$ 313.30	$ 18.96
Physician - Physical Health	11,253	$ 1,015,125	1,332	$ 90.21	$ 10.01	12,343	$ 1,191,454	1,482	$ 96.53	$ 11.92
Physician - Mental Health	2,294	$ 392,564	272	$ 171.12	$ 3.87	4,024	$ 498,276	483	$ 123.82	$ 4.99
Pharmacy	18,552	$ 1,410,118	2,196	$ 76.01	$ 13.91	19,477	$ 1,215,863	2,338	$ 62.43	$ 12.16
Transportation	3,478	$ 193,408	412	$ 55.61	$ 1.91	4,654	$ 258,758	559	$ 55.60	$ 2.59
Dental	8,630	$ 2,113,311	1,022	$ 244.89	$ 20.85	10,508	$ 2,331,924	1,262	$ 221.92	$ 23.33
Residential Treatment Center	389	$ 218,337	46	$ 564.17	$ 2.16	743	$ 372,014	89	$ 500.41	$ 3.72
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	8,168	$ 443,704	967	$ 54.32	$ 4.38	10,061	$ 538,151	1,208	$ 53.49	$ 5.38
Subtotal **		**$ 12,396,755**			**$ 122.29**		**$ 13,663,102**			**$ 136.70**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 19-36 Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	232,799					292,311				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	3,885	$ 6,136,612	200	$ 1,580.26	$ 26.37	4,032	$ 8,057,756	166	$ 1,998.31	$ 27.57
Inpatient Hospital - Mental Health	583	$ 542,040	30	$ 930.50	$ 2.33	1,248	$ 873,156	51	$ 699.56	$ 2.99
Outpatient Hospital - Physical Health (ER Excluded)	23,739	$ 14,695,020	1,224	$ 619.01	$ 63.12	26,113	$ 16,275,300	1,072	$ 623.27	$ 55.68
Outpatient Hospital - Mental Health	377	$ 110,917	19	$ 294.43	$ 0.48	458	$ 108,085	19	$ 236.14	$ 0.37
Emergency Room	26,567	$ 6,130,856	1,369	$ 230.77	$ 26.34	42,338	$ 9,414,294	1,738	$ 222.36	$ 32.21
Physician - Physical Health	64,305	$ 6,893,905	3,315	$ 107.21	$ 29.61	85,506	$ 9,696,625	3,510	$ 113.40	$ 33.17
Physician - Mental Health	3,569	$ 342,995	184	$ 96.11	$ 1.47	5,983	$ 495,212	246	$ 82.76	$ 1.69
Pharmacy	145,524	$ 6,206,667	7,501	$ 42.65	$ 26.66	186,572	$ 8,426,585	7,659	$ 45.17	$ 28.83
Transportation	14,869	$ 1,075,156	766	$ 72.31	$ 4.62	21,428	$ 1,890,478	880	$ 88.23	$ 6.47
Dental	14,572	$ 3,302,801	751	$ 226.65	$ 14.19	23,115	$ 4,324,090	949	$ 187.07	$ 14.79
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	3	$ 2,090	0	$ 679.33	$ 0.01	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	64,350	$ 6,014,866	3,317	$ 93.47	$ 25.84	81,691	$ 7,844,326	3,354	$ 96.02	$ 26.84
Subtotal **		**$ 51,455,926**			**$ 221.03**		**$ 67,405,906**			**$ 230.60**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 19-36 Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	57,513					151,022				
Category of Service	Units	Expenses	Util/1,000	Unit Cost	PMPM	Units	Expenses	Util/1,000	Unit Cost	PMPM
Inpatient Hospital - Physical Health	743	$ 1,823,219	155	$ 2,453.80	$ 31.70	2,128	$ 5,727,411	169	$ 2,691.29	$ 37.92
Inpatient Hospital - Mental Health	214	$ 207,365	45	$ 966.75	$ 3.61	685	$ 487,855	54	$ 712.37	$ 3.23
Outpatient Hospital - Physical Health (ER Excluded)	1,520	$ 1,247,410	317	$ 820.63	$ 21.69	3,393	$ 2,608,824	270	$ 768.89	$ 17.27
Outpatient Hospital - Mental Health	70	$ 23,122	15	$ 331.40	$ 0.40	310	$ 130,304	25	$ 419.68	$ 0.86
Emergency Room	3,729	$ 898,805	778	$ 241.05	$ 15.63	14,281	$ 3,440,679	1,135	$ 240.93	$ 22.78
Physician - Physical Health	5,196	$ 666,089	1,084	$ 128.18	$ 11.58	16,617	$ 2,147,579	1,320	$ 129.24	$ 14.22
Physician - Mental Health	512	$ 53,300	107	$ 104.20	$ 0.93	1,685	$ 144,689	134	$ 85.87	$ 0.96
Pharmacy	12,080	$ 951,832	2,520	$ 78.80	$ 16.55	42,576	$ 4,542,543	3,383	$ 106.69	$ 30.08
Transportation	1,007	$ 150,615	210	$ 149.52	$ 2.62	2,899	$ 572,320	230	$ 197.44	$ 3.79
Dental	2,571	$ 632,631	536	$ 246.11	$ 11.00	7,937	$ 1,622,036	631	$ 204.35	$ 10.74
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	4,102	$ 334,733	856	$ 81.61	$ 5.82	13,199	$ 1,090,450	1,049	$ 82.61	$ 7.22
Subtotal **		$ 6,989,122			$ 121.52		$ 22,514,690			$ 149.08

