SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

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

Petitioner,

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No. 2012-8227
Judge Melvin R. Wright
Next Event: Status Hearing
August 21, 2013 at 9:30 a.m.

D.C. HEALTHCARE SYSTEMS, INC.'S MEMORANDUM IN OPPOSITION TO MOTION TO APPROVE SETTLEMENT AGREEMENT

DCHSI opposes the motion of the Commissioner of the District of Columbia Department of Insurance, Securities and Banking ("DISB"), as Rehabilitator of D.C. Chartered Health Plan, Inc. ("Chartered"), to approve a settlement agreement he negotiated on behalf of Chartered with his colleagues at the District of Columbia Department of Health Care Finance ("DHCF") and the Attorney General's office. The District has wrongfully withheld over $50 million, in addition to the proposed $48 million settlement payment, that it was contractually obligated to pay to Chartered based on actuarially sound rates applied to Chartered's member population. The District thereby caused the very capital depletion that permitted it to compel Chartered's rehabilitation. The proposed settlement agreement was negotiated among, and signed only by, representatives of the District. The resulting collusive agreement should be rejected for two independent reasons.

First, the Rehabilitator has not presented a factual basis for this Court to make the required informed and independent evaluation of the reasonableness of the proposed settlement. The proposed agreement would broadly release asserted and unasserted contract claims against the District, even though (1) the extent of the District's contractual liability depends on the extent of Chartered's liabilities to providers, as explained below and in the accompanying declaration of

Drew A. Joyce ("Joyce Dec."), and (2) Chartered's final liability to providers is unknowable at this time. The bar date for the assertion of provider claims is August 31, over one month *after* the proposed agreement was signed and ten days *after* the Rehabilitator wants this Court to approve the agreement. At this point, substantial provider claims remain unresolved, including a disputed claim by Medstar for approximately $30 million. By operation of the DHCF Contract, until Chartered's liabilities to providers are known, the extent of the District's liability to Chartered cannot be known.

The Rehabilitator also has not identified the additional, unasserted debts the District owes to Chartered that would be released under the proposed agreement. To permit a fair evaluation of the proposal, the Rehabilitator would need to disclose what claims are being released, their value, and whether there are any potential valid defenses. The Rehabilitator has proffered no such information. Accordingly, it is a mystery why the Rehabilitator has endorsed a proposed settlement agreement that would put Chartered's providers, other creditors and the residuary interest holder (DCHSI, Chartered's sole shareholder) at unnecessary risk of loss.

Second, even without further information, some provisions of the proposed agreement on their face are unreasonable and contrary to Chartered's best interests. For example, the proposed agreement provides that the bulk of the discounted payment would bypass Chartered's estate altogether and potentially be made to an unnamed third party of the District's choosing. There is no valid justification for allowing Chartered's asset to bypass Chartered's estate, but in any event, the Rehabilitator further abdicated his duties by failing at least to require that such third party recipient be creditworthy or that the District guarantee payment in the event of misconduct by the third party. Further, the third party presumably would be compensated for its services from the settlement proceeds, further bleeding Chartered's resources.

As another example, the District and its past and present employees and officers would benefit from a broad release of claims, yet the Rehabilitator has provided no analysis of what rights Chartered is surrendering and their value. Further, while giving a broad release, the Rehabilitator obtained from the District (i.e., itself) only a limited covenant not to sue Chartered

(which does not extend to Chartered's former employees and officers). These provisions are not in the best interests of Chartered and its creditors; to the contrary, they appear to serve only the District's political and financial purposes, and are red flags of collusion.

This Court should require an especially searching and independent review in the extraordinary circumstances present here, where the District negotiated its debt to Chartered, and the scope of its own release, *with itself*. The District has every incentive to pay as little to Chartered as it can get away with. The Rehabilitator, an agent of the District, plainly has capitulated to the District's interests. If the Rehabilitator were vigorously pursuing Chartered's interests, he would demand that the District pay its debt in full. As explained below and in the Joyce Declaration, there is no reason to provide a discount on the District's objective and easily calculated debt. The District's full satisfaction of its financial obligations would allow Chartered to pay its creditors in full, and there likely would be surplus capital available for distribution to DCHSI.[1]

DCHSI respectfully submits that the proposed settlement agreement should be rejected outright. Alternatively, the decision concerning the proposed settlement should be deferred until after the provider claims are resolved and DCHSI has time to obtain discovery and approximately 60 days to analyze the data to calculate the District's full debt to Chartered.

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[1] In the meantime, the Rehabilitator is wasting Chartered's money by pursuing expensive litigation against DCHSI and its owner, Jeffrey Thompson, in a case pending before Judge Mott. If the District pays its bills in full, the effect of the Rehabilitator's litigation would be to recover money (if any) from the defendants, only to repay that money to DCHSI as the return of Chartered's surplus capital to its shareholder. Of course, the Rehabilitator and his professionals would be paid handsomely to produce this meaningless result. For that reason, the defendants have filed a motion to stay the litigation before Judge Mott. Although that suit presents issues that are separate and distinct from the rehabilitation proceeding, at this point, to preserve Chartered's rapidly dwindling assets, this Court would be well within its supervisory powers to preclude the rehabilitator from spending further estate funds in pursuit of collateral litigation until Chartered's other accounts are resolved. Only then will it be known whether any further pursuit of funds from the residuary beneficiary would be a totally useless exercise (as any recovery would inure only to the direct benefit of the residuary itself – less the costs bled out by the estate professionals in pursuing the useless action).

I. FACTS

A. The DCHF Contract

From 1987 through April 2013, Chartered provided managed health care services to needy District residents under the Medicaid and Alliance programs as an incumbent to the DHCF Contract. Under the DHCF Contract, the District was required to pay Chartered at rates that were actuarially sound. *See* DCHC-2007-R-5050 Solicitation, Contract and Award ("DHCF Contract") at Section B.3.[2] Services provided under the Medicaid portion of the contract are paid 70% by the federal government (the Center for Medicaid and Medicare Services, or CMS) and 30% by the District, and the District pays for 100% of the Alliance services. *See* Rehabilitator's Memorandum in Support of Approval of Proposed Settlement Agreement ("Rehabilitator Mem.") at 3.

Chartered built a network of healthcare providers to service the Medicaid and Alliance populations. The DHCF Contract required the District to pay Chartered actuarially sound rates applied across the member population. The rates must account for a number of factors relating to Chartered's prior medical loss experience and member population, and then are adjusted to pay for Chartered's administrative expenses (9.5% of the sum derived by applying the actuarial rates), the District premium tax (2%), and a profit margin (2%), for a total surcharge of 13.5%. *See* Joyce Dec. ¶ 15.

Under the DCHF Contract, there are at least two circumstances where the District can become obligated to pay additional compensation beyond the original contract sum. First, notwithstanding the requirement that an actuary (here, Mercer) certify the rates as sound (DHCF Contract at Section L.3.2.2.3), if the rates prove to have been unsound, then Chartered is entitled to recover from the District the amount it would have been paid had the rates been actuarially sound (i.e., the full sound rates plus the 13.5% surcharge, as well as interest). Joyce Dec. ¶ 20; Rehabilitator Retrospective Claim at 11. Second, even if the rates are sound when set, if the

[2] The DHCF contract is available in its entirety at http://app.ocp.dc.gov/RUI/information/scf/solicitation_detail.asp?solicitation=DCHC-2007-R-5050.

District subsequently changes the contract requirements so as to "cause an increase or decrease in the cost of performance ..., *an equitable adjustment shall be made*." DHCF Contract § B.3.1 (emphasis added). Chartered has experienced both circumstances; yet the proposed settlement fails adequately to account for them.

B. The District Unilaterally Added Costly Services to the DCHF Contract and Chartered Asserted an Initial Claim Pre-Rehabilitation

In 2010, the District unilaterally transferred approximately 23,000 people (the "774/775 Populations") from the District's Alliance program to Chartered's Medicaid program as part of the District's early implementation of the federal Affordable Care Act.[3] Prior to that time, the 774/775 Populations received pharmacy benefits without Chartered's involvement. Based on the transfer of the 774/775 Populations, Chartered became responsible to provide pharmacy benefits to 23,000 people, a significant cost increase, particularly given the prevalence of HIV/AIDs and other chronic illnesses among that population. *See* Rehabilitator Retrospective Claim at 5. The District, however, resisted Chartered's demands that its reimbursement rates be adjusted, retrospectively and prospectively, as required by the DHCF Contract. That problem was compounded by the fact that, as the Director of DHCF subsequently admitted, "[DHCF] leadership directed Mercer to set the MCO rates for the Alliance *below* the lowest level considered actuarially sound." (original emphasis). Wayne Turnage, Letter to Mayor Vincent Gray, April 4, 2011 (Ex. 4). As such, prior to the transfer the Alliance rates had been set below actuarially sound levels as a purposeful strategy by the District to balance its budget on the back of Chartered and others. After the transfer, the District ultimately adjusted its Medicaid rates, but did so only prospectively and even then in an amount that even the Rehabilitator has stated was inadequate. *See* Rehabilitator Retrospective Claim at 11 ("Whether the rates certified and set were actuarially sound for the Medicaid population, which included the 774 and 775

[3] The 774 population consisted of childless adults who had incomes at or below 133% of the federal poverty level. The 775 population consisted of childless adults who had incomes between 133% and 200% of the federal poverty level. *See* Rector Report (Ex. 2 hereto) at 2.

populations *after* the District made a change in the Contract regarding populations covered, is certainly doubtful and debatable") (original emphasis). As a result of the District's deliberate underpayments, Chartered's capital reserves, predictably, were depleted.

On November 30, 2011, Chartered filed a claim with the District to recover $25.8 million for pharmacy-related losses incurred due to the 774/775 Population transfer ("Pharmacy Claim"). That claim proceeded substantially through the administrative process. Chartered won a motion in December 2012 compelling DHCF Director Turnage to testify, and with non-expert discovery set to close on April 12, 2013, Chartered was building substantial leverage over DHCF. *See* DCHSI Memorandum in Support of Motion to Compel Rehabilitator to Pursue Chartered Claim (April 2, 2013) at 2. The Rehabilitator, although acknowledging that depositions were important to Chartered's claim, took no depositions and, as explained below, ultimately withdrew the claim. *See* Consent Motion to Stay All Proceedings (March 18, 2012) at 1.

C. DISB Determined that the District Owed Chartered for the Increased Pharmacy Costs and More

As of June 30, 2012, Chartered booked the Pharmacy Claim as a premium receivable based on its conclusion that the DCHF Contract was retrospectively rated, meaning that Chartered was entitled to recover retrospective premiums if DHCF changed the contract requirements so as to increase Chartered's costs. Thereafter, DISB hired an outside insurance regulatory consulting firm, Rector & Associates, Inc. ("Rector"), to conduct a Limited Scope Financial Examination to determine the appropriateness of Chartered's accounting for that premium receivable.

On November 27, 2012, DISB Commissioner White entered an administrative Order officially adopting and entering as a final administrative decision Rector's November 8, 2012 Report on Limited Scope Financial Examination of Chartered. Ex. 2 hereto (Order and attached Report). In the report, Rector concluded that Section B.3.1 of the contract "require[s] that if the Contract is changed to add, delete or change services covered by DC Chartered, the *DHCF must*

review the effect of the change and equitably adjust the capitation rate," *id.* at 6 (emphasis added), and as such, the DHCF Contract is retrospectively rated. Chartered thus was entitled to "receive premium adjustments based on [its] loss experience relating to the Contract," and the adjustment "should take into account its *entire* loss experience to determine its final policy premium, not just the loss experience resulting from the transfer of the 774 and 775 populations from the Alliance Program to the [Medicaid] Program." *Id.* at 4 (original emphasis), 9. In short, the transfer of members from Alliance to Medicaid was a "change [that] created a liability for DHCF and an asset (premium receivable) for DC Chartered." *Id.* at 7.

In addition to a retrospective premium payment, Rector also concluded that the District was required to adjust Chartered's capitation rates prospectively to account for Chartered's loss experience following the transfer of the 774/775 Populations. The DHCF Contract requires "that any changes to the capitation rate be actuarially sound," defined in accordance with federal standards. *Id.* at 8 (rates must be set in accordance with generally accepted actuarial principles and practices, be appropriate given the populations to be covered and services to be provided, and be certified by a qualified actuary). If DHCF failed "to perform the required annual review," or its review "failed to establish actuarially sound rates," then any "deficiency in the capitated rates would be a liability for the DHCF and an asset (premium receivable) for DC Chartered." *Id.* at 8-9.