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 37-49 Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	94,181					127,079				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	3,624	$ 7,127,398	462	$ 1,966.77	$ 75.68	4,254	$ 8,492,947	402	$ 1,996.52	$ 66.83
Inpatient Hospital - Mental Health	272	$ 249,654	35	$ 917.21	$ 2.65	613	$ 510,773	58	$ 832.60	$ 4.02
Outpatient Hospital - Physical Health (ER Excluded)	10,350	$ 8,506,726	1,319	$ 821.92	$ 90.32	12,896	$ 10,023,733	1,218	$ 777.25	$ 78.88
Outpatient Hospital - Mental Health	256	$ 50,908	33	$ 199.15	$ 0.54	304	$ 54,288	29	$ 178.71	$ 0.43
Emergency Room	9,502	$ 2,311,469	1,211	$ 243.27	$ 24.54	16,678	$ 4,104,856	1,575	$ 246.12	$ 32.30
Physician - Physical Health	32,896	$ 4,312,650	4,191	$ 131.10	$ 45.79	52,683	$ 7,220,787	4,975	$ 137.06	$ 56.82
Physician - Mental Health	2,298	$ 205,640	293	$ 89.50	$ 2.18	4,451	$ 346,925	420	$ 77.95	$ 2.73
Pharmacy	135,653	$ 7,131,004	17,284	$ 52.57	$ 75.72	199,473	$ 10,698,646	18,836	$ 53.63	$ 84.19
Transportation	11,282	$ 501,856	1,438	$ 44.48	$ 5.33	21,425	$ 858,570	2,023	$ 40.07	$ 6.76
Dental	5,740	$ 1,347,285	731	$ 234.71	$ 14.31	10,572	$ 2,029,370	998	$ 191.96	$ 15.97
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	135	$ 139,744	17	$ 1,035.18	$ 1.48	67	$ 54,862	6	$ 819.48	$ 0.43
Other (DME, Home Health, Vision, Lab, & X-Ray)	28,250	$ 2,597,777	3,600	$ 91.96	$ 27.58	42,787	$ 3,783,382	4,040	$ 88.42	$ 29.77
Subtotal **		**$ 34,482,311**			**$ 366.13**		**$ 48,179,139**			**$ 379.13**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 37-49 Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	23,426					94,706				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	554	$ 1,283,322	284	$ 2,316.22	$ 54.78	2,912	$ 7,534,386	369	$ 2,587.76	$ 79.56
Inpatient Hospital - Mental Health	37	$ 32,858	19	$ 882.12	$ 1.40	767	$ 984,148	97	$ 1,283.69	$ 10.39
Outpatient Hospital - Physical Health (ER Excluded)	1,143	$ 1,021,110	585	$ 893.62	$ 43.59	4,243	$ 3,092,944	538	$ 728.95	$ 32.66
Outpatient Hospital - Mental Health	26	$ 12,361	13	$ 479.74	$ 0.53	202	$ 98,578	26	$ 488.82	$ 1.04
Emergency Room	1,786	$ 437,295	915	$ 244.91	$ 18.67	11,141	$ 2,806,699	1,412	$ 251.92	$ 29.64
Physician - Physical Health	4,955	$ 708,863	2,538	$ 143.06	$ 30.26	23,602	$ 3,508,581	2,991	$ 148.65	$ 37.05
Physician - Mental Health	231	$ 21,937	119	$ 94.76	$ 0.94	1,978	$ 170,627	251	$ 86.28	$ 1.80
Pharmacy	17,253	$ 830,284	8,838	$ 48.13	$ 35.44	84,888	$ 6,230,959	10,756	$ 73.40	$ 65.79
Transportation	456	$ 62,991	234	$ 138.08	$ 2.69	4,052	$ 394,862	513	$ 97.45	$ 4.17
Dental	1,223	$ 250,696	626	$ 205.06	$ 10.70	6,184	$ 1,309,654	784	$ 211.77	$ 13.83
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	48	$ 56,237	25	$ 1,162.79	$ 2.40	25	$ 23,737	3	$ 934.73	$ 0.25
Other (DME, Home Health, Vision, Lab, & X-Ray)	3,508	$ 307,644	1,797	$ 87.69	$ 13.13	15,823	$ 1,409,996	2,005	$ 89.11	$ 14.89
Subtotal **		**$ 5,025,597**			**$ 214.53**		**$ 27,565,171**			**$ 291.06**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 50+ Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	34,658					80,626				
Category of Service	Units	Expenses	Util/1,000	Unit Cost	PMPM	Units	Expenses	Util/1,000	Unit Cost	PMPM
Inpatient Hospital - Physical Health	2,256	$ 5,547,454	781	$ 2,458.94	$ 160.06	3,619	$ 9,187,070	539	$ 2,538.45	$ 113.95
Inpatient Hospital - Mental Health	99	$ 96,241	34	$ 966.49	$ 2.78	306	$ 250,538	46	$ 818.96	$ 3.11
Outpatient Hospital - Physical Health (ER Excluded)	4,999	$ 3,920,831	1,731	$ 784.34	$ 113.13	11,053	$ 8,296,688	1,645	$ 750.59	$ 102.90
Outpatient Hospital - Mental Health	88	$ 19,867	30	$ 226.51	$ 0.57	230	$ 31,848	34	$ 138.30	$ 0.40
Emergency Room	3,100	$ 813,311	1,073	$ 262.40	$ 23.47	9,553	$ 2,360,538	1,422	$ 247.09	$ 29.28
Physician - Physical Health	16,927	$ 2,346,687	5,861	$ 138.65	$ 67.72	46,520	$ 6,644,524	6,924	$ 142.83	$ 82.41
Physician - Mental Health	852	$ 72,820	295	$ 85.46	$ 2.10	2,816	$ 209,352	419	$ 74.35	$ 2.60
Pharmacy	81,646	$ 3,549,085	28,269	$ 43.47	$ 102.40	210,496	$ 8,105,101	31,329	$ 38.50	$ 100.53
Transportation	5,285	$ 196,376	1,830	$ 37.16	$ 5.67	13,545	$ 499,768	2,016	$ 36.90	$ 6.20
Dental	2,163	$ 498,065	749	$ 230.27	$ 14.37	6,797	$ 1,395,966	1,012	$ 205.39	$ 17.31
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ 18,848	-	$ -	$ 0.23
Other (DME, Home Health, Vision, Lab, & X-Ray)	12,801	$ 1,099,749	4,432	$ 85.91	$ 31.73	31,851	$ 2,754,454	4,740	$ 86.48	$ 34.16
Subtotal **		**$ 18,160,685**			**$ 524.00**		**$ 39,754,705**			**$ 493.08**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 50+ Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	24,737					83,564				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	1,037	$ 2,308,125	503	$ 2,226.40	$ 93.31	4,194	$ 10,547,558	602	$ 2,515.00	$ 126.22
Inpatient Hospital - Mental Health	63	$ 43,327	30	$ 692.20	$ 1.75	448	$ 427,975	64	$ 955.16	$ 5.12
Outpatient Hospital - Physical Health (ER Excluded)	1,878	$ 1,754,048	911	$ 934.05	$ 70.91	5,864	$ 4,802,463	842	$ 819.00	$ 57.47
Outpatient Hospital - Mental Health	55	$ 44,959	27	$ 815.44	$ 1.82	180	$ 70,488	26	$ 392.51	$ 0.84
Emergency Room	1,825	$ 510,482	885	$ 279.70	$ 20.64	9,126	$ 2,311,552	1,310	$ 253.30	$ 27.66
Physician - Physical Health	8,326	$ 1,139,920	4,039	$ 136.90	$ 46.08	34,817	$ 5,653,927	5,000	$ 162.39	$ 67.66
Physician - Mental Health	305	$ 27,408	148	$ 89.74	$ 1.11	1,879	$ 157,864	270	$ 84.03	$ 1.89
Pharmacy	33,278	$ 1,637,724	16,143	$ 49.21	$ 66.21	132,204	$ 6,674,671	18,985	$ 50.49	$ 79.87
Transportation	1,350	$ 90,234	655	$ 66.82	$ 3.65	6,404	$ 449,967	920	$ 70.26	$ 5.38
Dental	1,415	$ 304,445	686	$ 215.16	$ 12.31	6,216	$ 1,444,607	893	$ 232.41	$ 17.29
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	37	$ 35,062	5	$ 950.82	$ 0.42
Other (DME, Home Health, Vision, Lab, & X-Ray)	5,039	$ 483,855	2,444	$ 96.02	$ 19.56	20,504	$ 1,910,429	2,944	$ 93.18	$ 22.86
Subtotal **		**$ 8,344,526**			**$ 337.33**		**$ 34,486,561**			**$ 412.70**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: Infants Month of Birth

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	3,115					3,276				
Category of Service	Units	Expenses	Util/1,000	Unit Cost	PMPM	Units	Expenses	Util/1,000	Unit Cost	PMPM
Inpatient Hospital - Physical Health	4,583	$ 5,118,421	17,654	$ 1,116.92	$ 1,643.15	4,040	$ 4,330,232	14,798	$ 1,071.85	$ 1,321.80
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Outpatient Hospital - Physical Health (ER Excluded)	134	$ 63,223	517	$ 471.19	$ 20.30	146	$ 86,782	533	$ 664.66	$ 29.54
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Emergency Room	228	$ 56,109	879	$ 245.90	$ 18.01	340	$ 90,918	1,245	$ 267.47	$ 27.75
Physician - Physical Health	5,754	$ 1,038,408	22,167	$ 180.46	$ 333.36	7,421	$ 1,318,762	27,184	$ 177.70	$ 402.55
Physician - Mental Health	5	$ 904	19	$ 180.34	$ 0.29	4	$ 484	14	$ 123.88	$ 0.15
Pharmacy	47	$ 584	181	$ 12.41	$ 0.19	30	$ 369	110	$ 12.27	$ 0.11
Transportation	14	$ 4,456	54	$ 318.19	$ 1.43	12	$ 5,326	44	$ 439.21	$ 1.63
Dental	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	572	$ 26,230	2,204	$ 45.85	$ 8.42	601	$ 23,051	2,203	$ 38.32	$ 7.04
Subtotal **		$ 6,308,334			$ 2,025.15		$ 5,865,923			$ 1,790.57

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: Mothers Month of Delivery

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	2,968					3,069				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	10,501	$ 12,937,816	42,456	$ 1,232.08	$ 4,359.10	9,905	$ 12,639,138	38,727	$ 1,276.10	$ 4,116.32
Inpatient Hospital - Mental Health	3	$ 3,100	12	$ 1,033.33	$ 1.04	8	$ 313	32	$ 37.81	$ 0.10
Outpatient Hospital - Physical Health (ER Excluded)	2,273	$ 1,047,752	9,190	$ 460.97	$ 353.02	2,248	$ 977,175	8,791	$ 434.62	$ 318.40
Outpatient Hospital - Mental Health	3	$ 765	12	$ 254.49	$ 0.26	-	$ -	-	$ -	$ -
Emergency Room	699	$ 102,562	2,828	$ 146.64	$ 34.56	712	$ 124,447	2,785	$ 174.70	$ 40.55
Physician - Physical Health	9,960	$ 4,423,940	40,268	$ 444.19	$ 1,490.55	10,215	$ 4,682,588	39,943	$ 458.38	$ 1,525.77
Physician - Mental Health	37	$ 27,652	150	$ 743.52	$ 9.32	64	$ 26,030	251	$ 406.24	$ 8.48
Pharmacy	4,482	$ 81,369	18,122	$ 18.15	$ 27.42	4,993	$ 94,748	19,523	$ 18.98	$ 30.87
Transportation	519	$ 177,797	2,099	$ 342.40	$ 59.90	577	$ 254,348	2,257	$ 440.69	$ 82.88
Dental	71	$ 15,671	287	$ 220.56	$ 5.28	81	$ 15,209	315	$ 188.77	$ 4.96
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	4,225	$ 334,494	17,084	$ 79.16	$ 112.70	4,569	$ 380,631	17,865	$ 83.31	$ 124.02
Subtotal **		**$ 19,152,918**			**$ 6,453.14**		**$ 19,194,625**			**$ 6,254.36**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid Overall

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	1,251,556					1,631,272				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	35,270	$ 63,017,665	338	$ 1,786.70	$ 50.35	43,644	$ 87,014,346	321	$ 1,993.73	$ 53.34
Inpatient Hospital - Mental Health	3,586	$ 4,606,718	34	$ 1,284.67	$ 3.68	5,934	$ 6,314,385	44	$ 1,064.13	$ 3.87
Outpatient Hospital - Physical Health (ER Excluded)	78,218	$ 50,664,787	750	$ 647.74	$ 40.48	94,288	$ 64,719,520	694	$ 686.40	$ 39.67
Outpatient Hospital - Mental Health	1,381	$ 699,848	13	$ 506.73	$ 0.56	2,047	$ 779,829	15	$ 380.94	$ 0.48
Emergency Room	102,093	$ 26,688,742	979	$ 261.42	$ 21.32	187,752	$ 47,668,416	1,381	$ 253.89	$ 29.22
Physician - Physical Health	312,418	$ 34,492,875	2,995	$ 110.41	$ 27.56	460,557	$ 55,346,461	3,388	$ 120.17	$ 33.93
Physician - Mental Health	23,606	$ 2,914,360	228	$ 122.42	$ 2.33	45,794	$ 4,979,291	337	$ 108.73	$ 3.05
Pharmacy	630,223	$ 29,635,670	6,043	$ 47.02	$ 23.68	1,063,665	$ 54,124,953	7,825	$ 50.89	$ 33.18
Transportation	73,126	$ 3,999,739	701	$ 54.70	$ 3.20	112,444	$ 7,341,930	827	$ 65.29	$ 4.50
Dental	99,404	$ 21,124,853	953	$ 212.52	$ 16.88	148,101	$ 27,622,267	1,089	$ 186.51	$ 16.93
Residential Treatment Center	484	$ 310,697	5	$ 641.97	$ 0.25	775	$ 386,121	6	$ 498.07	$ 0.24
Long Term Care	186	$ 198,072	2	$ 1,062.41	$ 0.16	129	$ 132,509	1	$ 1,025.48	$ 0.08
Other (DME, Home Health, Vision, Lab, & X-Ray)	190,106	$ 14,896,602	1,823	$ 78.36	$ 11.90	289,375	$ 23,604,844	2,129	$ 81.57	$ 14.47
Subtotal **		**$ 253,250,628**			**$ 202.35**		**$ 380,034,852**			**$ 232.97**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 19-36 Female

	Prior Year N/A					December 2010 - July 2011				
Member Months						2,736				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	52	$ 215,799	228	$ 4,148.69	$ 78.87
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	19	$ 11,282	84	$ 589.16	$ 4.12
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	157	$ 83,745	688	$ 533.60	$ 30.61
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	3	$ 457	15	$ 136.75	$ 0.17
Emergency Room	-	$ -	-	$ -	$ -	318	$ 76,745	1,396	$ 241.08	$ 28.05
Physician - Physical Health	-	$ -	-	$ -	$ -	949	$ 93,712	4,163	$ 98.74	$ 34.25
Physician - Mental Health	-	$ -	-	$ -	$ -	63	$ 5,801	275	$ 92.42	$ 2.12
Pharmacy	-	$ -	-	$ -	$ -	1,833	$ 69,735	8,040	$ 38.04	$ 25.49
Transportation	-	$ -	-	$ -	$ -	7	$ 3,510	32	$ 478.07	$ 1.28
Dental	-	$ -	-	$ -	$ -	255	$ 54,058	1,120	$ 211.74	$ 19.76
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	633	$ 63,056	2,776	$ 99.61	$ 23.05
Subtotal **		**$ -**			**$ -**		**$ 677,911**			**$ 247.77**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 19-36 Male

	Prior Year N/A					December 2010 - July 2011				
Member Months						2,447				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	47	$ 87,022	231	$ 1,846.05	$ 35.56
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	7	$ 4,675	32	$ 716.67	$ 1.91
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	65	$ 53,145	320	$ 813.74	$ 21.72
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	3	$ 1,555	17	$ 460.78	$ 0.64
Emergency Room	-	$ -	-	$ -	$ -	240	$ 67,120	1,178	$ 279.34	$ 27.43
Physician - Physical Health	-	$ -	-	$ -	$ -	465	$ 53,969	2,278	$ 116.18	$ 22.06
Physician - Mental Health	-	$ -	-	$ -	$ -	30	$ 2,658	145	$ 89.72	$ 1.09
Pharmacy	-	$ -	-	$ -	$ -	1,199	$ 235,183	5,880	$ 196.14	$ 96.11
Transportation	-	$ -	-	$ -	$ -	8	$ 3,670	41	$ 439.29	$ 1.50
Dental	-	$ -	-	$ -	$ -	168	$ 32,802	823	$ 195.55	$ 13.40
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	232	$ 22,915	1,138	$ 98.74	$ 9.36
Subtotal **		**$ -**			**$ -**		**$ 564,712**			**$ 230.78**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 37-49 Female

	Prior Year N/A					December 2010 - July 2011				
Member Months						2,700				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	56	$ 55,329	247	$ 995.24	$ 20.49
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	3	$ 872	12	$ 334.50	$ 0.32
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	303	$ 176,419	1,345	$ 582.85	$ 65.34
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	7	$ 1,196	31	$ 170.34	$ 0.44
Emergency Room	-	$ -	-	$ -	$ -	273	$ 65,597	1,211	$ 240.72	$ 24.30
Physician - Physical Health	-	$ -	-	$ -	$ -	1,229	$ 174,812	5,463	$ 142.21	$ 64.75
Physician - Mental Health	-	$ -	-	$ -	$ -	91	$ 6,822	406	$ 74.76	$ 2.53
Pharmacy	-	$ -	-	$ -	$ -	4,114	$ 264,058	18,283	$ 64.19	$ 97.80
Transportation	-	$ -	-	$ -	$ -	20	$ 8,630	89	$ 429.83	$ 3.20
Dental	-	$ -	-	$ -	$ -	222	$ 39,096	987	$ 176.05	$ 14.48
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	862	$ 82,518	3,833	$ 95.69	$ 30.56
Subtotal **		**$ -**			**$ -**		**$ 875,349**			**$ 324.20**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 37-49 Male

	Prior Year N/A					December 2010 - July 2011				
Member Months						3,264				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	202	$ 533,010	744	$ 2,632.42	$ 163.30
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	55	$ 61,372	203	$ 1,112.35	$ 18.80
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	147	$ 170,289	540	$ 1,160.39	$ 52.17
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	4	$ 3,507	13	$ 961.54	$ 1.07
Emergency Room	-	$ -	-	$ -	$ -	353	$ 85,914	1,297	$ 243.51	$ 26.32
Physician - Physical Health	-	$ -	-	$ -	$ -	1,202	$ 198,265	4,419	$ 164.93	$ 60.74
Physician - Mental Health	-	$ -	-	$ -	$ -	83	$ 6,042	305	$ 72.94	$ 1.85
Pharmacy	-	$ -	-	$ -	$ -	4,702	$ 528,803	17,286	$ 112.47	$ 162.01
Transportation	-	$ -	-	$ -	$ -	25	$ 10,570	90	$ 431.17	$ 3.24
Dental	-	$ -	-	$ -	$ -	262	$ 43,408	963	$ 165.70	$ 13.30
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	703	$ 59,601	2,583	$ 84.82	$ 18.26
Subtotal **		**$ -**			**$ -**		**$ 1,700,781**			**$ 521.07**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 50+ Female

	Prior Year N/A					December 2010 - July 2011				
Member Months						5,022				
Category of Service	Units	Expenses	Util/1,000	Unit Cost	PMPM	Units	Expenses	Util/1,000	Unit Cost	PMPM
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	224	$ 883,785	535	$ 3,948.74	$ 175.98
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	25	$ 19,042	59	$ 765.85	$ 3.79
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	853	$ 610,070	2,037	$ 715.51	$ 121.48
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	6	$ 872	15	$ 137.42	$ 0.17
Emergency Room	-	$ -	-	$ -	$ -	481	$ 126,141	1,148	$ 262.50	$ 25.12
Physician - Physical Health	-	$ -	-	$ -	$ -	3,541	$ 535,775	8,461	$ 151.30	$ 106.69
Physician - Mental Health	-	$ -	-	$ -	$ -	118	$ 7,805	283	$ 65.99	$ 1.55
Pharmacy	-	$ -	-	$ -	$ -	15,447	$ 571,133	36,911	$ 36.97	$ 113.73
Transportation	-	$ -	-	$ -	$ -	40	$ 18,477	96	$ 459.80	$ 3.68
Dental	-	$ -	-	$ -	$ -	480	$ 102,167	1,147	$ 212.86	$ 20.34
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	2,151	$ 210,145	5,140	$ 97.70	$ 41.84
Subtotal **		**$ -**			**$ -**		**$ 3,085,413**			**$ 614.38**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 50+ Male

	Prior Year N/A					December 2010 - July 2011				
Member Months						3,857				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	183	$ 742,381	570	$ 4,048.58	$ 192.48
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	38	$ 54,462	119	$ 1,425.43	$ 14.12
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	305	$ 195,137	950	$ 638.87	$ 50.59
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	7	$ 5,989	22	$ 848.55	$ 1.55
Emergency Room	-	$ -	-	$ -	$ -	282	$ 72,650	879	$ 257.23	$ 18.84
Physician - Physical Health	-	$ -	-	$ -	$ -	1,974	$ 321,880	6,143	$ 163.02	$ 83.45
Physician - Mental Health	-	$ -	-	$ -	$ -	74	$ 5,455	229	$ 74.18	$ 1.41
Pharmacy	-	$ -	-	$ -	$ -	8,426	$ 637,010	26,214	$ 75.60	$ 165.16
Transportation	-	$ -	-	$ -	$ -	37	$ 16,309	115	$ 440.16	$ 4.23
Dental	-	$ -	-	$ -	$ -	315	$ 69,985	981	$ 222.02	$ 18.14
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	9	$ 8,379	29	$ 905.78	$ 2.17
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	1,135	$ 131,475	3,530	$ 115.89	$ 34.09
Subtotal **		**$ -**			**$ -**		**$ 2,261,112**			**$ 586.24**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population Overall