The DISB Commissioner adopted the Rector report and made it an official administrative ruling. As such, there is no dispute that the DHCF Contract is retrospectively rated, and that the transfer of the 774/775 Populations from Alliance to Medicaid constituted a change triggering the right to retrospective compensation accounting for Chartered's "entire loss experience" and to an actuarially sound rate adjustment prospectively. By its terms, the DISB Commissioner's Order adopting the Report is final and appealable; there was no appeal. The District, however, has never paid the retrospective premium adjustment, and its prospective rate adjustment was inadequate.

D. The Rehabilitator's Claims for Some of the District's Debts

On January 4, 2013, the Rehabilitator filed a claim seeking $2.2 million for dental benefits that DHCF had required Chartered to provide from January 2011 through November 2012, but for which the District, again, had not paid ("Dental Crown Claim").

On February 21, 2013, the Rehabilitator filed two further claims. The first included the Pharmacy Claim and additional losses stemming from District's failure to pay retrospective premiums due on account of the transfer of the 774/775 Population ("Retrospective Claim"), totaling $51,287,369, plus interest, covering the period from August 1, 2010 through April 30, 2012. The Rehabilitator could have supplemented the procedurally-advanced Pharmacy Claim or filed only the additional aspects as a new claim. Instead, he filed the entire Retrospective Claim as a new claim and walked away from the Pharmacy Claim, resetting the procedural clock on $26 million in claims.

The second February 21 claim stems from the District's failure to establish actuarially sound capitation rates for services Chartered provided under the Alliance program from July 2010 through July 2011 ("Alliance Claim"). The Rehabilitator determined that the District owes Chartered $9,086,929 for the Alliance Claim.

The Rehabilitator has not disclosed his methodology for calculating the Medicaid Retrospective Premium. Without disclosure of certain information DCHSI has sought in discovery, there is no way to confirm whether these claims are appropriately calculated (putting aside that the proposed settlement would, inappropriately, dramatically discount them). *See* Joyce Dec. ¶ 30.

E. Unasserted Claims Against the District Have Not Been Valued

After DCHSI was able to review the Rehabilitator's claims, DCHSI noted that they did not begin to capture the entirety of the District's underpayments to Chartered. By letter dated April 11, 2013, DCHSI brought to the Rehabilitator's attention a number of additional respects in which the District had underpaid Chartered. *See* Exhibit 3 hereto (including the full chain of

correspondence). The proposed settlement agreement recites (at Recital K) that "Chartered has been investigating and believes that it could file additional claims against DHCF, including claims for what Chartered believes may be actuarially unsound rates during the last year of Chartered's contract with DHCF (May 2012 – April 2013)." The Rehabilitator has not articulated the District's additional debts or estimated their value.[4]

DCHSI's expert, based on the available information, has been able to identify a variety of respects in which (subject to review of the relevant documentation) the District has underpaid Chartered in addition to the asserted claims. *See generally* Joyce Dec. ¶¶ 44. For example, Mr. Joyce points out that the Medicaid Retrospective Claim is under-inclusive; the Dental Claim fails to assert the required 13.5% surcharge; the Alliance Claim is too limited in time; the discounts given are unwarranted because there is no credible defense to payment; and most importantly, the Rehabilitator has not asserted any retrospective rating claim for the final year of Chartered's contract, which, depending on how unresolved provider claims ultimately are resolved, could result in a very large debt owed from the District to Chartered. In total, in addition to the $48 million settlement amount, Mr. Joyce concludes that *the District may owe Chartered more than an additional $50 million.*

F. The Proposed Settlement Agreement

On July 22, 2013, the Rehabilitator and other representatives of the District executive branch signed the proposed settlement agreement among themselves. The agreement would release all of Chartered's claims, asserted and unasserted, arising from the Medicaid and Alliance programs ("Released Claims"). The Released Claims constitute "Chartered's most significant asset." Rehabilitator Mem. at 2. The Rehabilitator's proposed settlement would

[4] The Rehabilitator states that the proposed "settlement consideration [$48 million] constitutes roughly 60% of Chartered's outside estimate of its actual damages, and approximately 80% of Chartered's estimated damages for its pending claims." Rehabilitator Mem. at 7. The Rehabilitator's math is erroneous, because he fails to include interest due and because, as stated, he has not valued the unasserted claims. Further, as stated, there is no basis for any discount because the District has no legitimate defense to payment.

heavily discount the pending claims, and would recover little to no value for the other unasserted debts the District has refused to pay in violation of its contractual obligations.

The proposed settlement would release the District and "its current and former officers, officials, and employees, of any and all claims ... that Chartered has asserted *or could have asserted* … relating to both the Medicaid and Alliance programs under any theory of liability." Proposed Settlement at 8-9 (emphasis added). In contrast to this broad release, the District would provide Chartered only with a limited covenant not to sue Chartered (a covenant that does not extend to Chartered's "current and former officers, officials, and employees") based on "any legal or equitable theory that seeks recovery or indemnification from Chartered of amounts paid to providers pursuant to [the proposed settlement]." *Id.* at 9.

The proposed agreement would resolve all Released Claims for $48 million, to be distributed in two parts. First, $18 million (Part I) would be paid to Chartered upon Court approval and approval by CMS (the Rehabilitator has not disclosed the likelihood or expected timing of CMS's approval). This $18 million would be distributed "in accordance with the Plan of Reorganization to providers with undisputed Class 3 claims allowed by the Rehabilitator." *Id.* at 5. Second, the remaining $30 million (Part II) would bypass Chartered altogether, and instead would be paid either (1) directly to Chartered's providers with undisputed, allowed Class 3 claims or (2) if the Fiscal Year 2013 District Litigation Fund otherwise first would lapse, to an unnamed third-party selected by the District, which would hold the funds and pay them to providers, presumably charging an undisclosed fee out of the Part II settlement fund.[5] *Id.*

By funding the bulk of the proposed (inadequate) settlement payment from the set-aside litigation fund, the District avoids the need for D.C. Council approval. *See* D.C. Code § 47-355.02 ("D.C. Anti-Deficiency Act" prohibiting District agencies from making unauthorized expenditures). If Council approval were required, the DHCF or the mayor would have to explain

[5] The Rehabilitator suggests that the Court should rush to accept the proposed settlement because the FY2013 litigation fund might lapse. The District, however, could resolve a portion of Chartered's long-pending claims from the 2013 fund and then, if it chose, seek to satisfy some or all of its remaining obligations from the FY2014 litigation fund or other funds.

that Chartered provided services and was entitled to payment, but that the District had intentionally underpaid Chartered for years and thereby drove it into rehabilitation. That is a message that would be entirely inconsistent with the mayor's political messaging. Robert McCartney, *Why Give A Contract to a 'Rotten Businessman'?*, Washington Post, Mar. 3, 2013, at C5 (quoting Mayor Gray spokesman Pedro Ribeiro as stating "Maybe [Jeffrey Thompson] was just an awful, rotten businessman, and I think that's pretty well established now....He ran Chartered into the ground.").

G. The Rehabilitator's Efforts to Obtain Approval Without Scrutiny and DCHSI's Effort to Obtain Discovery and Ensure a Reasoned Evaluation

The Rehabilitator seeks expedited approval of the settlement agreement. DCHSI has objected and asked to take focused discovery. To that end, on August 8, 2013, DCHSI served written discovery requests on the Rehabilitator. (Ex. 5 hereto) Mr. Joyce's declaration (Ex. 1 at, e.g., ¶¶ 18-20) explains that significant aspects of the proposed settlement cannot be evaluated without certain information that is (or when completed will be) readily available to Chartered and the District, and that once he has that data, he will be able to analyze it and calculate the District's actual debt to Chartered in roughly 60 days.

II. ARGUMENT

A. <u>The Settlement Agreement Should be Rejected Because It Can Not Be Adequately Evaluated</u>

Courts are given discretion in approving settlement agreements, but this discretion must be exercised conscientiously. Prior to approving a settlement agreement, a court must make an "informed and independent judgment as to whether a proposed compromise is fair and equitable." *Protective Comm. for Indep. Stockholders of TMT Trailer Ferry Inc. v. Anderson*, 390 U.S. 414, 424 (1968). Key to making an informed judgment is ensuring that there is a sufficient factual basis underpinning the court's evaluation of a proposed settlement. As the Supreme Court has stated, "[t]here can be no informed and independent judgment as to whether a proposed compromise is fair and equitable until the ... judge has apprised himself of all facts

necessary for an intelligent and objective opinion of the probabilities of ultimate success should the claim be litigated"). *Id. at 424; see also In re: American Reserve Corp.*, 841 F.2d 159, 162 (7th Cir. 1987) (bankruptcy case; "[the judge] may not simply accept the trustee's word that the settlement is reasonable, nor may he merely 'rubber-stamp' the trustee's proposal," but instead the judge "must apprise himself of all facts necessary to evaluate the settlement and make an 'informed and independent judgment' about the settlement" (citations omitted)).

Where there is an insufficient factual record for a reviewing court to make an informed and independent judgment about a proposed settlement agreement, the proposed agreement should not be approved. *See TMT Trailer Ferry*, 390 U.S. at 434 (holding it was "error to affirm" proposed settlement agreement where factual basis underlying trial court's approval was deficient); *American Reserve Corp.*, 841 F.2d at 163 (reversing and remanding lower court approval of settlement agreement because approving court lacked evidence sufficient to make an independent judgment). Here, the Rehabilitator and the District control the information, but have provided no factual basis to permit the Court to make an "informed and independent judgment."

First, significant information required to evaluate the proposed settlement does not yet exist. The proposed settlement would broadly release Chartered's asserted and unasserted claims against the District arising from the Medicaid and Alliance programs. The full value of that release cannot be known until after the Bar Date has passed and the filed provider claims have been evaluated and resolved. That is, the District's final debt to Chartered cannot be determined until Chartered's obligations to providers are determined, and those will not be known at least until (1) the August 31, 2013 bar date has passed, (2) all claims are evaluated and reduced to exclude such common billing problems as double billings, use of wrong billing codes, and the like, and (3) disputed claims are resolved. *E.g.*, Joyce Dec. ¶¶ 18, 20, 30.

At that point, however, the full extent of the retrospective rating adjustments to which Chartered is contractually entitled will be objectively calculable as a matter of straightforward arithmetic. *See id.* at 20, 28. Rather than wait for this information, the Rehabilitator asks this

Court to approve the settlement of an unknown amount of claims for well less than even the known amount of the District's debt, an unreasonable result from a collusive negotiation.

Second, there is no information to justify any discount, let alone a substantial discount, from the known amount of the District's debt (even without accounting for the Rehabilitator's failure to recover the District's other debts to Chartered). Citing only the proposed agreement itself, the Rehabilitator asserts that "a probable recovery, when viewed through the lens of the risks and costs of protracted litigation, plainly brings this Settlement Agreement squarely within the range of which is fair, reasonable and adequate." Rehabilitator Mem. at 11; *see also id.* ("as evidenced by the Agreement itself, both parties recognize substantial risks of proceeding with the litigation, and substantial costs, in terms of both time and money, in doing so"). Reciting the truism that litigation requires time and money does not provide a basis for independently evaluating the proposed settlement. As the Supreme Court has made clear, "[l]itigation and delay are always the alternative to settlement, and whether that alternative is worth pursuing depends upon a reasoned judgment as to the probable outcome of that litigation." *TMT Trailer Ferry*, 390 U.S. at 434. Moreover, the Rehabilitator has not identified a single defense to payment, and none is apparent. *See* Joyce Dec. at ¶¶ 25-26 (discussing the District's administrative order holding that the DHCF Contract is retrospectively rated).

Third, the Rehabilitator concedes that the claims he has asserted are not comprehensive of the District's debts to Chartered. *See* Rehabilitator Mem. at 6–7; Proposed Agreement Recital K. Yet, the Rehabilitator has provided no information to assess the nature or value of the unasserted claims. Indeed, he again merely asserts that these other potential claims were "considered" and that Chartered was "investigating" them. Rehabilitator Mem. at 3-4. For its part, DCHSI has estimated that the District owes Chartered at least $50 million beyond the proposed $48 million settlement payment as a matter of objective math. *See* Joyce Dec. ¶ 44. DCHSI lacks all the information necessary to make a final calculation, but all that information is (or, once it exists, will be) in the possession of Chartered or the District. There is no justification for underpaying providers simply because the Rehabilitator has determined not to pursue

recovery of *all* of the District's indebtedness. The Rehabilitator's mere statement that these other underpayments were "considered" and "factor" into the proposed consideration is an entirely inadequate basis on which to ask this Court to approve an agreement that would put providers (and DCHSI) at risk and terminate Chartered's valuable rights to payment. The Rehabilitator abdicated his duties to Chartered in signing the proposed agreement.