	Prior Year N/A					December 2010 - July 2011				
Member Months						20,026				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	764	$ 2,517,327	458	$ 3,293.16	$ 125.70
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	147	$ 151,705	88	$ 1,035.36	$ 7.58
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	1,830	$ 1,288,806	1,096	$ 704.35	$ 64.36
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	31	$ 13,586	18	$ 440.23	$ 0.68
Emergency Room	-	$ -	-	$ -	$ -	1,947	$ 494,167	1,167	$ 253.82	$ 24.68
Physician - Physical Health	-	$ -	-	$ -	$ -	9,360	$ 1,378,413	5,609	$ 147.26	$ 68.83
Physician - Mental Health	-	$ -	-	$ -	$ -	458	$ 34,583	275	$ 75.46	$ 1.73
Pharmacy	-	$ -	-	$ -	$ -	35,720	$ 2,305,922	21,404	$ 64.55	$ 115.15
Transportation	-	$ -	-	$ -	$ -	138	$ 61,166	82	$ 444.76	$ 3.05
Dental	-	$ -	-	$ -	$ -	1,702	$ 341,515	1,020	$ 200.62	$ 17.05
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	9	$ 8,379	6	$ 905.78	$ 0.42
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	5,716	$ 569,710	3,425	$ 99.68	$ 28.45
Subtotal **		**$ -**			**$ -**		**$ 9,165,278**			**$ 457.67**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: DCHFP Overall

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	1,251,556					1,651,298				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	35,270	$ 63,017,665	338	$ 1,786.70	$ 50.35	44,408	$ 89,531,672	323	$ 2,016.09	$ 54.22
Inpatient Hospital - Mental Health	3,586	$ 4,606,718	34	$ 1,284.67	$ 3.68	6,080	$ 6,466,069	44	$ 1,063.44	$ 3.92
Outpatient Hospital - Physical Health (ER Excluded)	78,218	$ 50,664,787	750	$ 647.74	$ 40.48	96,118	$ 66,008,326	698	$ 686.74	$ 39.97
Outpatient Hospital - Mental Health	1,381	$ 699,848	13	$ 506.73	$ 0.56	2,078	$ 793,415	15	$ 381.83	$ 0.48
Emergency Room	102,093	$ 26,688,742	979	$ 261.42	$ 21.32	189,699	$ 48,162,583	1,379	$ 253.89	$ 29.17
Physician - Physical Health	312,418	$ 34,492,875	2,995	$ 110.41	$ 27.56	469,918	$ 56,724,874	3,415	$ 120.71	$ 34.35
Physician - Mental Health	23,806	$ 2,914,360	228	$ 122.42	$ 2.33	46,252	$ 5,013,874	336	$ 108.40	$ 3.04
Pharmacy	630,223	$ 29,635,670	6,043	$ 47.02	$ 23.68	1,099,385	$ 56,430,875	7,989	$ 51.33	$ 34.17
Transportation	73,126	$ 3,999,739	701	$ 54.70	$ 3.20	112,582	$ 7,403,096	818	$ 65.76	$ 4.48
Dental	99,404	$ 21,124,853	953	$ 212.52	$ 16.88	149,804	$ 27,963,782	1,089	$ 186.67	$ 16.93
Residential Treatment Center	484	$ 310,697	5	$ 641.97	$ 0.25	775	$ 386,121	6	$ 498.07	$ 0.23
Long Term Care	186	$ 198,072	2	$ 1,062.41	$ 0.16	138	$ 140,888	1	$ 1,017.48	$ 0.09
Other (DME, Home Health, Vision, Lab, & X-Ray)	190,106	$ 14,896,602	1,823	$ 78.36	$ 11.90	285,091	$ 24,174,554	2,144	$ 81.92	$ 14.64
Subtotal **		**$ 253,250,628**			**$ 202.35**		**$ 389,200,130**			**$ 235.69**

** Subtotal may not equal sum of individual category of services due to rounding

5

Financial Data

Financial Summaries

At the top of each page, the fiscal year and rate cell are listed. Below this information is the MMs associated with each rate cell. The MMs listed on the financial data pages are carried forward from the encounter data summaries for FY10 in order to capture the Health Right enrollment. For FY11, the MMs reflect the data reported by the MCOs.

Note the Data Book pages are arranged by first delineating the experience for the twelve Medicaid rate cells followed by an overall Medicaid summary. Following those pages are the experience for the six program code 775 rate cells followed by a 775-specific subtotal and finally an overall DCHFP summary.

The remaining columns on each page are described below:

- **COS** — As described in Section 2, each of the covered services is listed
- **Units** — Utilization for each service line item. This represents the number of visits, days, or services for each category (see chart in Section 3) calculated as the utilization per 1000 multiplied by the total MMs divided by 12,000
- **Expenses** — Amount paid for each service line item calculated as the total MMs from the encounter data multiplied by the PMPM. As stated previously, these amounts are based on date of service, not date of payment
- **Utilization Per 1,000** — Annual utilization for each service divided by MMs multiplied by 12,000. This is based on the data collected from Chartered and Unison adjusted for the differential for Health Right.
- **Unit Cost** — Average cost of each service line item; expenses divided by the utilization of services delivered
- **PMPM** — Expenses divided by MMs based on the data collected from Chartered and Unison adjusted for the PMPM differential for Health Right

Rate Cell: Medicaid: Less Than 1 Male and Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	57,568					56,601				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	6,361	$ 6,355,324	1,326	$ 999.07	$ 110.40	4,700	$ 6,952,305	997	$ 1,479.09	$ 122.83
Inpatient Hospital - Mental Health	17	$ 186	4	$ 11.02	$ 0.00	6	$ 212	1	$ 38.27	$ 0.00
Outpatient Hospital - Physical Health (ER Excluded)	5,094	$ 1,296,528	1,062	$ 254.53	$ 22.52	3,781	$ 1,101,612	802	$ 291.32	$ 19.46
Outpatient Hospital - Mental Health	5	$ 1,405	1	$ 292.72	$ 0.02	1	$ 68	0	$ 68.20	$ 0.00
Emergency Room	6,252	$ 2,716,295	1,303	$ 434.46	$ 47.18	6,611	$ 3,368,660	1,402	$ 509.57	$ 59.52
Physician - Physical Health	39,801	$ 2,919,857	8,296	$ 73.36	$ 50.72	33,732	$ 2,588,646	7,152	$ 76.74	$ 45.74
Physician - Mental Health	18	$ 5,438	4	$ 302.19	$ 0.09	18	$ 6,227	4	$ 345.99	$ 0.11
Pharmacy	15,923	$ 663,582	3,319	$ 41.67	$ 11.53	14,815	$ 696,467	3,141	$ 47.01	$ 12.30
Transportation	2,646	$ 130,842	552	$ 49.44	$ 2.27	2,791	$ 172,039	592	$ 61.64	$ 3.04
Dental	90	$ 7,353	19	$ 81.69	$ 0.13	104	$ 7,842	22	$ 75.69	$ 0.14
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	56,300	$ 482,982	11,736	$ 8.58	$ 8.39	43,126	$ 646,932	9,143	$ 15.00	$ 11.43
Subtotal **		**$ 14,579,793**			**$ 253.26**		**$ 15,541,009**			**$ 274.57**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 1-12 Male and Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	508,697					530,822				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	8,466	$ 13,607,361	200	$ 1,607.27	$ 26.75	8,453	$ 13,673,588	191	$ 1,617.63	$ 25.76
Inpatient Hospital - Mental Health	10,682	$ 2,340,759	252	$ 218.93	$ 4.60	11,805	$ 1,856,494	267	$ 157.26	$ 3.50
Outpatient Hospital - Physical Health (ER Excluded)	28,374	$ 7,322,823	669	$ 258.08	$ 14.40	24,801	$ 7,956,573	561	$ 320.90	$ 14.99
Outpatient Hospital - Mental Health	26	$ 6,923	1	$ 265.80	$ 0.01	17	$ 1,526	0	$ 89.80	$ 0.00
Emergency Room	31,768	$ 12,900,651	749	$ 406.10	$ 25.36	39,908	$ 17,911,385	902	$ 448.81	$ 33.74
Physician - Physical Health	154,722	$ 12,850,024	3,650	$ 83.05	$ 25.26	149,989	$ 11,978,417	3,391	$ 79.86	$ 22.57
Physician - Mental Health	1,614	$ 158,848	38	$ 98.44	$ 0.31	3,957	$ 547,561	89	$ 138.37	$ 1.03
Pharmacy	143,040	$ 5,314,612	3,374	$ 37.15	$ 10.45	151,237	$ 5,841,297	3,419	$ 38.62	$ 11.00
Transportation	31,560	$ 711,910	744	$ 22.56	$ 1.40	26,411	$ 784,100	597	$ 29.69	$ 1.48
Dental	66,808	$ 10,851,183	1,576	$ 162.42	$ 21.33	67,744	$ 10,144,660	1,531	$ 149.75	$ 19.11
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	192,525	$ 2,253,388	4,542	$ 11.70	$ 4.43	167,595	$ 3,647,910	3,789	$ 21.77	$ 6.87
Subtotal **		**$ 68,318,480**			**$ 134.30**		**$ 74,345,510**			**$ 140.06**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 13-18 Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	113,492					111,652				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	3,790	$ 3,100,038	401	$ 817.87	$ 27.32	2,565	$ 2,753,313	276	$ 1,073.39	$ 24.66
Inpatient Hospital - Mental Health	3,908	$ 2,113,620	413	$ 540.84	$ 18.62	5,066	$ 1,446,934	545	$ 285.59	$ 12.96
Outpatient Hospital - Physical Health (ER Excluded)	9,010	$ 1,980,249	953	$ 219.79	$ 17.45	7,714	$ 2,427,516	829	$ 314.69	$ 21.74
Outpatient Hospital - Mental Health	1	$ 199	0	$ 169.64	$ 0.00	10	$ 3,034	1	$ 303.47	$ 0.03
Emergency Room	6,759	$ 3,041,935	715	$ 450.05	$ 26.80	7,077	$ 4,074,561	761	$ 575.74	$ 36.49
Physician - Physical Health	39,087	$ 3,255,829	4,133	$ 83.30	$ 28.69	33,246	$ 2,900,349	3,573	$ 87.24	$ 25.98
Physician - Mental Health	488	$ 53,300	52	$ 109.20	$ 0.47	978	$ 84,803	105	$ 86.73	$ 0.76
Pharmacy	41,870	$ 1,294,045	4,427	$ 30.91	$ 11.40	42,338	$ 1,292,989	4,550	$ 30.54	$ 11.58
Transportation	7,230	$ 209,343	764	$ 28.96	$ 1.84	7,317	$ 242,589	786	$ 33.15	$ 2.17
Dental	16,793	$ 3,576,592	1,776	$ 213.10	$ 31.53	18,022	$ 3,609,695	1,937	$ 200.29	$ 32.33
Residential Treatment Center	11	$ 15,565	1	$ 1,477.50	$ 0.14	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	85,902	$ 1,059,883	9,083	$ 12.34	$ 9.34	70,731	$ 1,404,521	7,602	$ 19.86	$ 12.58
Subtotal **		**$ 19,702,597**			**$ 173.60**		**$ 20,240,305**			**$ 181.28**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 13-18 Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	101,370					99,920				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	2,016	$ 3,128,016	239	$ 1,551.88	$ 30.86	2,394	$ 3,510,972	287	$ 1,466.87	$ 35.14
Inpatient Hospital - Mental Health	3,299	$ 2,029,453	391	$ 615.14	$ 20.02	4,319	$ 2,083,710	519	$ 482.42	$ 20.85
Outpatient Hospital - Physical Health (ER Excluded)	3,899	$ 1,233,328	462	$ 316.31	$ 12.17	3,588	$ 1,462,698	431	$ 407.64	$ 14.64
Outpatient Hospital - Mental Health	11	$ 1,759	1	$ 167.22	$ 0.02	9	$ 1,583	1	$ 175.94	$ 0.02
Emergency Room	4,386	$ 1,905,688	519	$ 434.48	$ 18.80	4,398	$ 2,307,367	528	$ 524.66	$ 23.09
Physician - Physical Health	20,351	$ 1,848,529	2,409	$ 90.83	$ 18.24	17,361	$ 1,593,129	2,085	$ 91.76	$ 15.94
Physician - Mental Health	479	$ 118,849	57	$ 248.01	$ 1.17	990	$ 146,173	119	$ 147.68	$ 1.46
Pharmacy	19,276	$ 1,410,280	2,282	$ 73.16	$ 13.91	20,895	$ 1,274,811	2,509	$ 61.01	$ 12.76
Transportation	4,331	$ 136,976	513	$ 31.63	$ 1.35	4,459	$ 138,875	535	$ 31.15	$ 1.39
Dental	11,532	$ 2,418,612	1,365	$ 209.74	$ 23.86	12,261	$ 2,488,315	1,473	$ 202.94	$ 24.90
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	40,690	$ 525,465	4,817	$ 12.91	$ 5.18	35,698	$ 739,897	4,287	$ 20.73	$ 7.40
Subtotal **		**$ 14,756,954**			**$ 145.58**		**$ 15,747,531**			**$ 157.60**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 19-36 Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	232,799					292,347				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	13,619	$ 8,941,906	702	$ 656.59	$ 38.41	12,468	$ 10,625,478	512	$ 852.24	$ 36.35
Inpatient Hospital - Mental Health	5,309	$ 1,065,219	274	$ 200.64	$ 4.58	6,599	$ 1,357,283	271	$ 205.70	$ 4.64
Outpatient Hospital - Physical Health (ER Excluded)	26,777	$ 5,288,322	1,380	$ 197.50	$ 22.72	32,292	$ 7,468,782	1,326	$ 231.29	$ 25.55
Outpatient Hospital - Mental Health	15	$ 1,829	1	$ 122.87	$ 0.01	51	$ 4,239	2	$ 83.14	$ 0.01
Emergency Room	26,725	$ 10,823,073	1,378	$ 404.97	$ 46.49	33,524	$ 15,324,281	1,376	$ 457.12	$ 52.42
Physician - Physical Health	127,626	$ 12,775,355	6,579	$ 100.10	$ 54.88	132,270	$ 14,623,758	5,429	$ 110.56	$ 50.02
Physician - Mental Health	788	$ 86,233	41	$ 109.48	$ 0.37	1,414	$ 149,259	58	$ 105.58	$ 0.51
Pharmacy	163,834	$ 6,053,301	8,445	$ 36.95	$ 26.00	214,406	$ 8,440,245	8,801	$ 39.37	$ 28.87
Transportation	16,269	$ 819,737	839	$ 50.38	$ 3.52	19,352	$ 984,878	794	$ 51.41	$ 3.40
Dental	20,279	$ 3,732,588	1,045	$ 184.06	$ 16.03	26,580	$ 4,701,497	1,091	$ 176.88	$ 16.08
Residential Treatment Center	53	$ 80,712	3	$ 1,532.61	$ 0.35	-	$ -	-	$ -	$ -
Long Term Care	-	$ 8,683	-	$ -	$ 0.04	31	$ 16,021	1	$ 525.00	$ 0.05
Other (DME, Home Health, Vision, Lab, & X-Ray)	356,385	$ 3,652,921	18,370	$ 10.25	$ 15.69	385,197	$ 4,995,898	15,811	$ 12.97	$ 17.09
Subtotal **		**$ 53,329,880**			**$ 229.08**		**$ 68,701,631**			**$ 235.00**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 19-36 Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	57,513					151,320				
Category of Service	Units	Expenses	Util/1,000	Unit Cost	PMPM	Units	Expenses	Util/1,000	Unit Cost	PMPM
Inpatient Hospital - Physical Health	1,902	$ 2,562,909	397	$ 1,347.18	$ 44.56	4,904	$ 7,548,832	389	$ 1,539.47	$ 48.89
Inpatient Hospital - Mental Health	878	$ 304,871	183	$ 347.31	$ 5.30	1,812	$ 641,929	144	$ 354.35	$ 4.24
Outpatient Hospital - Physical Health (ER Excluded)	1,826	$ 636,972	381	$ 348.92	$ 11.08	5,041	$ 1,673,456	400	$ 331.94	$ 11.06
Outpatient Hospital - Mental Health	6	$ 1,080	1	$ 190.44	$ 0.02	32	$ 3,480	3	$ 108.77	$ 0.02
Emergency Room	4,040	$ 1,315,452	843	$ 325.64	$ 22.87	12,083	$ 4,532,523	958	$ 375.13	$ 29.95
Physician - Physical Health	10,824	$ 1,199,191	2,258	$ 110.79	$ 20.85	25,189	$ 2,938,961	1,998	$ 116.68	$ 19.42
Physician - Mental Health	195	$ 25,670	41	$ 131.62	$ 0.45	768	$ 83,580	61	$ 108.85	$ 0.55
Pharmacy	12,432	$ 953,130	2,594	$ 76.67	$ 16.57	43,597	$ 4,593,134	3,457	$ 105.35	$ 30.35
Transportation	1,091	$ 97,689	228	$ 89.52	$ 1.70	2,174	$ 278,741	172	$ 128.24	$ 1.84
Dental	3,501	$ 689,933	730	$ 197.09	$ 12.00	9,327	$ 1,796,687	740	$ 192.64	$ 11.87
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ 1,626	-	$ -	$ 0.03	105	$ 33,051	8	$ 315.89	$ 0.22
Other (DME, Home Health, Vision, Lab, & X-Ray)	33,241	$ 327,962	6,936	$ 9.87	$ 5.70	75,556	$ 1,141,094	5,992	$ 15.10	$ 7.54
Subtotal **		**$ 8,116,484**			**$ 141.12**		**$ 25,265,468**			**$ 166.97**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 37-49 Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	94,181					126,673				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	9,842	$ 9,452,831	1,254	$ 960.50	$ 100.37	11,649	$ 12,373,776	1,104	$ 1,062.18	$ 97.68
Inpatient Hospital - Mental Health	3,580	$ 492,205	456	$ 137.47	$ 5.23	4,489	$ 744,478	425	$ 165.84	$ 5.88
Outpatient Hospital - Physical Health (ER Excluded)	14,725	$ 5,728,305	1,876	$ 389.03	$ 60.82	20,293	$ 7,655,162	1,922	$ 377.24	$ 60.43
Outpatient Hospital - Mental Health	18	$ 2,000	2	$ 108.82	$ 0.02	35	$ 3,959	3	$ 113.14	$ 0.03
Emergency Room	9,894	$ 4,264,903	1,261	$ 431.04	$ 45.28	13,762	$ 6,528,659	1,304	$ 474.39	$ 51.54
Physician - Physical Health	62,563	$ 6,743,499	7,971	$ 107.79	$ 71.60	73,609	$ 9,227,638	6,973	$ 125.36	$ 72.85
Physician - Mental Health	574	$ 66,125	73	$ 115.14	$ 0.70	1,342	$ 131,541	127	$ 98.04	$ 1.04
Pharmacy	148,704	$ 7,114,947	18,947	$ 47.85	$ 75.55	220,927	$ 10,594,028	20,928	$ 47.95	$ 83.63
Transportation	13,283	$ 436,027	1,692	$ 32.83	$ 4.63	21,874	$ 450,041	2,072	$ 20.57	$ 3.55
Dental	8,252	$ 1,499,593	1,051	$ 181.73	$ 15.92	12,036	$ 2,196,168	1,140	$ 182.47	$ 17.34
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ 4,229	-	$ -	$ 0.04	211	$ 68,718	20	$ 325.00	$ 0.54
Other (DME, Home Health, Vision, Lab, & X-Ray)	187,729	$ 1,823,818	23,919	$ 9.72	$ 19.37	225,804	$ 2,740,798	21,391	$ 12.14	$ 21.64
Subtotal **		**$ 37,628,482**			**$ 399.53**		**$ 52,714,965**			**$ 416.15**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 37-49 Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	23,426					94,351				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	2,212	$ 2,009,996	1,133	$ 908.48	$ 85.80	6,727	$ 10,156,183	856	$ 1,509.80	$ 107.64
Inpatient Hospital - Mental Health	409	$ 61,202	209	$ 149.76	$ 2.61	1,890	$ 796,014	240	$ 421.15	$ 8.44
Outpatient Hospital - Physical Health (ER Excluded)	1,961	$ 697,510	1,005	$ 355.69	$ 29.78	7,848	$ 2,289,881	998	$ 291.78	$ 24.27
Outpatient Hospital - Mental Health	5	$ 426	2	$ 91.72	$ 0.02	61	$ 13,569	8	$ 222.49	$ 0.14
Emergency Room	1,951	$ 704,087	1,004	$ 359.09	$ 30.06	9,567	$ 3,744,942	1,217	$ 391.43	$ 39.69
Physician - Physical Health	8,103	$ 983,452	4,151	$ 121.36	$ 41.98	31,126	$ 4,005,276	3,959	$ 128.68	$ 42.45
Physician - Mental Health	209	$ 20,039	107	$ 95.77	$ 0.86	1,101	$ 124,888	140	$ 113.45	$ 1.32
Pharmacy	17,863	$ 859,192	9,150	$ 48.10	$ 36.68	86,686	$ 6,407,873	11,025	$ 73.92	$ 67.92
Transportation	608	$ 54,165	312	$ 89.06	$ 2.31	3,771	$ 190,619	480	$ 50.54	$ 2.02
Dental	1,837	$ 288,072	941	$ 156.78	$ 12.30	7,231	$ 1,393,091	920	$ 192.64	$ 14.76
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	154	$ 48,854	20	$ 317.91	$ 0.52
Other (DME, Home Health, Vision, Lab, & X-Ray)	34,117	$ 294,408	17,476	$ 8.63	$ 12.57	94,343	$ 1,263,951	11,999	$ 13.40	$ 13.40
Subtotal **		**$ 5,972,550**			**$ 254.95**		**$ 30,435,141**			**$ 322.57**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 50+ Female