B. The Settlement Agreement is Not Fair, Adequate and Reasonable

Despite the lack of critical information necessary to support a meaningful, independent and informed review of the terms of the settlement agreement – some of which the Rehabilitator has chosen not to disclose and some of which does not yet exist – several provisions in the proposed agreement, on their face, are unreasonable and contrary to Chartered's best interests. In the class action and bankruptcy contexts, courts have required a showing that a settlement is "fair, adequate and reasonable." *Meijer, Inc. v. Warner Chilcott Holdings Co. III, Ltd.*, 565 F. Supp.2d 49, 54 (D.D.C. 2008); *Cotton v. Hinton*, 559 F.2d 1326, 1330 (5th Cir. 1977) ("In determining whether to approve a proposed settlement, the cardinal rule is that the District Court must find that the settlement is fair, adequate and reasonable and is not the product of collusion between the parties."); *In re Copperfield Invs., LLC*, 401 B.R. 87, 91 (E.D.N.Y. 2009). To meet this standard, the proposed settlement must be both substantively and procedurally fair. *See D'Amato v. Deutsche Bank*, 236 F.3d 78, 85 (2nd Cir. 2001). The proposed settlement agreement is neither.

1. The Proposed Agreement Lacks Substantive Fairness

In evaluating whether a proposed settlement is substantively fair, courts in the class action and bankruptcy contexts generally look to the following factors:

- The likelihood of success compared to the present and future benefits offered by the settlement;
- The prospect of complex and protracted litigation if the settlement is not approved; and
- The terms of the settlement in relation to the strength of the plaintiff's case.

See Copperfield Invs., 401 B.R. at 92; *In re Vitamins Antitrust Litig.* 305 F. Supp. 2d 100, 104 (D.D.C. 2004); *Thomas v. Albright*, 139 F.3d 227, 231 (D.C. Cir. 1998). Additionally, in the analogous bankruptcy context, a proposed settlement must be determined to be in the best interests of the estate. *See, e.g., In re Doctor's Hosp. of Hyde Park, Inc.*, 474 F.3d 421, 426 (7th Cir. 2007). Applying these factors, the proposed settlement agreement is not substantively fair.

Chartered has a significant likelihood of success on the merits of its claims against the District if litigated. There simply could be no credible defense to Chartered's retrospective rating claims given the District's prior determination that the DHCF Contract is retrospectively rated and the right to retrospective payment was triggered. *See* Joyce Dec. ¶¶ 25-26; DISB Order and Rector Report (Ex. 2 hereto) at 4. Whether the Retrospective Claim was calculated properly should be confirmed with the as-yet undisclosed proper documentation. Whatever the final value of the current approximately $64 million claim (including interest), that sum excludes tens of millions of dollars in other underpayments that can only be calculated with certainty with additional information, some of which the Rehabilitator and the District possess, some of which does not yet exist. Yet, the Rehabilitator effectively achieved *no* value in the proposed settlement.

When weighed against the strength of Chartered's claims against the District, the benefits offered by the settlement are difficult to ascertain. It is unclear, and the Rehabilitator has provided no insight into, why settling claims with a *minimum admitted value* of $64 million for $48 million is more advantageous *for Chartered* than pursuing litigation, given the lack of defenses to the claimed amount. Of course, when the valuable additional claims that have not yet been pursued are included, pursing litigation plainly is in Chartered's best interests. In any event, the administrative process for claims determination of which the District complains is a process of the District's own creation and is required by the DHCF Contract. The Rehabilitator cannot justify an unreasonably discounted settlement on the ground that the delay occasioned by pursuing the contract's dispute resolution provisions would be unreasonable, particularly when

he opted to withdraw the advanced Pharmacy Claim that could have produced a near-term benefit to Chartered.

As to delay, and the Rehabilitator's contention that litigation would be "measured in years, not months" (Rehabilitator Mem. at 7), the District could mitigate this problem of its own orchestration by making a good faith down payment on its debt to fund an initial, partial payment to providers. In any event, a concern about some delay, by itself, cannot justify an unreasonable settlement that is not in the best interests of Chartered, the providers, other creditors and DCHSI.

In addition to failing to recover payments due, the proposed agreement also contains several provisions that are unnecessarily harmful to Chartered. For example, the two-part payment scheme has most of Chartered's settlement compensation bypass Chartered altogether, and has the potential to reduce the settlement consideration through unnecessary transaction costs due to the involvement of an unnamed third party. *See* Proposed Settlement at 5. Moreover, the proposed agreement provides no guarantee that the money paid to the third party is safe or guaranteed.

As another example, Chartered would be responsible to pay interest to providers out of its own funds, but the Rehabilitator failed to secure the interest – indeed, all the principal – the District owes Chartered. *See id.* at 6. The Rehabilitator has proffered no justification for this injurious and one-sided provision, which flies in the face of the underlying precept of the DHCF Contract that Chartered is to be paid the provider costs plus 13.5%, not a portion of the provider costs. This is particularly egregious since it was the District's failure to pay, not any conduct of Chartered, that gave rise to the provider's interest claims.

Finally, the proposed agreement provides non-parallel releases and covenants giving the District (and its past and present employees and officers) far broader protection than Chartered (and its past and present employees and officers). Chartered would release the District from asserted claims *and* "any and all claims, demands suits and causes of action that Chartered ... could have asserted against the District ... related to both the Medicaid and Alliance programs." Proposed Settlement at 8-9. In contrast to Chartered's broad release of the District, the District

would provide only a covenant not to sue Chartered limited to "any legal or equitable theory that seeks recovery or indemnification from Chartered of amounts paid to providers by the District under [the proposed settlement]." *Id.* at 9. The agreement arguably would leave Chartered exposed to future suits from the District stemming from Chartered's services and involvement in the Medicaid and Alliance programs, but would forever release Chartered's ability to collect amounts the District owes, even if the Rehabilitator has not pursued collection of those amounts. This is not in Chartered's best interests, but again serves the District's purposes, which is hardly surprising given that the District negotiated the agreement with itself.

2. The Proposed Agreement Also Lacks Procedural Fairness

In determining whether a proposed settlement agreement is procedurally fair, a court "must pay close attention to the negotiating process, to ensure that the settlement resulted from arm's-length negotiations" and was not collusive. *D'Amato*, 236 F.3d at 85; *Thomas v. Albright*, 139 F.3d 227, 231-33(D.C. Cir. 1998). Factors that courts evaluate to "ascertain that the settlement was reached as a result of good-faith bargaining at arm's length" include the posture of the case at the time settlement is proposed and the circumstances surrounding the negotiations. *See In re Montgomery Cnty. Real Estate Antitrust Litig.*, 83 F.R.D. 305, 315 (D. Md. 1979). Despite the Rehabilitator's strenuous assertions otherwise, the proposed settlement agreement was not the product of arm's-length negotiations.

A review of the agreement's signature pages makes the point potently: all signatories are members of the executive branch of the District of Columbia government, all reporting to the mayor. Thus, the District reached this agreement with itself. Moreover, it did so at an early stage of the proceedings, and the District avoided having to produce DHCF Director Turnage for deposition even though Chartered previously had won a motion to compel his deposition. With these undisputed facts, this Court cannot accept the Rehabilitator's effort to explain away the "red flags" surrounding the settlement with the mere assertion that the negotiations were "hard-fought." Rehabilitator Mem. at 9-11. It is hardly surprising that the result of this negotiation

process was a proposed agreement that wholly serves the purposes of the District of Columbia, but greatly disserves Chartered, the providers, other creditors, and DCHSI.

III. Conclusion

The motion to approve the proposed settlement agreement should be rejected outright because (1) there is an insufficient factual basis for this Court to make an independent and informed evaluation of the agreement and (2) the proposed agreement is not fair, reasonable and adequate. Alternatively, decision concerning the proposed settlement should be deferred until after the provider claims are resolved, DCHSI obtains discovery concerning the resolved claims and other necessary information, and DCHSI has approximately 60 days to analyze the discovery to calculate the District's full debt to Chartered.

Dated: August 9, 2013

Respectfully submitted,

_____/s/_____

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CERTIFICATE OF SERVICE

I hereby certify that on this 9th day of August, 2013, a copy of the foregoing was filed and served by email upon:

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_____/s/_____
Jennifer 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 2
Judge Melvin R. Wright

v.

DC CHARTERED HEALTH PLAN, INC.,

Respondent.

ORDER DENYING REHABILITATOR'S MOTION FOR APPROVAL OF THE SETTLEMENT AGREEMENT BETWEEN D.C. CHARTERED HEALTH PLAN, INC. AND THE DISTRICT OF COLUMBIA

Before this Court is the Rehabilitator's Consent Motion for Expedited Hearing to Set a Briefing Schedule and for Order Approving the Settlement Agreement Between D.C. Chartered Health Plan, Inc. and the District of Columbia, and Party-in-Interest D.C. Healthcare Systems, Inc.'s ("DCHSI") Opposition thereto. The Court having considered the arguments of the parties hereby orders that:

1. Because there is an insufficient factual basis for this Court to make an independent and informed evaluation of the proposed settlement agreement, and the proposed agreement is not fair, reasonable and adequate, the Rehabilitator's Motion for Order Approving the Settlement Agreement Between D.C. Chartered Health Plan, Inc. and the District of Columbia is DENIED.

SO ORDERED.

_____
Judge Melvin R. Wright

Entered on: _____

Copies to be Served:

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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

DECLARATION OF DREW A. JOYCE IN SUPPORT OF D.C. HEALTHCARE SYSTEMS, INC.'S OPPOSITION TO PROPOSED SETTLEMENT

The undersigned, Drew Joyce, provide this declaration in this matter, and states as follows:

1. My name is Drew Joyce and the facts set forth below are true based on my personal knowledge and the facts I have been provided.

2. As explained in detail below, I have examined the proposed settlement agreement between the District of Columbia insurance commissioner (Rehabilitator), on behalf of D.C. Chartered Health Plan (Chartered), and the District of Columbia concerning the District's debt to Chartered under Chartered's contract with the D.C. Department of Health Care Finance (DHCF, and DHCF Contract). In my opinion based on my decades of experience with HMO operations, finance, contracts and insurance contracts generally, and my evaluation of Chartered's business, the DHCF Contract and the facts available to me, the proposed agreement is unreasonable for a number of reasons, but most importantly because it would pay Chartered dramatically less than the objectively determinable amount to which Chartered is entitled under the DHCF Contract. The settlement for $48 million does not account for Chartered's contractual right to recover an even greater amount, over $50 million, in additional underpayments, some portion of which already has been asserted by the Rehabilitator and unreasonably compromised, and the majority of which the Rehabilitator apparently has not claimed.

3. BACKGROUND AND EXPERIENCE

4. I am and since June 2012 have been a Managing Director of HMO Affiliates, Inc., which is a national special projects healthcare consulting firm intensively focused on Managed Care Organizations. I have 30 years of experience with Health Insurance, HMOs, Medicaid, and rating structures including retrospectively rated contracts. My resume is attached hereto as Exhibit A. I graduated from Wake Forest University in 1974 with a degree in Biology, and obtained my MBA from the University of North Carolina, Chapel Hill in 1982. Since 1982, I have worked in the health insurance industry in a series of positions including CEO, CFO, COO and National CFO of one of the largest HMOs. I have a broad understanding of the health insurance industry.

5. I have held officer level insurance and HMO positions over the last 20 years with responsibility for operations, underwriting, rating, contracting and financial reporting.

6. I have served as Chief Executive Officer (CEO), Chief Financial Officer (CFO), and Chief Operating Officer COO of Medicaid contracting Health plans.

7. I most recently served as the National CFO for the Medicaid line of business for a major multistate MCO.

DISCUSSION AND OPINIONS

8. In the course of preparing this report and opinion, I have reviewed and relied on the documents attached hereto as Exhibit B.

9. I rely on the facts stated herein based on my review of the above documents, the support of my staff and, where noted, facts provided by counsel.