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	34,658					80,630				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	5,602	$ 6,481,429	1,939	$ 1,157.08	$ 187.01	9,568	$ 13,211,755	1,424	$ 1,380.85	$ 163.86
Inpatient Hospital - Mental Health	1,314	$ 206,758	455	$ 157.34	$ 5.97	2,669	$ 400,017	397	$ 149.89	$ 4.96
Outpatient Hospital - Physical Health (ER Excluded)	7,918	$ 2,988,272	2,742	$ 377.39	$ 86.22	18,123	$ 6,885,648	2,697	$ 379.94	$ 85.40
Outpatient Hospital - Mental Health	2	$ 489	1	$ 212.94	$ 0.01	26	$ 2,603	4	$ 100.14	$ 0.03
Emergency Room	3,052	$ 1,300,521	1,057	$ 426.08	$ 37.52	7,560	$ 3,533,849	1,125	$ 467.46	$ 43.83
Physician - Physical Health	28,840	$ 3,313,917	9,985	$ 114.91	$ 95.62	60,082	$ 8,054,649	8,942	$ 134.06	$ 99.90
Physician - Mental Health	274	$ 30,620	95	$ 111.64	$ 0.88	928	$ 85,332	138	$ 91.97	$ 1.06
Pharmacy	88,331	$ 3,504,918	30,584	$ 39.68	$ 101.13	226,865	$ 8,132,951	33,764	$ 35.85	$ 100.87
Transportation	6,563	$ 185,068	2,273	$ 28.20	$ 5.34	14,696	$ 260,445	2,187	$ 17.72	$ 3.23
Dental	3,139	$ 550,257	1,087	$ 175.31	$ 15.88	7,830	$ 1,519,067	1,165	$ 194.01	$ 18.84
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ 651	-	$ -	$ 0.02	166	$ 65,148	25	$ 393.26	$ 0.81
Other (DME, Home Health, Vision, Lab, & X-Ray)	93,467	$ 879,533	32,362	$ 9.41	$ 25.38	180,310	$ 2,224,364	26,835	$ 12.34	$ 27.59
Subtotal **		**$ 19,442,432**			**$ 560.98**		**$ 44,375,830**			**$ 550.37**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: 50+ Male

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	24,737					83,832				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	2,956	$ 2,807,823	1,434	$ 949.85	$ 113.51	9,994	$ 14,294,939	1,431	$ 1,430.41	$ 170.52
Inpatient Hospital - Mental Health	447	$ 60,406	217	$ 135.27	$ 2.44	1,526	$ 363,627	218	$ 238.34	$ 4.34
Outpatient Hospital - Physical Health (ER Excluded)	2,946	$ 1,113,455	1,429	$ 377.97	$ 45.01	10,564	$ 4,016,084	1,512	$ 380.18	$ 47.91
Outpatient Hospital - Mental Health	17	$ 1,790	8	$ 105.13	$ 0.07	60	$ 18,330	9	$ 305.55	$ 0.22
Emergency Room	2,030	$ 702,877	985	$ 346.30	$ 28.41	7,794	$ 3,122,048	1,116	$ 400.57	$ 37.24
Physician - Physical Health	12,961	$ 1,553,524	6,288	$ 120.72	$ 63.21	42,978	$ 6,304,922	6,152	$ 146.70	$ 75.21
Physician - Mental Health	139	$ 20,118	67	$ 145.21	$ 0.81	1,091	$ 123,093	156	$ 112.85	$ 1.47
Pharmacy	33,931	$ 1,729,440	16,460	$ 50.97	$ 69.91	133,298	$ 7,088,844	19,081	$ 53.18	$ 84.56
Transportation	1,637	$ 91,863	794	$ 56.13	$ 3.71	6,290	$ 223,830	900	$ 35.59	$ 2.67
Dental	2,093	$ 345,518	1,016	$ 165.05	$ 13.97	7,283	$ 1,575,119	1,043	$ 216.27	$ 18.79
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ 18,942	-	$ -	$ 0.77	300	$ 100,543	43	$ 335.45	$ 1.20
Other (DME, Home Health, Vision, Lab, & X-Ray)	44,619	$ 418,692	21,645	$ 9.36	$ 16.93	119,458	$ 1,902,408	17,100	$ 15.93	$ 22.69
Subtotal **		**$ 8,874,448**			**$ 358.75**		**$ 39,133,786**			**$ 466.61**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: Infants Month of Birth

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	3,115					3,427				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	13,520	$ 10,265,294	52,085	$ 759.25	$ 3,295.44	14,774	$ 10,410,584	51,732	$ 704.66	$ 3,037.81
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	1	$ -	4	$ -	$ -
Outpatient Hospital - Physical Health (ER Excluded)	487	$ 103,761	1,875	$ 213.14	$ 33.31	432	$ 90,899	1,513	$ 210.32	$ 26.52
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Emergency Room	360	$ 132,558	1,387	$ 368.12	$ 42.55	387	$ 180,466	1,354	$ 466.71	$ 52.66
Physician - Physical Health	4,827	$ 358,382	18,594	$ 74.25	$ 115.05	4,480	$ 440,356	15,686	$ 98.30	$ 128.50
Physician - Mental Health	5	$ 1,554	18	$ 341.97	$ 0.50	-	$ -	-	$ -	$ -
Pharmacy	834	$ 19,036	3,212	$ 22.63	$ 6.11	1,384	$ 24,387	4,847	$ 17.62	$ 7.12
Transportation	177	$ 9,793	683	$ 55.24	$ 3.14	174	$ 9,905	610	$ 56.85	$ 2.89
Dental	2	$ 182	9	$ 80.00	$ 0.06	-	$ -	-	$ -	$ -
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	4,577	$ 78,473	17,631	$ 17.15	$ 25.19	3,495	$ 103,740	12,239	$ 29.68	$ 30.27
Subtotal **		**$ 10,969,033**			**$ 3,521.36**		**$ 11,260,336**			**$ 3,285.77**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid: Mothers Month of Delivery

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	2,968					3,393				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	13,104	$ 16,652,180	52,981	$ 1,270.78	$ 5,610.57	14,460	$ 21,068,953	51,141	$ 1,457.04	$ 6,209.54
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	2	$ 4,626	7	$ 2,313.51	$ 1.36
Outpatient Hospital - Physical Health (ER Excluded)	7,227	$ 2,624,543	29,218	$ 363.17	$ 884.28	7,832	$ 2,863,384	27,699	$ 365.60	$ 843.91
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Emergency Room	1,904	$ 1,046,583	7,697	$ 549.79	$ 352.62	2,162	$ 1,602,429	7,647	$ 741.11	$ 472.28
Physician - Physical Health	11,084	$ 1,675,113	44,813	$ 151.13	$ 564.39	11,139	$ 2,359,062	39,394	$ 211.79	$ 695.27
Physician - Mental Health	4	$ 2,306	17	$ 548.74	$ 0.78	12	$ 1,312	42	$ 109.40	$ 0.39
Pharmacy	621	$ 141	2,510	$ 0.23	$ 0.05	1,288	$ 1,056	4,554	$ 0.82	$ 0.31
Transportation	274	$ 17,015	1,109	$ 62.03	$ 5.73	218	$ 3,631	772	$ 16.64	$ 1.07
Dental	12	$ 2,788	47	$ 241.18	$ 0.94	22	$ 5,584	79	$ 251.27	$ 1.65
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	2,414	$ 331,766	9,761	$ 137.43	$ 111.78	2,198	$ 486,950	7,775	$ 221.51	$ 143.52
Subtotal **		**$ 22,352,435**			**$ 7,531.14**		**$ 28,396,989**			**$ 8,369.29**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: Medicaid Overall

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	1,251,556					1,631,574				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	83,390	$ 85,365,106	800	$ 1,023.68	$ 68.21	102,655	$ 126,580,677	755	$ 1,233.07	$ 77.58
Inpatient Hospital - Mental Health	29,852	$ 8,674,680	286	$ 290.59	$ 6.93	40,184	$ 9,695,324	296	$ 241.28	$ 5.94
Outpatient Hospital - Physical Health (ER Excluded)	110,242	$ 31,014,068	1,057	$ 281.33	$ 24.78	142,310	$ 45,893,706	1,047	$ 322.49	$ 28.13
Outpatient Hospital - Mental Health	105	$ 17,898	1	$ 170.02	$ 0.01	302	$ 52,392	2	$ 173.52	$ 0.03
Emergency Room	99,131	$ 40,854,623	950	$ 412.13	$ 32.64	144,833	$ 66,231,169	1,065	$ 457.29	$ 40.59
Physician - Physical Health	520,778	$ 49,486,672	4,993	$ 95.02	$ 39.54	615,201	$ 67,015,164	4,525	$ 108.93	$ 41.07
Physician - Mental Health	4,787	$ 589,099	46	$ 123.07	$ 0.47	12,598	$ 1,483,769	93	$ 117.78	$ 0.91
Pharmacy	686,658	$ 28,916,624	6,584	$ 42.11	$ 23.10	1,157,736	$ 54,388,081	8,515	$ 46.98	$ 33.33
Transportation	85,671	$ 2,900,429	821	$ 33.86	$ 2.32	109,528	$ 3,749,693	806	$ 34.24	$ 2.30
Dental	134,338	$ 23,964,670	1,288	$ 178.39	$ 19.15	168,441	$ 29,437,727	1,239	$ 174.77	$ 18.04
Residential Treatment Center	63	$ 96,277	1	$ 1,523.42	$ 0.08	-	$ -	-	$ -	$ -
Long Term Care	-	$ 34,130	-	$ -	$ 0.03	966	$ 332,336	7	$ 344.16	$ 0.20
Other (DME, Home Health, Vision, Lab, & X-Ray)	1,131,966	$ 12,129,292	10,853	$ 10.72	$ 9.69	1,403,512	$ 21,298,463	10,323	$ 15.18	$ 13.05
Subtotal **		**$ 284,043,569**			**$ 226.95**		**$ 426,158,501**			**$ 261.19**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 19-36 Female

	Prior Year N/A					December 2010 - July 2011				
Member Months						3,083				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	165	$ 197,757	642	$ 1,199.59	$ 64.14
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	48	$ 3,075	185	$ 64.72	$ 1.00
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	349	$ 57,633	1,359	$ 165.06	$ 18.69
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Emergency Room	-	$ -	-	$ -	$ -	401	$ 144,537	1,561	$ 360.36	$ 46.88
Physician - Physical Health	-	$ -	-	$ -	$ -	1,630	$ 144,217	6,344	$ 88.48	$ 46.76
Physician - Mental Health	-	$ -	-	$ -	$ -	34	$ 3,362	132	$ 98.87	$ 1.09
Pharmacy	-	$ -	-	$ -	$ -	2,452	$ 79,680	9,544	$ 32.50	$ 25.84
Transportation	-	$ -	-	$ -	$ -	-	$ 5,024	-	$ -	$ 1.63
Dental	-	$ -	-	$ -	$ -	366	$ 68,133	1,425	$ 186.16	$ 22.10
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	436	$ 40,269	1,697	$ 92.36	$ 13.06
Subtotal **		**$ -**			**$ -**		**$ 743,687**			**$ 241.22**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 19-36 Male

	Prior Year N/A					December 2010 - July 2011				
Member Months						2,912				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	73	$ 87,152	302	$ 1,190.72	$ 29.93
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	36	$ 9,175	150	$ 251.75	$ 3.15
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	134	$ 45,502	554	$ 338.59	$ 15.63
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	2	$ 184	8	$ 91.95	$ 0.06
Emergency Room	-	$ -	-	$ -	$ -	292	$ 110,012	1,204	$ 376.57	$ 37.78
Physician - Physical Health	-	$ -	-	$ -	$ -	872	$ 79,818	3,593	$ 91.54	$ 27.41
Physician - Mental Health	-	$ -	-	$ -	$ -	23	$ 3,470	95	$ 150.88	$ 1.19
Pharmacy	-	$ -	-	$ -	$ -	1,620	$ 324,583	6,675	$ 200.39	$ 111.46
Transportation	-	$ -	-	$ -	$ -	-	$ 1,263	-	$ -	$ 0.43
Dental	-	$ -	-	$ -	$ -	257	$ 45,226	1,058	$ 176.13	$ 15.53
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	221	$ 9,296	911	$ 42.07	$ 3.19
Subtotal **		**$ -**			**$ -**		**$ 715,681**			**$ 245.77**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 37-49 Female

	Prior Year N/A					December 2010 - July 2011				
Member Months						3,292				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	272	$ 273,884	993	$ 1,005.08	$ 83.20
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	95	$ 6,441	346	$ 67.79	$ 1.96
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	645	$ 258,937	2,352	$ 401.29	$ 78.66
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	4	$ 517	15	$ 129.30	$ 0.16
Emergency Room	-	$ -	-	$ -	$ -	367	$ 153,759	1,339	$ 418.44	$ 46.71
Physician - Physical Health	-	$ -	-	$ -	$ -	2,449	$ 278,379	8,928	$ 113.66	$ 84.56
Physician - Mental Health	-	$ -	-	$ -	$ -	76	$ 6,973	277	$ 91.75	$ 2.12
Pharmacy	-	$ -	-	$ -	$ -	6,525	$ 334,563	23,785	$ 51.27	$ 101.63
Transportation	-	$ -	-	$ -	$ -	8	$ 5,933	30	$ 730.93	$ 1.80
Dental	-	$ -	-	$ -	$ -	351	$ 59,366	1,280	$ 169.01	$ 18.03
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	632	$ 55,019	2,304	$ 87.04	$ 16.71
Subtotal **		**$ -**			**$ -**		**$ 1,433,770**			**$ 435.53**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 37-49 Male

	Prior Year N/A					December 2010 - July 2011				
Member Months						3,674				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	314	$ 499,403	1,026	$ 1,589.51	$ 135.93
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	120	$ 65,371	393	$ 543.08	$ 17.79
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	345	$ 176,582	1,127	$ 511.69	$ 48.06
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	1	$ 43	3	$ 43.07	$ 0.01
Emergency Room	-	$ -	-	$ -	$ -	397	$ 142,518	1,297	$ 358.97	$ 38.79
Physician - Physical Health	-	$ -	-	$ -	$ -	1,936	$ 204,161	6,324	$ 105.44	$ 55.57
Physician - Mental Health	-	$ -	-	$ -	$ -	49	$ 4,144	160	$ 84.58	$ 1.13
Pharmacy	-	$ -	-	$ -	$ -	5,659	$ 625,429	18,483	$ 110.52	$ 170.23
Transportation	-	$ -	-	$ -	$ -	4	$ 2,327	13	$ 573.42	$ 0.63
Dental	-	$ -	-	$ -	$ -	406	$ 69,940	1,327	$ 172.18	$ 19.04
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	12	$ 2,482	41	$ 200.00	$ 0.68
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	539	$ 43,501	1,762	$ 80.65	$ 11.84
Subtotal **		**$ -**			**$ -**		**$ 1,835,902**			**$ 499.70**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 50+ Female