10. Chartered operated as a District of Columbia HMO until April 30, 2013. Chartered is in Rehabilitation under the supervision and control of the Department of Insurance, Securities and Banking (the Rehabilitator). The entire business of Chartered consisted only of contracts with the District of Columbia Department of Healthcare Finance (DHCF) by which, in return for insurance premiums paid to Chartered, Chartered arranged for and managed the provision of healthcare services to low-income residents of the District of Columbia under both the Medicaid program and the Alliance program. This report addresses issues arising under the DHCF Contract with Chartered that was in effect from May 1, 2008 to April 30, 2013.

11. The Rehabilitator proposes to settle all amounts due to Chartered from DHCF for the sum of $48 Million, which the Rehabilitator argues is 80% of the total of claims asserted to date and 60% of all possible claims.

12. The proposed settlement requires Chartered to release DHCF from any further liability for amounts owed to Chartered.

13. I am advised that providers have until August 31, 2013 to assert payment claims against Chartered in relation to services provided under the DHCF Contract. I further am advised that some provider claims are in dispute, including that Medstar is in arbitration with Chartered over Medstar's claim for approximately $30 million it contends are due for services provided in relation to the DHCF Contract.

14. The Rehabilitator is effectively shutting down and liquidating Chartered's operations and accounts. Chartered is no longer operating as an HMO and it is not providing services under a contract with DHCF. In this circumstance and under the facts here, what Chartered is owed, for the most part, can be objectively determined as a matter of math. Chartered was entitled to be paid by the District under the DHCF contract at predetermined actuarially sound rates. [DHCF Contract L.3.2.2.3]

15. Actuarially sound rates are rates that an actuary (here, Mercer) would certify as adequate to pay for services rendered in a given year based on guidance in 42 CFR and standard actuarial practice. To be sound, under the applicable DHCF contract, the rates must be designed to pay Chartered 100% of what Chartered is expected to pay providers plus approximately 13.5% - 9.5% to cover Chartered's administrative costs, 2% to fund a premium tax, and 2% for profit (or what is sometimes referred to as cost of capital), as described in Mercer's rate setting reports.

16. Under the DHCF Contract (and under Medicaid regulations), Chartered was entitled to have its reimbursement rates adjusted prospectively every 12 months. If its medical loss experience in a given year was worse than anticipated that experience would be included in rate setting for the following year. Indeed, Mercer was obligated to certify that the rates were sound for both the Alliance and Medicaid programs. [DHCF Contract B.3.3]

17. In addition, if the District imposed additional or changed conditions on Chartered that increased Chartered's costs of providing services during a year, Chartered was entitled to a retrospective premium rating adjustment to account for its entire loss experience under the contract. The DC Insurance Commissioner specifically found that the Chartered/DHCF Contract

is a retrospectively rated contract. The DC Insurance Commissioner signed a November 27, 2012 order finding that the DHCF Contract is retrospectively rated and that certain events described below triggered the DHCF's obligation to pay Chartered a retrospectively-rated premium adjustment for the period August 1, 2010 through April 30, 2012, as well as to set higher, actuarially sound rates going forward.

18. In relation to the $51 million claim the Rehabilitator asserted on February 21, 2013, I initially sought to confirm the claim amount by calculating the full amount due to Chartered by the District for retrospective rate adjustments for the period covered by the claim. However, information relevant to that calculation is unavailable to me, it was not attached to the claim itself, so I could not do so. Some of that information should be in the possession of Chartered, the Rehabilitator and/or the District. Other of the information does not yet exist because it is apparent that certain amounts claimed by providers have not yet been resolved.

19. Even from the limited information available to us, however, it is clear that the proposed settlement agreement would relieve the District from significant and certain retrospective premium adjustments, both reflected in the asserted claims and not yet asserted, that the District owes to Chartered. The District's debt can be objectively determined with the relevant information as a matter of simple math. The proposed settlement for $48 million would relieve the District from a debt that I assess as in excess of $50 million in addition to the amount that would be paid under the settlement, as discussed below. Because I do not have the information to determine the precise amount, it is possible the District's debt could be higher. The District is benefiting from this discount without having any apparent defense to payment given the undisputed retrospectively rated nature of the DHCF Contract and a number of rating deficiencies.

20. In relation to DHCF's debt under the retrospective rating agreement, most of the District's debt to Chartered could be determined objectively if the Rehabilitator were to provide access to Chartered's final expense information data listing the final, undisputed provider billings, and possibly certain other information. From that data, it is a simple matter of math to determine the retrospective premium payments that Chartered is due. Under industry standard retrospective rating expectations, this would be accomplished arithmetically by summing the resolved provider claims and other expenses under the contract and additional sums to which Chartered is entitled under the contract (13.5% for Admin, Tax and Profit). In this case, interest payments to Chartered also should be considered expenses and thus are reimbursable by the DHCF. Chartered possesses the necessary information as to final, undisputed provider claims,

but we are advised that other provider claims remain open and that providers have until August 31, 2013 to file additional claims against Chartered. We also understand that some provider claims are disputed, including Medstar's $30 million claim. In this circumstance, it is a substantial departure from industry standard practice and premature for Chartered to release the District from all payment obligations to Chartered before those obligations can even be calculated, which is precisely what the proposed settlement agreement would do. As currently structured, this settlement would not even fully pay the objectively determinable minimum amount the District owes to Chartered based on already asserted claims, and as stated, significant debts have not even been claimed yet. In contrast, it would be consistent with industry standard practice if the Rehabilitator and the District reached an interim retrospective rate agreement, to allow current undisputed claims to be paid without delay, leaving final adjustment of undisputed claims for a later date.

21. The Rehabilitator's claim against the Alliance program for the period July 2010 to July 2011 is based on a straightforward calculation. [February 21, 2013, Claim under DCHC-2008-D-5-52]. It asserts that the rates paid were below the range of actuarially sound rates calculated in accordance with the contract. The claim for approximately $9.1 million seems well supported by the material provided with it. The claim seeks payment of the rate differential times the known enrollment for the period. At this point it is unclear whether DHCF contests the Rehabilitator's claim and if so on what basis. If this claim were to be paid in full it would bring revenue for the specific period for this one service up to the lowest possible actuarially sound rate (which would not impact the other unsound rates paid for other services and other periods). While the settlement does not ascribe specific payments to the various claims, this claim states the objectively calculated extent of the DHCF's debt to Chartered, and there is no basis for discounting it.

22. The Dental claim for period January 2011 to November 2012 is based on an equally straightforward calculation (January 4, 2013, Dental Crown Claim). Dental Crowns were added as a new benefit without increasing the payment rate. Another $2.2 million is due to Chartered because this change was imposed on Chartered without compensation. Again, there is no basis for discounting this claim. In fact, the claim asserted is too low in that the Rehabilitator failed to include a 13.5% upward adjustment to which Chartered is entitled for administrative expenses, premium taxes and profit.

23. In my opinion, the proposed settlement agreement is unreasonable and outside industry norms for the following four reasons.

1. The Settlement Is Unreasonable Because There Is No Basis For Discounting The District's Debt To Chartered for Asserted Retrospective Premium Claims

24. The District of Columbia, Division of Insurance, Securities and Banking, commissioned a study to determine if the contract between Chartered and DHCF is retrospectively rated. The Commissioner reached his conclusion that the contract is retrospectively rated in a November 27, 2012 order adopting a Report of Limited Scope Examination.

25. The last paragraph on Page 8 of the report states, "Based on this analysis, we believe it is appropriate to consider the Contract to be a retrospectively rated contract due to the DHCF's required annual review of capitation rates in accordance with Sections B.3.2 and B.3.3. We note that if the DHCF failed to perform the required annual review or, alternatively, performed the review and failed to establish actuarially sound rates, the amount of the deficiency in the capitated rates would be a liability for the DHCF and an asset (premium receivable) for DC Chartered."

26. Given this order and decision by the head of the District's insurance department and the District's authorship of the Medicaid/Alliance contract, there should be no dispute related to the fact that the DHCF Contract is subject to retrospective premium liability by DHCF.

27. Reconciliation of retrospectively rated contracts is an activity performed in the normal course of business in the insurance industry. These processes are routine and proceed smoothly driven by the calculation of the reconciling amount due (or credit in the event of favorable medical experience). The obligations are clear and protracted litigation around the reconciled settlement is unusual. When litigation occurs, in my experience, there is some delay but where the contract is determined to be retrospectively rated, the outcome is seldom in doubt.

28. The calculation is simple. Assuming, for purposes of this point only, that the pending unpaid bills (Claims) are undisputed, the unpaid bills represent **objectively determined debts of the District under the DHCF Contract**, not debatable subjective assertions. This is because the "bills" are (and should be) based on the sum of costs generated under the contract plus the additions for Admin, Taxes and Profit used in the initial prospective rating, plus interest. Simply stated, retrospective rating is the application of the rating formula to known cost exposure, whereas prospective rating is based on actuarial estimates of projected costs. In the simplest terms, prospective rating seeks to project the health care bills the HMO will need to pay, with the addition of admin, taxes and profit. Retrospective rating sums actual

provider bills and then adds the admin, taxes and profit, as well as interest. The medical expense in this formula is the reconciled liability to providers. The entire amount is either paid or obligated for payment to healthcare providers. No information has been provided to show that there should be a discount of this arithmetic formula. (DCHF contract B.3.1)

2. The Settlement Is Unreasonable Because the Rehabilitator has not and cannot at this Date Calculate the Total Amount Chartered Should be Paid In Connection with the Asserted $51 million retrospective premium claim.

29. Under the industry standard expectation for retrospective rating, Chartered is entitled to a payment that will make it whole for 100% of the provider bills paid under the contract, plus the 13.5% administrative/tax/profit increase to which it is entitled under the contract, plus interest.

30. It is unclear whether the Rehabilitator applied the correct methodology to the calculation of the 2/21/2013 claims for Medicaid retrospective premiums because he has not disclosed sufficient information. The sources and dates for the data are not attached to the claim filing, but it appears to be calculated on undiscounted medical services costs under the contact. This calculation was then compared to imputed medical services costs embedded in the original prospective rating. That calculation excludes outstanding hospital payment disputes and any disputes or resubmitted claims still unresolved. As such, this calculation understates the District's indebtedness to Chartered because it captured only a portion of the expenses under this contract for the time period covered by the claim. Until complete loss experience information for the relevant period is provided, the calculation cannot be completed or verified.

31. This calculation is straightforward arithmetic once the claim experience is known. Industry practice would call for an interim reconciliation if early reimbursement were a goal with final reconciliation at a later date when all or substantially all information is known.

3. Chartered Should Not Discount Other claims in the Absence of Meritorious Defenses to Payment, Which Do Not Appear Here

32. As explained above in paragraph 22, the Dental claim, as filed, was calculated properly and accurately states the amount the District owes to Chartered for the time period of the claim. There is no justification for discounting it. In fact, it appears that the claim is understated by the allowance for admin., taxes and profit – 13.5% -- and interest.

33. Similarly, the Alliance retrospective claim discussed in paragraph 21 was properly calculated and there is no basis for discounting it either.

34. It was unreasonable, and contrary to best practices in the industry, for the Rehabilitator to accept substantial discounts of these claims.

4. The Proposed Settlement is Unreasonable Because It Fails to Account for Debts of the District that the Rehabilitator Has Not Formally Asserted

35. As discussed above, the Rehabilitator has asserted three specifically limited claims. Beyond those, however, there are significant additional deficiencies in the District's payments to Chartered that the Rehabilitator has not asserted, and he has not negotiated for their payment in the proposed settlement agreement.

36. The $9 million Alliance claim discussed above is limited to the period July 2010 through July 2011. [February 21, 2013, Claim under DCHC-2008-D-5-52] This claim appropriately contends that the District set rates at a level that were not actuarially sound. This claim is supported by the admissions of impropriety on the part of DHCF as reflected in DHCF Director Wayne Turnage's letter to Mayor Gray dated April 4, 2011 and his presentation to the DC Council on June 24, 2011. There, the DHCF admitted that it had deliberately set reimbursement rates at a level that was below actuarially sound levels. Given the extent of subsequent contracting activities, additional instances of potential improper rate setting and underpayment should be evaluated. We lack information to assess this potential, but DCHSI has asked for relevant information to do so in discovery requests and may have additional information needs as investigations proceed. A thorough review of the populations, benefits, and rate setting under the DHCF contracts may result in additional instances of appropriate retrospective rating or claims of actuarially unsound rate selection.

37. The Medicaid/Alliance contract contains a feature for retrospective premium adjustment for all periods in which DHCF made unilateral changes in benefits or population. The contract specifies that this is a mandatory adjustment to be performed for contractual service increases and decreases.

38. Under the set of events that generate a retrospective rating for the Medicaid population, Chartered and DHCF should calculate the DHCF's debt under the 2010 to 2012 period for the Alliance program. The 774/775 populations were moved from Alliance to the Health Families (Medicaid) program. This resulted on a unilateral un-rated population change for the Healthy Families and a corresponding population change for the Alliance program.

39. I believe that this analysis will demonstrate the underrating of the Alliance program by the District because of DHCF's deliberate use of unsound rates, as reflected in Mr.

Turnage's letter to the Mayor and presentation to the DC Council, which show that DHCF manipulated Alliance rates, setting them below actuarially projected levels, to minimize the District's financial exposure. Retrospective rating extended to this population would demonstrate additional debts by the District to Chartered.

40. As above, this arithmetic calculation of the amount owed would be straightforward based on the sum of bills paid plus the original additions to rates compared to the original payment rates (as well as the 13.5% admin/tax/profit charge, plus interest).

41. The claim for retrospective rating would mirror that for Medicaid, expect for the period October 2010 to April 2012. The retrospective rating claim would overlap, in part, with the Rehabilitator's claim for failure to pay actuarially sound rates for the period July 2010 to July 2011 and so an adjustment would have to be made.

42. The underpayment of Chartered appears to have generated delays and issues with the flow of financial and payment records as well as precipitated provider conflicts. With that level of disruption, there is potential to have under-estimated the base period population expense in setting rates in 2012. Therefore, I believe records would substantiate a further claim for "unsound actuarial rating" for Chartered's most recent periods under the Medicaid/Alliance contract, including rates set as of May 1, 2012 for the final contract year. Given the rolling impact of prior rate setting problems that infected earlier years, the base data used for setting the May 1, 2012 rates likely understated population costs. The required data is not now available to us but evaluation would require revisiting the base data used by Mercer, comparing it to data enriched by the settlement of outstanding claims and re-evaluation of the actuarially sound rate range.

43. Timing to complete the analysis of the District's indebtedness to Chartered once we have possession of the relevant database(s) and documents should be approximately 60 days. At that point, we should be able to calculate with precision the District's objectively determined contractual debt to Chartered.

44. In sum, visible potential claims include those asserted by the Rehabilitator, $9.1 million related to Alliance, $2.2 million related to Dental, plus $51 mm for retrospective rating for Medicaid, totaling $63.3 mm. The total asserted claims of $63.3 million is $14.5 million more than the $48 million settlement recommended by the Receiver. Known potential additional amounts due include, $0.3 million for the addition of 13.5% on the Dental claim and $3 million to $5 million to account for interest generated by DCHF's actions. Approval of Medstar's $30

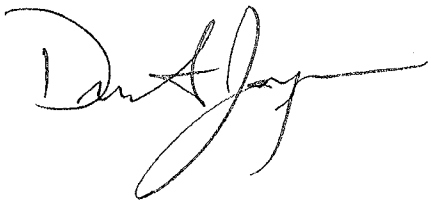
million claim would impact the retrospective rating period for Medicaid, whether paid in full or in part (recognizing it is disputed), and additional claims may be filed and resolved. These claims, once approved for payment, would be added to the retrospective medical experience. The amount plus 13.5% would be added to DCHF's debt to Chartered. Settlement of the $30 million claim (assuming settlement in full for present purposes only), plus 13.5%, would bring total potential claims to $50 million in excess of the $48 million settlement proposed. While the Medstar assertions are disputed, there are other providers that could assert claims or submit claims for reconsideration before the bar date. Additionally, as described, above there are other claims that Chartered should pursue.

CONCLUSION

45. The Proposed Settlement is unreasonable, and is contrary to the best interests of Chartered, the providers and other creditors.

I, Drew Joyce, declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on this 9th day of August, 2013.



Drew Joyce
HMO Affiliates LLC
Charlottesville, Virginia

****

Exhibit A

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HEALTHCARE ADMINISTRATION

Finance~ Regulatory Affairs ~ Senior Management ~ Provider Network Services ~ Managed Care

ADDITIONAL KEY AREAS OF EXPERTISE

Staff Management	**Mergers and Acquisitions**	**Compliance / Audits**
Health Plan Operations	**Treasury**	**Pricing and Underwriting**
Provider Contracting	**Medical Analysis**	**Organizational Operations**

PROFESSIONAL EXPERIENCE

HMO AFFILIATES, LLC Charlottesville, VA — June. 2012 – Present

HMO Affiliates, LLC is a nationally recognized and established managed care consulting firm with extensive experience in development and operational management of Health Plans.

Managing Director

- Consulted on ACO CO-OP application and development and Medicaid RFP development.
- Contributed insurance, managed care, operational, and health care marketing expertise to hospital and clinic health care providers.
- Generated operational, contracting and marketing plans along with implementation plans and schedules to support successful development.

GLG RESEARCH Charlottesville, VA — June. 2012 – Present

The Gerson Lehrman Group Councils are industry- and discipline focused networks of consultants, physicians, scientists, engineers, attorneys, market researchers and other professionals from around the world. GLG Council Members enable decision-makers at investment firms, corporations and non-profit organizations to better understand the products, services, companies, issues, and industries on which they focus. provides systems to manage expert consulting.

Council Member

- Engaged in "micro-consulting" telephonic engagements related to managed care, network contracting, HMO management, and market expertise.

COVENTRY HEALTH CARE, INC. Charlottesville, VA Jan. 2002 – Mar. 2012

Coventry is a diversified Fortune 500 national managed health care company based in Bethesda, Maryland operating health plans, insurance companies, network rental services companies, and workers' compensation services companies.

Coventry Health Care Medicaid Division

Chief Financial Officer Jan. 2011 – Mar. 2012

- Member of national senior leadership team responsible for the largest Medicaid growth in Coventry history. Annualized revenue as of Dec. 2011, $1.2 billion, membership up 50% to 690K members; revenue up 70%, same store profit contribution up 10% from year previous.
- Active in growth strategy, RFP / State negotiations, development of health care savings, network expansion & management, quarterly reporting and centralized medical prior authorization development. Worked closely with staffs in Florida, Kentucky, Virginia and Missouri to develop Medicaid programs.
- Stabilized Coventry's first centralized prior authorization function meeting staffing and production goals. Developed processes and organization to triple staff and volume as a result of centralization and membership growth.

Virginia / West Virginia Health Plans

President and CEO Jan. 2010 – Dec. 2010

- Engaged in extended push to improve pricing and profitability, through improved medical cost positioning. Established three multi-disciplinary teams to improve positioning in all lines, Operations- claim payment/editing savings, Network- quality performance/fee evaluation, and Medical Management- utilization and quality program savings.
- Year over year profit contribution increased 37% or $26 mm to 15% of Revenue.
- Increased underwriting / sales discipline; reduced MLR by 500 basis points to 78.1% with loss of less than 7% of revenue.
- 260,000 members; 65% VA, 35% WV; 40% Commercial Risk, 30% Medicaid, 30% ASO.
- Coventry's 4th largest health plan. Staff included 200 employees in 5 offices.
  Key reports were the CFO, Medical Directors, VP of Health Services & Quality, Medicaid VP, VP- Operations and West Virginia and Virginia Commercial Sales VPs, and Human Resources, Legal, Underwriting and Actuarial through matrix relations.

Chief Operating Officer May 2006 – Dec. 2010

- Expanded VA HMO service area into DC metro area. Initiated and grew small group sales in DC market.
- Built RFP sales team resulting in expanded large group municipal and ASO enrollment.
- Successfully addressed contract and network challenges to maintain unit cost and access position.
- Developed network and initiated State-wide West Virginia Medicare Advantage program.
- Focused West Virginia strategy on Medicaid expansion. Completed contracting and expansion into 40 counties (all but three rural counties)- yielding 90% growth.
- Developed WV's first HMO POS product and individual non-employer group trust filed in

WV and sold in VA and WV.

- Key reports were the CFO, Network Development VPs for WV and VA, VP of Health Services & Quality, Medicaid Director, VP- Operations and WV Commercial Sales VP.

Chief Financial Officer — Jan. 2002 – April 2008

- Active in integrating two Coventry health plans in Virginia. Organized the integrated staff functions, managed network relations during conversion claim / Rx administration.
- Grew Virginia membership by 28% from 2002 to 2009 and WV membership by 28% from 2006 to 2009.
- 2002 to 2009 MLR avg. 79.8% (worst year 83%) and average corporate profit contribution equal to 12% - one of the best in Coventry.
- Planned and managed integration of Virginia and West Virginia health plans in 2006
- Reporting to the CEO, responsible for the following functions for all business lines; budget, audit, reporting, State and Federal compliance activities, medical economics, multi-functional medical savings initiative process, RFP review and approval, VA / WV Medicaid Program (Member outreach, State liaison, contract renewal), Medicare bid/contract renewal. Underwriting, Actuarial, Claims, Customer Service, Legal and Facilities Management local responsibility through matrix relationships.
- Key staff included VP-Operations, Controller, Director of Medical Economics, and Director- Medicaid Programs.

VISTA HEALTH PLAN HOLDINGS, Durham, NC — Jan. 2000 – Dec. 2002

Vista was a privately held health plan development company with commercial, individual and Medicare enrollment in North Carolina and Florida.

CFO, Treasurer, various health plans in FL and NC

- Participated in acquisitions and restructuring of health plan holdings resulting in divesture of North Carolina holdings and building a 400,000 member health plan operation in Florida.
- Managed capital needs, assisted with integration, system evaluation, vendor selection, risk management, filings and regulatory negotiations for development of multi-health plan organization.
- Planned and managed one-year orderly wind-down of 12,000 member North Carolina Health Plan, Doctors Health Plan. Interfaced with regulators, organized planned and retained staffing.
- Contributed to Financial Management, Strategic Planning and M&A reporting to owner of multiple health plan organization.

GULF SOUTH HEALTH PLAN, Baton Rouge, LA — May 1999 – Dec. 1999

Gulf South was a for-profit, hospital owned, Louisiana health plan and TPA with approximately 21,000 Medicare+Choices, 50,000 at risk commercial members and 120,000 self-funded TPA covered lives.

CFO / VP – Finance and Operations

- Maintained profitability, staff and membership while preparing attempts to market health plan to potential purchasers.
- Successfully responded to and implemented Medicare Y2K requirements

- Streamlined individual product underwriting and administration to improve profitability.
- Chief Financial Officer and HMO operational head responsible for Finance, Underwriting, Actuarial, Claim Payment, Enrollment and Billing. IT management through matrix responsibility.

ADVANTAGE HEALTH, New Orleans, LA **July 1996 – April 1999**

Advantage Health was a statewide for-profit, Louisiana health plan start-up owned by three hospital systems, Advantage Health, and a network rental business, HealthCare Advantage, serving 250,000 members across the Gulf States.

VP and Chief Financial Officer

- Financial leadership through development of the HMO from 7,900 members in July 1996 to 73,500 commercial, individual plus 20,000 Medicare risk members in December 1997.
- Managed Claims and Customer Service function; successfully stabilized operations, resolved claims payment and systems issues.
- Assisted with sale of PPO network rental business, March 1999. Planned and assisted with execution of plan closure and market withdrawal, June 30, 1999.

LIFEGUARD, INC., San Jose, Calif. **May 1993 – June 1996**

Lifeguard was a not-for-profit northern California health plan, which grew out of the San Jose physician association. 107,000 members in 1993 consisted exclusively of southern bay area, large group, commercial enrollment.

Vice-President Corporate Planning and Development

President Lifeguard Life Insurance Company

- Assisted with growth of this Northern California HMO from 107,000 members to 173,000.
- Developed POS product, small group market entry, and Medicare risk program start-up.
- Planned and managed Lifeguard's acquisition and operation of Travelers Health Network of California in Sacramento and Fresno. Managed all functions including claims and customer service of this health plan on a separate PC system through system conversion and integration.
- Managed pricing, placement, entry and participation in California State HIPC, small group exchange.
- Managed start-up of Lifeguard's insurance subsidiary, Lifeguard Life Insurance Company. Certificate of Authority issued Dec. 30, 1993. First products filed June 1994. Statewide PPO introduced July 1995.
- Responsible for business and product development, underwriting, actuarial, and billing and enrollment.

THE TRAVELERS, Dallas, TX. **Sept. 1990 – May 1993**

Travelers was a diversified national multi-line insurer based in Hartford, Connecticut offering 10 HMO entities

and national PPO / managed indemnity insurance products.