	Prior Year N/A					December 2010 - July 2011				
Member Months						5,818				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	555	$ 1,393,821	1,145	$ 2,511.32	$ 239.57
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	94	$ 16,241	194	$ 172.35	$ 2.79
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	1,705	$ 674,603	3,516	$ 395.68	$ 115.95
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	1	$ 1,150	2	$ 1,150.00	$ 0.20
Emergency Room	-	$ -	-	$ -	$ -	576	$ 257,232	1,188	$ 446.48	$ 44.21
Physician - Physical Health	-	$ -	-	$ -	$ -	6,362	$ 704,516	13,121	$ 110.74	$ 121.09
Physician - Mental Health	-	$ -	-	$ -	$ -	56	$ 5,947	116	$ 106.19	$ 1.02
Pharmacy	-	$ -	-	$ -	$ -	21,649	$ 882,956	44,651	$ 40.79	$ 151.76
Transportation	-	$ -	-	$ -	$ -	9	$ 8,632	19	$ 945.35	$ 1.48
Dental	-	$ -	-	$ -	$ -	732	$ 130,751	1,510	$ 178.58	$ 22.47
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	1,517	$ 212,315	3,129	$ 139.95	$ 36.49
Subtotal **		**$ -**			**$ -**		**$ 4,288,164**			**$ 737.04**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population: 50+ Male

	Prior Year N/A					December 2010 - July 2011				
Member Months	0					4,447				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	553	$ 1,163,414	1,493	$ 2,102.81	$ 261.61
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	104	$ 16,424	281	$ 157.96	$ 3.69
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	702	$ 312,320	1,895	$ 444.68	$ 70.23
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	5	$ 430	13	$ 86.05	$ 0.10
Emergency Room	-	$ -	-	$ -	$ -	378	$ 150,441	1,019	$ 398.34	$ 33.83
Physician - Physical Health	-	$ -	-	$ -	$ -	3,135	$ 373,277	8,459	$ 119.08	$ 83.94
Physician - Mental Health	-	$ -	-	$ -	$ -	32	$ 3,074	86	$ 96.06	$ 0.69
Pharmacy	-	$ -	-	$ -	$ -	10,982	$ 797,774	29,635	$ 72.64	$ 179.39
Transportation	-	$ -	-	$ -	$ -	7	$ 5,090	19	$ 716.66	$ 1.14
Dental	-	$ -	-	$ -	$ -	496	$ 88,383	1,339	$ 178.13	$ 19.87
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	986	$ 132,265	2,661	$ 134.13	$ 29.74
Subtotal **		**$ -**			**$ -**		**$ 3,042,892**			**$ 684.25**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: 775 Population Overall

	Prior Year N/A					December 2010 - July 2011				
Member Months						23,226				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	-	$ -	-	$ -	$ -	1,933	$ 3,615,431	999	$ 1,870.36	$ 155.66
Inpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	498	$ 116,727	257	$ 234.60	$ 5.03
Outpatient Hospital - Physical Health (ER Excluded)	-	$ -	-	$ -	$ -	3,881	$ 1,525,578	2,005	$ 393.07	$ 65.68
Outpatient Hospital - Mental Health	-	$ -	-	$ -	$ -	13	$ 2,324	7	$ 178.80	$ 0.10
Emergency Room	-	$ -	-	$ -	$ -	2,412	$ 958,499	1,246	$ 397.47	$ 41.27
Physician - Physical Health	-	$ -	-	$ -	$ -	16,384	$ 1,784,368	8,465	$ 108.91	$ 76.83
Physician - Mental Health	-	$ -	-	$ -	$ -	270	$ 26,969	139	$ 99.89	$ 1.16
Pharmacy	-	$ -	-	$ -	$ -	48,887	$ 3,044,985	25,258	$ 62.29	$ 131.10
Transportation	-	$ -	-	$ -	$ -	28	$ 28,269	15	$ 995.11	$ 1.22
Dental	-	$ -	-	$ -	$ -	2,609	$ 461,798	1,348	$ 177.03	$ 19.88
Residential Treatment Center	-	$ -	-	$ -	$ -	-	$ -	-	$ -	$ -
Long Term Care	-	$ -	-	$ -	$ -	12	$ 2,482	6	$ 200.00	$ 0.11
Other (DME, Home Health, Vision, Lab, & X-Ray)	-	$ -	-	$ -	$ -	4,332	$ 492,666	2,238	$ 113.74	$ 21.21
Subtotal **		**$ -**			**$ -**		**$ 12,060,097**			**$ 519.25**

** Subtotal may not equal sum of individual category of services due to rounding

Rate Cell: DCHFP Overall

	August 2009 - July 2010					August 2010 - July 2011				
Member Months	1,251,556					1,654,800				
Category of Service	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**	**Units**	**Expenses**	**Util/1,000**	**Unit Cost**	**PMPM**
Inpatient Hospital - Physical Health	83,390	$ 85,365,106	800	$ 1,023.68	$ 68.21	104,588	$ 130,196,108	756	$ 1,244.85	$ 78.68
Inpatient Hospital - Mental Health	29,852	$ 8,674,680	286	$ 290.59	$ 6.93	40,681	$ 9,812,051	295	$ 241.19	$ 5.93
Outpatient Hospital - Physical Health (ER Excluded)	110,242	$ 31,014,068	1,057	$ 281.33	$ 24.78	146,191	$ 47,419,284	1,060	$ 324.37	$ 28.66
Outpatient Hospital - Mental Health	105	$ 17,898	1	$ 170.02	$ 0.01	315	$ 54,716	2	$ 173.73	$ 0.03
Emergency Room	99,131	$ 40,854,623	950	$ 412.13	$ 32.64	147,244	$ 67,189,668	1,068	$ 456.32	$ 40.60
Physician - Physical Health	520,778	$ 49,486,672	4,993	$ 95.02	$ 39.54	631,585	$ 68,799,532	4,580	$ 108.93	$ 41.58
Physician - Mental Health	4,787	$ 589,099	46	$ 123.07	$ 0.47	12,868	$ 1,510,738	93	$ 117.41	$ 0.91
Pharmacy	686,658	$ 28,916,624	6,584	$ 42.11	$ 23.10	1,206,623	$ 57,433,066	8,750	$ 47.60	$ 34.71
Transportation	85,671	$ 2,900,429	821	$ 33.86	$ 2.32	109,556	$ 3,777,962	794	$ 34.48	$ 2.28
Dental	134,338	$ 23,964,670	1,288	$ 178.39	$ 19.15	171,049	$ 29,899,525	1,240	$ 174.80	$ 16.07
Residential Treatment Center	63	$ 96,277	1	$ 1,523.42	$ 0.08	-	$ -	-	$ -	$ -
Long Term Care	-	$ 34,130	-	$ -	$ 0.03	978	$ 334,818	7	$ 342.33	$ 0.20
Other (DME, Home Health, Vision, Lab, & X-Ray)	1,131,966	$ 12,129,292	10,853	$ 10.72	$ 9.69	1,407,843	$ 21,791,129	10,209	$ 15.48	$ 13.17
Subtotal **		**$ 284,043,569**			**$ 226.95**		**$ 438,218,598**			**$ 264.82**

** Subtotal may not equal sum of individual category of services due to rounding

6

Adjustments that will be made to Calculate the Capitation Rate Ranges

This Section describes the adjustments that Mercer will make to calculate the capitation rates. Mercer makes adjustments to the base data to match the experience of an actuarially equivalent population. These adjustments are required by the Centers for Medicare and Medicaid Services (CMS) in determining rates for Medicaid managed care programs. Mercer will certify to CMS that the final rates are actuarially sound.

These adjustments have **not** been reflected in the Data Book pages:

- Anomalies may exist in the data; therefore, all of the historical data are considered when setting the rates. Mercer will blend the data placing the most reliance on the most recent full year of data.
- Mercer will project costs and utilization as part of the rate development. The trends used to project these costs will be based on historical managed care data across different years and services in the DCHFP program. In addition to the managed care data, Mercer will review national CPI indices, and similar trend information from surrounding states.
- Cost and utilization will be trended to the midpoint of the initial contract year.
- In addition to making the above adjustments, Mercer will adjust for programmatic changes:
  - Those that occurred during the base years (August 2009 through July 2011) and are not fully reflected in the data
  - Those that occurred after the base data time periods
  - Known programmatic changes included in the rate development are listed below
    - Reduction of Medicaid Physician fee schedule to 80% of Medicare
    - Reduction to the dental fee schedules
    - Impact of the Affordable Care Act related to prescription rebate collections and primary care physician reimbursement
- An administrative assumption to account for MCOs administrative expenses will be applied in the capitation rate development process. This will include consideration for the premium tax and a load for profit/contingency margin.