National Director of Operations Planning & Analysis, Managed Care Div. **Sept. 1990 – May 1993**

Chief Financial Officer Travelers Health Network Oct. 1992 – May 1993

- Financial officer with budget, evaluation and profitability for HMO entities and over $100 million operating expense budget responsibility for 42 integrated managed care sites with over 500,000 members.
- Planned and budgeted for expanded local managed care sites to meet national client needs.
- Evaluated and approved contracts for multiple networks to improve PPO access and discounts.
- Worked with small management team to "right size" staffing and capabilities to balance with emerging managed PPO sales results.

CIGNA COMPANIES, Bloomfield, CT. **July 1982 – Sept. 1990**

CIGNA is a global health service company that offers health, life, accident, dental, and disability insurance,

and related health services.

Director of Planning & Analysis

CIGNA Healthplan, Inc. May 1987 – Sept. 1990

CIGNA Management Development Program,

Various Positions July 1982 – Aug. 1987

Education

University of North Carolina

Chapel Hill – MBA, 1982 Chapel Hill, NC

Wake Forest University – BA, 1974 Winston-Salem, NC

EXHIBIT B

LIST OF DOCUMENTS RELIED ON

1. DHCF Contract
2. July 23, 2013: DC Chartered Health Plan Settlement Agreement
3. July 9, 2013: Special Deputy Rehabilitator's Fifth Status Report
4. Exhibits to Special Deputy Rehabilitator's Fifth Status Report, July 9, 2013
5. May 30, 2013: Order Approving the Establishment of a Bar Date of August 31, 2013
6. May 17, 2013: Special Deputy Rehabilitator's Fourth Status Report
7. April 19, 2013: Special Deputy to the Rehabilitator's Third Status Report
8. April 19, 2013: Annual Statement for the Year 2012 of the DC Chartered Health Plan Inc.
9. March 1, 2013: Order Approving the Asset Purchase Agreement, Plan of Reorganization and Related Matters
10. DC Chartered Health Plan Inc. 2011 Independent Auditor's Report
11. Notice of Filing Special Deputy to the Rehabilitators First Status Report to D.C. Superior Court – Jan. 11, 2013
12. Receiver's Status Report on Chartered Health Plan Inc.
13. Commissioner William P. White Testimony Oct. 25, 2012 at Joint Oversight Roundtable on the DC Chartered Health Plan, Inc. Receivership of the Committee on Public Services and Consumer Affairs
14. November 2012 DISB Order and DC Chartered Report limited scope exam final
15. CFR-2011-title42-vol4-sec438-6
16. DC $52 mm charter424exhibit2_reduced_1-1
17. dc_chartered_2007_final_exam_report
18. February 21, 2013 Claim Under Contract DCHC-2008-D-5052 (Part 1 of 2)
19. February 21, 2013 Claim Under Contract DCHC-2008-5052 Submitted Pursuant to Section 14 of the Standard Contract Provisions Included in the Contract
20. Millennium Review 2045_001 copy
21. April 4, 2011 Letter from DHCF Director Turnage to Mayor Gray & DC Council Presentation
22. January 4, 2013 Letter re DCHC-2008-D-5052 Modification 24

EXHIBIT 2

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

William P. White
Acting Commissioner

BEFORE THE
INSURANCE COMMISSIONER OF
THE DISTRICT OF COLUMBIA

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

ORDER

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

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

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

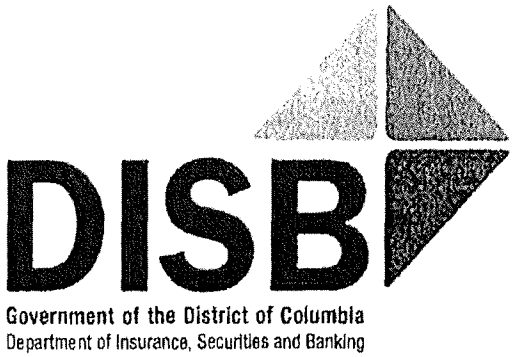
Pursuant to Section 31-1404(d)(1) of the D.C. Official Code, within 30 days of the issuance of the adopted report, the Company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related order.

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

William P. White
Commissioner

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF INSURANCE, SECURITIES AND BANKING



REPORT ON LIMITED SCOPE EXAMINATION

OF

DC CHARTERED HEALTH PLAN, INC.

NAIC #95748

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SALUTATION

Washington, D.C.
November 8, 2012

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

Dear Commissioner White:

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

DC CHARTERED HEALTH PLAN, INC. – NAIC #95748

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

BACKGROUND

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

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

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

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

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

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

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

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

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

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

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

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

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

SCOPE OF EXAMINATION

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

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

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

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

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

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

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

SUMMARY FINDINGS

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

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

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

ANALYSIS

Relevant Statements of Statutory Accounting Principles

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

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

In addition, SSAP No. 66 provides that:

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

DC Chartered's Position on Premium Receivable

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

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

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

Capitation Rate Retrospective Adjustment Due To Contract Change

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Annual Capitation Rate Adjustment

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

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

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

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

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

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

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

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

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

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

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

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

Determination of Retrospective Rate for Entire Contract

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

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

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

Additional Considerations

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

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

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

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

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

RECOMMENDATION

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

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

SIGNATURES

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

Sarah W. Schroeder
Neil K. Rector

Respectfully submitted,

_____
Edward A. Dinkel
Rector & Associates, Inc.

Under the Supervision of,

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

EXHIBIT 3

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April 11, 2013

A. Scott Bolden
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Charles T. Richardson
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Washington, DC 20001

William "Billy" Martin
Martin and Gitner, PLLC
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Washington, D.C. 20037

Re: D.C. Chartered Health Plan Claims Against the District of Columbia

Dear Counsel:

We write on behalf of D.C. Healthcare Systems, Inc. ("DCHSI") to each of you as counsel to D.C. Chartered Health Plan, Inc. ("Chartered") or its Rehabilitator. We write to remind you of the requirement to seek shareholder approval of certain actions, and to request that the Rehabilitator pursue certain claims on behalf of Chartered.

As you know, the Articles of Incorporation of Chartered require that decisions of the Chartered Board of Directors be approved by a unanimous vote of its shareholders. Also, as you know, DCHSI is the sole shareholder of Chartered. On any decision that requires shareholder approval, please contact me, as counsel for DCHSI, to seek DCHSI's approval.

On April 2, 2013, DCHSI filed a motion in the D.C. Superior Court seeking to compel the Rehabilitator and Chartered to pursue, and not stay, Chartered's pending pharmacy-related claim against the District that was filed November 30, 2011. Although DCHSI disagrees with the Rehabilitator's decision to seek a stay of that claim, there should be no disagreement over the underlying principle that Chartered should be pursuing *all* of its claims against the District under the Department of Health Care Finance Medicaid/Alliance Contract (the "DHCF Contract").

In this regard, DCHSI, as Chartered's sole shareholder, the holder of all residual interest in Chartered and a creditor of Chartered, brings to your attention the following additional claims that Chartered should assert against the District that are not included within any pending claim. DCHSI demands that Chartered promptly analyze and aggressively pursue these claims against the District.

Specifically, Chartered has at least the following additional, potentially significant claims against the District:

I. Claims for Actuarially Unsound Capitation Rates

The Rehabilitator presented two claims on February 21, 2013, one concerning the Medicaid aspects of the DHCF Contract (the "Medicaid Claim") and the other concerning the Alliance aspects of that contract (the "Alliance Claim").

A. The Medicaid Claim Understates the District's Debt to Chartered

The Rehabilitator and Chartered have overlooked a number of respects in which the District has underpaid Chartered. They admit as much in the Medicaid Claim (at 11) in stating

that it "is certainly doubtful and debatable" that "the rates certified and set were actuarially sound for the Medicaid population," but "**that is not the issue in this claim.**" (Original emphasis.) Chartered should demand to be paid based on actuarially sound rates. Further, the Medicaid Claim is limited to Chartered's net loss experience from August 1, 2010 through April 30, 2012, and thus does not account for the District's actuarially unsound rates prior to August 1, 2010 and after April 30, 2012. Rather than the Rehabilitator's overall profit-and-loss-statement approach pursued in the Medicaid Claim, it is likely that a detailed, line-by-line examination of actual cost and reimbursement experience would show that the District owes Chartered well more than the approximately $51 million claimed in the Medicaid Claim. The Rehabilitator should pursue at least the following claims.

1. Adverse Selection. The District's actuarial rates failed to account for adverse selection; that is, Chartered was reimbursed with the same rates as the other HMOs even though Chartered served a population of members that was disproportionately composed of individuals suffering from HIV and other chronic illnesses. Section B.3.2. of the DHCF Contract requires that reimbursement rates take account of any such "disproportionate enrollment selection of [Chartered] by members in certain rate cohorts." Yet, Chartered's adverse selection was never factored into the rate setting.

This problem dates back to the beginning of the DHCF Contract, when AmeriGroup and Health Right exited the District Medicaid-HMO market in 2008 and a disproportionate proportion of the chronically-ill enrollees of these entities selected Chartered for service. The

District, however, has never adjusted Chartered's rates to account for this ongoing adverse selection. In fact, Chartered has been reimbursed at rates identical to those paid to other HMOs that did not have the same number or proportion of chronically-ill enrollees. The failure to set Chartered's rates at a higher level is contrary to the express provisions of the DHCF Contract and resulted in an actuarially unsound rate for which the District owes Chartered substantial compensation for the entire contract period.

2. Dental. Chartered settled with the District concerning underpayments in the 2008 and 2009 DHCF Contract years arising from the costs of paying dental claims mandated by the *Salazar* court; the dental claims were the direct responsibility of Bob Watkins, Chartered's former COO. Chartered now has asserted a prospective claim concerning dental reimbursement rates, but the fact is that the same underpayments Chartered resolved for 2008 and 2009 continue to this date. Chartered has been required to handle child and adult dental claims, which greatly increased Chartered's costs, but these costs still have not been adequately accounted for in the rate setting. Chartered should pursue a claim against the District to recover these underpayments.

3. Additional Grounds. The Medicaid Claim is limited to the period from August 1, 2010 to April 30, 2012, when the District raised rates. But, as the Rehabilitator stated in the Medicaid Claim (at 10), "[a]lthough the [rate schedule beginning on May 1, 2012] is higher, Chartered continues to doubt that the new rate adequately compensates it for the benefits required to be provided under the Contract." The Rehabilitator and Chartered should seek to

recover the full amounts due for the entire contract period, not just the period from August 2010 through April 2012.

B. The Alliance Claim Also Understates the District's Debt to Chartered

The Alliance Claim is not comprehensive in that it alleges actuarially unsound rates only for the period from July 2010 – July 2011. The rates, however, also likely were actuarially unsound both prior to and after this time period. The Rehabilitator should examine the adequacy of the Alliance rates for the entire DHCF Contract periods, and not merely July 2010 to July 2011, and pursue a claim against the District to recover all amounts the District should have paid for the entire contract period.

II. United Medical Center Reimbursement Claim

In 2008, Chartered agreed, at the insistence of then-Attorney General Peter Nichols and Council member David Catania, to increase payments to United Medical Center ("UMC"), which was struggling financially. They forced Chartered to increase UMC's reimbursement rate 25% from March 18, 2008 - July 27, 2008 and to maintain those rates for the next three contract years. The District required Chartered to increase its reimbursement to UMC for all provider rates. As a consequence, Chartered paid UMC more than it was paying other providers for like services. The District, however, never adjusted Chartered's reimbursement rates to account for these additional costs that the District required Chartered to bear. To the extent they are not included in the existing claims – and, at a minimum, the existing claims would cover these added

costs only for a portion of the time they were imposed and not reimbursed – Chartered should calculate and promptly assert them.

III. Premiums Due. The District failed to pay all the amounts Chartered properly billed to the District for premiums for certain members. That is, even at the District's inadequate capitation rates, the District failed to pay Chartered all charges due for all members enrolled each month during the period of the DHCF Contract. Chartered previously demanded payment from the District and booked the unpaid premiums as a receivable due from the District. The Rehabilitator inexplicably has written off premium receivables, as reflected in Chartered's September 30, 2012 financial statement. The premium receivables are valid claims of Chartered, and Chartered should be pursuing their collection, not writing them off.

IV. Premium Taxes/Administrative Expenses. When the District imposed a 2% premium tax, it reduced Chartered's administrative expense allocation to pay for the taxes. At the same time, the District imposed additional contractual reporting requirements that increased Chartered's administrative costs, creating an administrative expense and premium tax rate funding deficit. The District has never adequately accounted for these premium tax and administrative expenses in paying Chartered. To the extent they are not included in the existing claims – and, at a minimum, the existing claims would cover these expenses only for a portion of the time they were imposed and not reimbursed – Chartered should calculate and promptly assert them.

As stated, DCHSI's interests and Chartered's interests should be fully aligned concerning the collection of all amounts owed to Chartered by the District. We stand available to provide assistance to Chartered, but in any event demand that you respond by Friday, April 19, 2013, with the Rehabilitator's and Chartered's plan for pursuing these claims.

We look forward to your prompt response.

Very truly yours,

David Killalea

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VIA E-MAIL

April 19, 2013

David Killalea
Manatt, Phelps & Phillips, LLP
700 12th Street, N.W., Suite 1100
Washington, D.C. 2005

Dear Mr. Killalea:

In response to your letter dated April 11, 2013, and as we have described in multiple court filings, the Rehabilitator currently is pursuing approximately $60 million for claims under the contract between D.C. Chartered Health Plan, Inc. ("Chartered") and the Department of Health Care Finance ("DHCF"). As you know, the Rehabilitator already significantly expanded the nature and scope of the DHCF claims beyond Chartered's pre-Rehabilitation submissions to the DHCF and the Contract Appeals Board.

We are willing to meet with you to discuss any additional reasonable, documented and timely potential claims against DHCF. In the meantime, we will continue to examine your letter's arguments for further expansion of the claims, but we decline your demand that the Rehabilitator and Chartered spell out their "plan for pursuing" the claims that you describe in your letter. We know of no basis for your making, or the Rehabilitator's having to fulfill, such a demand, and trust that you would identify it if there were one. As it is, the Rehabilitator and his counsel have plenty to do already. We do of course welcome any additional suggestions or analyses that you care to provide.

Finally, your letter requests that we seek the approval of D.C. Healthcare System's Inc. ("DCHSI") for "any decision that requires shareholder approval." However, the Court already rejected DCHSI's arguments concerning shareholder approval in its April 2, 2013 Order in District of Columbia v. D.C. Chartered Health Plan, Inc., Civil No. 2012 CA 008227 2 (D.C. Super Ct.). The Rehabilitator will not voluntarily assume obligations contrary to the supervising Court's Order or in violation of his statutory duties.

Please let us know when you would be available to discuss potential claims so that we can arrange a mutually convenient time to meet.

Very truly yours,

Charles T. Richardson

cc: A. Scott Bolden, Reed Smith
William Martin, Martin & Gitner, PLLC
William P. White, Commissioner, c/o Thomas Glassic, General Counsel, DISB
Daniel Watkins, Special Deputy Rehabilitator

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May 23, 2013

Charles T. Richardson
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Washington, DC 20001

Re: D.C. Chartered Health Plan Claims Against the District of Columbia

Dear Mr. Richardson:

This is in response to your letter of April 19, 2013, concerning additional potential claims Chartered can assert against the District.

As you no doubt can appreciate, DCHSI does not have access to Chartered's book and records and therefore has a limited ability to document the potential claims. Although that responsibility must fall on the Rehabilitator, DCHSI does its best to . That said, we are able to provide additional information that should be of great value in recovering all that is due to Chartered under the DHCF Contract.

I. The claims for Retrospective Rate Adjustments are Understated

A. Adverse Selection

The Center for Medicaid and Medicaid Services ("CMS") has promulgated regulations that govern Medicaid contracts between managed care organizations and governmental entities. *See* 42 C.F.R. § 438 (mandating that the rates paid must be actuarially sound). The following factors have a direct bearing on the determination of the amounts due to Chartered because of the adverse selection experienced by Chartered during the term of its contract with DHCF.

- Health Right effectively was forced out of the system by DHCF in May 2010. Chartered then was left as the only health plan that had a MedStar provider agreement; MedStar and United Healthcare were unable to reach terms on a provider agreement. This had two cost impacts on Chartered. First, the sickest members chose Chartered as their HMO so that they could have access to the Washington Hospital Center, Georgetown Hospital, National Rehabilitation Hospital and at MedStar's other ancillary/affiliated providers. Second, costs also increased disproportionately because MedStar is the most costly of the hospital providers.

- Chronically sick members also disproportionately chose Chartered because Chartered had a much more extensive provider network than United Healthcare.
- DHCF did not distribute the 774/775 population on a pro rata basis, and a significantly larger number of the 774/775 and HIV population chose Chartered over United HealthCare as their HMO. As such, Chartered ended up with a much higher-risk population than was accounted for in the rates.
- The extremely high number of 774/775 and HIV members enrolled in Chartered not only drove up Chartered's pharmacy costs precipitously, but they also resulted in the significant escalation of nearly all of Chartered's medical cost line items.

Given the above factors and the data developed and published by DHCF and Chartered, it is clear that Chartered had a significantly high number of 774/775, HIV and chronically sick members because Chartered was selected disproportionately by high-risk populations (adverse selection). Chartered's Medical Loss Ratio (MLR) thus was significantly higher than the MLR data used by the District's actuary, Mercer, in setting rates. As you know and set forth in the claim documentation submitted by Mr. Watkins, Mercer excluded the pharmacy costs for 774/775. that Chartered's MLR cost numbers far exceeded the annual cost escalator assumptions applied by Mercer to develop the rate during the relevant contract years . The actuarial rates developed by Mercer and approved by DHCF also were unsound because the uniform rate given to both Chartered and United Healthcare ignored the MLR cost drivers for Chartered's much larger 774/775, HIV and chronically ill members. Although Chartered's MLR and the MLR cost drivers were significantly greater than United Healthcare's, DHCF paid both health plans the same rate.

Based on Chartered's consistently higher MLR and the adverse selection, which was beyond Chartered's control, the actuarial rates should be recalculated for each contract year and the rate paid to Chartered be retrospectively adjusted. DCHSI suggests that the individuals with the best knowledge to support these facts are the management of Chartered, including James Christian, Frenchie Smith, James Paran Dale and Dr. Orr, as well as Chartered's external actuaries.

B. Dental

Chartered had the most extensive dental provider network of all the HMOs and as such a disproportionately higher number of members and their families chose Chartered as their health plan. The rates paid to dental providers were set by DHCF and even though DHCF later relinquished the right to renegotiate the mandated rate, Chartered could not lower the dental rate because of the *Salazar* court requirements. Also, because DHCF had previously published the mandated dental rate schedule, this caused the dental providers to refuse to renegotiate the major dental rates to a lower rate schedule. In essence, DHCF and the *Salazar* court tied Chartered's

hands on the dental rates paid to provider. The previous claim submitted for excess mandated dental services was through April 30, 2009. The higher rates, however, were not limited to that period and, as such, the DHCF court-mandated dental costs incurred by Chartered (including the costs to administer the dental program) above the rate granted by DHCF should be calculated and a retrospective claim filed to reimburse Chartered for the actual excess dental costs incurred from May 1, 2009 to April 30, 2013.

DCHSI suggests that the individuals with the best knowledge to support these facts are James Christian, Frenchie Smith and Robert Watkins (Chartered's former COO).

C. Additional Grounds

The Rehabilitator has access to Chartered's financial claims data and Chartered's management personnel to compile the amount due from May 1, 2012 to April 30, 2013 for the benefits that were required to be provided under the DHCF Contract. The claim should not be limited to the period ending April 30, 2012.

II. The Alliance Claim

As previously stated, the Alliance Claim filed by the Rehabilitator understates the amount due to Chartered because it only covers the period of July 2010 to July 2011. Given the high level of chronic illness of the Alliance population and the fact that Chartered has the MLR and administrative costs for the Alliance program, the Rehabilitator should analyze the actual MLR incurred and compare it to the premium amount DHCF actually paid and submit a claim for the differential for the contract periods prior to July 2010 and after July 2011 to April 30, 2013.

DCHSI suggests that the individuals with the best knowledge to support this claim are James Christian and Robert Watkins.

III. The United Medical Center Mandated Cost Increases

As previously stated, the rates paid by Chartered to United Medical Center ("UMC") were imposed by the District's Attorney General Peter Nickels and Council member David Catania and the data for this claim is readily available in Chartered's claims database and various analyses prepared by James Christian. Chartered was compelled to pay the increased rates, but also was free to pass those increased costs on to the District. As the documentation should be readily available to the Rehabilitator, the unpaid differential also can be readily calculated. This analysis should be done and the retrospective claim submitted for these mandated increased costs for the period March 18, 2008 to July 27, 2008 and for the contract period after July 2008.

DCHSI suggests that the individuals with the best knowledge to support this claim are James Christian and Robert Watkins.

IV. Unpaid Medicaid Premiums Due to Chartered

The amount for this claim was previously computed by Mr. Summete of Chartered (for members covered by Chartered for which no premiums were paid by DHCF) and an invoice was submitted to DHCF. The amount due for this claim and the supporting calculations should be readily available at Chartered.

V. Premium Tax/Administrative Expenses

The claim for these amounts can be readily computed by comparing the premium taxes and administrative expenses set forth in Chartered's financial statements to the amount included by Mercer within the actuarial rates for such expenses. The actual premium tax/administrative expenses were greater than what were reimbursed. Chartered has done an analysis showing that the premium tax was funded by a reduction by DHCF of the percentage allocated for administrative costs. As such, DHCF never properly funded the premium tax cost, but instead increased the administrative requirements beyond what was provided in the contract, while reducing the administrative cost percentage to cover the unfunded premium tax. This violated the contract, and the District should pay the appropriate allocation for both administrative expenses and the premium tax. This claim should be calculated for each of the last four contract years.

DCHSI suggests that the individuals with the best knowledge to support this claim are Frenchie Smith and Chartered's finance staff, who should have the data on all the additional contractual requirements/conditions imposed on Chartered by DHCF that escalated Chartered's administrative costs above the administrative percentage allocated by Mercer.

* * *

As we sated on our April 11 letter, the interests of DCHSI and Chartered should be fully aligned concerning the collection of all amounts owed to Chartered by the District. We look forward to your response.

Very truly yours,

David Killalea

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July 12, 2013 ***BY EMAIL***

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David K. Herzog
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Indianapolis, Indiana 46204

Re: D.C. Chartered Health Plan Fifth Status Report and Claims Against the District of Columbia

Dear Charlie and David:

On behalf of DCHSI, we write further to the parties' prior correspondence of April 11, April 19 and May 23, 2013 concerning Chartered's potential additional claims against the District, as well as the statements in the Fifth Status Report concerning the potential settlement of those claims.

DCHSI previously explained that Chartered has additional claims to pursue against the District not included within the approximately $60 million (plus interest) claimed to date. You have not substantively responded to our inquiries about the Rehabilitator's consideration of such additional claims. At a bare minimum, the Rehabilitator admits in the Fifth Status Report that the current claims cut off as of March 31, 2012; that leaves a minimum of one more full year of underpayments from the District to Chartered that are not included in the pending claims, in addition to the other underpayments discussed in our letters of April 11 and May 23. As it stands, you have not revealed any information about what claims are being settled, what compromises are being made, and the basis for any compromises. One question will be how the proposed compromise compares to the value recovered by United Healthcare on its similar claim, on which it evidently is recovering over 80%. Given the nature of these disputes – as we have pointed out, the District, through the Rehabilitator, now controls Chartered and also is Chartered's creditor, transparency is critically important.

The Rehabilitator has a duty to all creditors and parties in interest, including DCHSI as the holder of any and all residual interest in Chartered, to recover the claim against the District to

the maximum extent reasonably practical. The Rehabilitator acknowledged in his First Status Report his duty to "preserve any residual value for Chartered's shareholder." That includes, at a minimum, asserting the full extent of the claims, vigorously pursuing the maximum recovery and, in the event of settlement, reaching the fullest possible settlement and not releasing claims that have not even been asserted. Given DCHSI's strong interest in having the fullest possible value on the claims recovered – which interest the Rehabilitator should share – DCHSI renews its request that the Rehabilitator respond substantively concerning its evaluation of the additional potential claims against the District. DCHSI submits that it will be far more efficient and effective to exchange information voluntarily in advance than to have to do so in the context of litigation over the settlement once an approval motion is filed. Among other things, such cooperation has the potential for reducing expensive litigation if the Rehabilitator in fact has acted prudently and in the best interests of Chartered's creditors and parties in interest.

We also note that reinsurance receivables or recoveries are listed as an asset. It is possible that reinsurance remains available to Chartered, and we would appreciate your clarification as to whether all reinsurance claims are being pursued vigorously..

Very truly yours,

/s/

David Killalea

EXHIBIT 4

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

April 4, 2011

To: Mayor Vincent Gray

From: Wayne Turnage

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

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

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

Issues of Concern at DHCF

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

F

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

Presentation for the:

District Council

Department of Health Care Finance

June 24, 2011
Washington DC

Presentation Outline

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

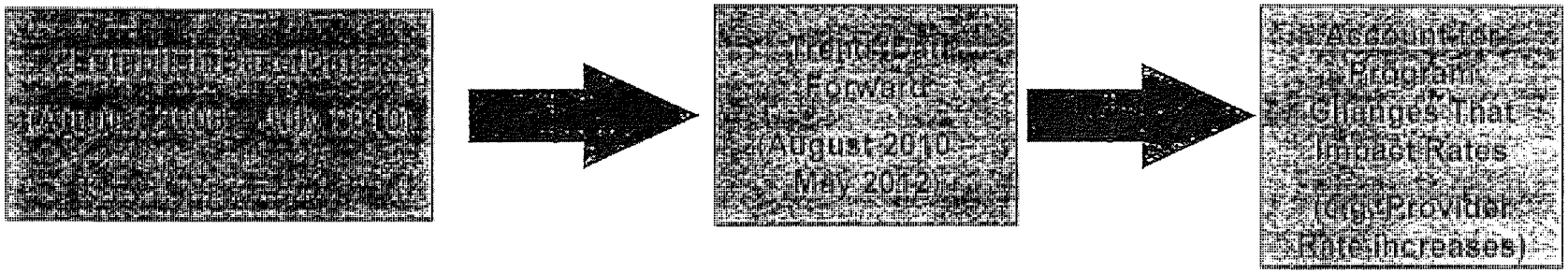
DHCF's Managed Care Program Governed By Federal Regulations

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

- Medicaid managed care governed by federal regulations
  - Rates must be actuarially sound, developed by a credentialed actuary – we use Mercer Consulting – and certified by CMS
  - Rates must be appropriate for covered populations and benefit package
  - Uncertified rates are not eligible for federal match

- Alliance program does not need federal approval
  - Actuarial soundness is not a requirement
  - Failure to establish actuarial sound rates will produce losses

How Managed Care Rates Are Set



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

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

DHCF Selects From Range and Starts Negotiations With MCOs

Presentation Outline

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

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

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

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

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

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

Presentation Outline

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

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

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

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

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

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

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

Presentation Outline

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

Factors Impacting Additional Local Cost Estimate For Managed Care Rates

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

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

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

EXHIBIT 5

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

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

Petitioner,

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No. 2012-8227
Judge Melvin R. Wright
Next Event: Status Hearing
August 21, 2013 at 9:30 a.m.

DCHSI'S REQUEST FOR PRODUCTION OF DOCUMENTS

Pursuant to Rules 26 and 34 of the District of Columbia Superior Court Rules of Civil Procedure ("DCRCP"), D.C. Healthcare Systems, Inc. ("DCHSI"), by counsel, request that D.C. Chartered Health Plan, Inc. ("Chartered") and its Rehabilitator produce the documents specified below, within thirty (30) days of service, to DCHSI's counsel, David Killalea, 700 12th Street, N.W., Suite 1100, Washington, D.C. 20005. The production of documents in response to these requests shall be in accordance with the Instructions and Definitions set forth below and District of Columbia Superior Court Rule of Civil Procedure 34.

INSTRUCTIONS AND DEFINITIONS

(a) "Chartered" means D.C. Chartered Health Plan, Inc., and shall include its current and former officers, directors, employees, agents, attorneys, consultants, experts, and other representatives.

(b) "Claims" means any and all claims, demands and causes of action that Chartered has, may have, or had, whether asserted or unasserted, against the District of Columbia and/or its current and former officials relating to the District of Columbia Medicaid and/or Alliance programs and the DHCF Contract.

(c) "CMS" means the Center for Medicaid and Medicare Services.

(d) "DHCF Contract" means that Contract DCHC-2008-D-5052 between Chartered and the District of Columbia Office of Contracting and Procurement on behalf of the District of Columbia Department of Health Care Finance concerning the provision of healthcare services under the Medicaid program and the Alliance program that was in effect from on or about May 1, 2008 through April 30, 2013.

(e) "Document" means all materials within the scope of DCRCP 34, including: all writings and recordings, including the originals and non-identical copies, whether different from the original by reason of any notation made on such copies or otherwise (including emails, correspondence, memoranda, notes, minutes, statistics, letters, contracts, reports, studies, statements, offers, notations of any conversations, graphic representations of any kind, electronic, magnetic or optical or electrical records of any kind, and any attachments to any of the above).

(f) "Person" means any natural person and entity, and shall include any and all of such person's principals, employees, agents, attorneys, consultants, and other representatives.

(g) "Rehabilitator" means the Commissioner of the District of Columbia Department of Insurance, Securities and Banking, and any of his current or former deputies, employees, agents, attorneys, consultants, experts, or other representatives that have any connection to or involvement with Chartered's rehabilitation proceeding, including Daniel Watkins and all attorneys, actuaries, accountants and others retained by him or on his behalf.

(h) "Settlement Agreement" means the proposed Settlement Agreement and Release between Chartered and the District of Columbia, executed on July 22, 2013.

DOCUMENT REQUESTS

Document Request No. 1: All documents referring, relating to or constituting communications between or among any of the Rehabilitator, Chartered, the Department of Health Care Finance and/or any other agent of the District of Columbia concerning the Claims and/or the Settlement Agreement, including all negotiations, offers and counteroffers concerning the Claims.

Document Request No. 2: All documents that the Rehabilitator and/or Chartered reviewed in connection with its evaluation of the Claims, the negotiation of the Settlement Agreement, or its consideration of whether to enter into the Settlement Agreement, including reports or analyses by Towers Watson, actuaries, accountants and other professionals.

Document Request No. 3: All documents on which the Rehabilitator and/or Chartered relied in negotiating and/or determining to execute the Settlement Agreement, including reports or analyses by Towers Watson, actuaries, accountants and other professionals.

Document Request No. 4: All documents referring or relating to the value of the Claims.

Document Request No. 5: All documents referring or relating to any defense or other opposing position taken by the District of Columbia in connection with any Claim at any time.

Document Request No. 6: All documents referring or relating to the decision to divide the proposed settlement payment between the $18 million "Part I" payment the $30 million "Part II" payment in the Settlement Agreement, including communications with CMS.

Document Request No. 7: A copy of the databases maintained by the District of Columbia and Chartered of disputed and undisputed provider claims from 2008 through 2013, whether for mental health claims, dental claims, pharmacy claims or otherwise, including encounter data, and any documents concerning reconciliation of provider billings and payments.

Document Request No. 8: Chartered's provider contracts in effect from 2008 through 2013.

Document Request No. 9: All documents relating to Mercer's setting of reimbursement or payment rates relating to Chartered for each year from 2008 through 2013, including communications between or among any of Chartered, the District of Columbia, Mercer and CMS.

Document Request No. 10: All documents referring or relating to or constituting payment or rate negotiations with providers concerning Chartered from 2010 through 2013.

Document Request No. 11: Working papers supporting the premium deficiency reserve noted in Chartered's financial reports as of March 31, 2013 and any documentation relating to subsequent changes to that reserve.

Document Request No. 12: Documents reflecting the District of Columbia's analysis of disease acuity relating to Chartered from 2008 through 2013.

Document Request No. 13: All documents relied on in preparing your responses to DCHSI's Interrogatories to Chartered and the Rehabilitator.

Dated: August 8, 2013 _____/s/_____

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Counsel for DCHSI

CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of August, 2013, a copy of the foregoing was served by email upon:

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_____*/s/*_____
David Killalea
Counsel to DCHSI

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CIVIL DIVISION

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

Petitioner,

v.

D.C. CHARTERED HEALTH PLAN, INC.,

Respondent.

Civil Action No. 2012-8227
Judge Melvin R. Wright
Next Event: Status Hearing
August 21, 2013 at 9:30 a.m.

DCHSI'S INTERROGATORIES TO CHARTERED AND THE REHABILITATOR

Pursuant to Rules 26 and 33 of the District of Columbia Superior Court Rules of Civil Procedure ("DCRCP"), D.C. Healthcare Systems, Inc. ("DCHSI"), by counsel, request that D.C. Chartered Health Plan, Inc. ("Chartered") and its Rehabilitator respond under oath to the interrogatories specified below, within thirty (30) days of service, to DCHSI's counsel, David Killalea, 700 12th Street, N.W., Suite 1100, Washington, D.C. 20005. These Interrogatories shall be answered in accordance with the Instructions and Definitions set forth below and District of Columbia Superior Court Rule of Civil Procedure 33.

INSTRUCTIONS AND DEFINITIONS

(a) "Chartered" means D.C. Chartered Health Plan, Inc., and shall include its current and former officers, directors, employees, agents, attorneys, consultants, experts, and other representatives.

(b) "Claim" means each claim, demand or cause of action that Chartered has, may have, or had, whether asserted or unasserted, against the District of Columbia and/or its current and former officials relating to the District of Columbia Medicaid and/or Alliance programs and/or the DHCF Contract.

(c) "DHCF Contract" means that Contract DCHC-2008-D-5052 between Chartered and the District of Columbia Office of Contracting and Procurement on behalf of the District of

Columbia Department of Health Care Finance concerning the provision of healthcare services under the Medicaid program and the Alliance program that was in effect from on or about May 1, 2008 through April 30, 2013.

(d) "Document" means all materials within the scope of DCRCP 34, including: all writings and recordings, including the originals and non-identical copies, whether different from the original by reason of any notation made on such copies or otherwise (including emails, correspondence, memoranda, notes, minutes, statistics, letters, contracts, reports, studies, statements, offers, notations of any conversations, graphic representations of any kind, electronic, magnetic or optical or electrical records of any kind, and any attachments to any of the above).

(e) "Person" means any natural person and entity, and shall include any and all of such person's principals, employees, agents, attorneys, consultants, and other representatives.

(f) "Rehabilitator" means the Commissioner of the District of Columbia Department of Insurance, Securities and Banking, and any of his current or former deputies, employees, agents, attorneys, consultants, experts, or other representatives that have any connection to or involvement with Chartered's rehabilitation proceeding, including Daniel Watkins and all attorneys, actuaries, accountants and others retained by him or on his behalf.

(g) "Settlement Agreement" means the proposed Settlement Agreement and Release between Chartered and the District of Columbia, executed on July 22, 2013.

INTERROGATORIES

Interrogatory No. 1: Identify all persons who participated in any discussions or negotiations at any time concerning the resolution of the Claims.

Interrogatory No. 2: Identify the date and location of each in person or telephonic meeting at any time during which the Claims were discussed or negotiated with the District of Columbia and the participants at each such meeting.

Interrogatory No. 3: Identify each and every Claim that you believe Chartered may have against the District of Columbia, and the value of each such Claim.

Interrogatory No. 4: Identify each and every Claim that you believe Chartered may have against the District of Columbia that you determined not to pursue by way of a formal demand for payment through the DCHF Contract process, and the value of each such Claim.

Interrogatory No. 5: Identify any Claim that you believe Chartered may have against the District of Columbia that you did not present or raise in any manner to the District of Columbia, and the value of each such Claim.

Interrogatory No. 6: Identify each and every Claim that you believe Chartered would be releasing under the Settlement Agreement if it becomes effective, and the value of each such Claim.

Interrogatory No. 7: With respect to each Claim identified in your answer to Interrogatory Nos. 3 through 6, identify all defenses that at any time were raised or brought to your attention by the District of Columbia, the date and manner you became aware of the defense, and the date and place of any discussions of such defense, including the persons involved.

Interrogatory No. 8: With respect to each defense identified in response to Interrogatory No. 7, identify each response you made to the District of Columbia countering or responding to any such proffered defense, any communications or assessments you made concerning such alleged defenses, and any further responses by the District of Columbia, including the date and place of the communications and the persons involved.

Interrogatory No. 9: Identify all actions you took in response to the letters from counsel to DCHSI dated April 11, 2013, May 23, 2013, and July 12, 2013, concerning Claims that neither Chartered nor the Rehabilitator had asserted against the District of Columbia.

Interrogatory No. 10: Identify each person who assisted in the preparation of your responses to these Interrogatories and to DCHSI's Request for Production of Documents.

Dated: August 8, 2013 _____/s/_____

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Counsel for DCHSI

CERTIFICATE OF SERVICE

I hereby certify that on this 8th day of August, 2013, a copy of the foregoing was served by email upon:

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