

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance



MEDICAID MANAGED CARE

PERFORMANCE REPORT

(January - December 2020)

January 13, 2022

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I. EXECUTIVE SUMMARY

A. BACKGROUND

The District of Columbia's (DC) Department of Health Care Finance's (DHCF) managed care program is the largest single expenditure in the agency's budget consisting of the District of Columbia Healthy Families Program (DCHFP) which covers individuals who meet the eligibility requirements for the District's Temporary Assistance for Needy Families (TANF) program as well as the Children's Health Insurance Program (CHIP)-funded Medicaid and children eligible for the Immigrant Children's Program (ICP)¹. The managed care program also includes the Alliance program which covers individuals with incomes at or below 200% of the federal poverty level and who are ineligible for Medicaid. Historically, eligible Medicaid adults were able to opt-out of managed care and receive coverage through DHCF's fee-for-service (FFS) program. To support DHCF's efforts to implement a more comprehensive managed care program, effective October 1, 2020, the DCHFP became mandatory through DHCF's contract procurement of the managed care contracts in Fiscal Year (FY) 2021. Additionally, non-dual Social Security Income (SSI) Adults ages 21+ were included in the program. The SSI Adult population has historically been covered through DHCF's FFS program.

As of December 2020, 225,901 Medicaid and ICP beneficiaries and 18,658 Alliance enrollees were assigned to one of the following Managed Care Organizations (MCOs)²:

- AmeriHealth Caritas DC (AmeriHealth)
- CareFirst BlueCross BlueShield Community Health Plan DC (CareFirst), formerly known as Trusted Health Plan³
- MedStar Family Choice, Inc. (MedStar)
- Health Services for Children with Special Needs (HSCSN)

Amerigroup DC, Inc. (Amerigroup) participated in the District's managed care program up through September 30, 2020 and exited the program with the start of the new FY 2021 managed care contracts effective October 1, 2020. Amerigroup's results of operations from January 1, 2020 through September 30, 2020 are included throughout this report. Correspondingly, MedStar entered the District's managed care program with the start of the new FY 2021 contracts. This report includes MedStar's results of operations for the first quarter of the FY 2021 contract (October 1, 2020 through December 31, 2020). All MCOs have continued to offer comprehensive benefits during calendar year 2020. Four of these MCOs – Amerigroup, AmeriHealth, CareFirst and MedStar – operated under full risk-based contracts while HSCSN operated under a risk sharing arrangement with the District.

¹ The DC Healthy Families Program (DCHFP) referenced throughout this report includes ICP for purposes of enrollment and expense results.

² In 2020, DHCF awarded contracts for the upcoming FY 2021 contract year for the three full risk-based MCOs. Two of the three MCOs, AmeriHealth and CareFirst, are returning MCOs, with one newly-awarded MCO, MedStar, and one exiting MCO, Amerigroup, as of October 2020.

³ CareFirst BlueCross BlueShield (CareFirst) purchased Trusted Health Plan (District of Columbia), Inc. (Trusted) in early 2020 and announced the new plan name of CareFirst BlueCross BlueShield Community Health Plan DC (CareFirst CHPDC). This report references CareFirst in the following exhibits and analysis for the corresponding reporting periods.

The District spent roughly \$1.2 billion⁴ on MCO services during 2020. Roughly 86% (\$1 billion) of this amount funded the full risk-based MCOs - Amerigroup, AmeriHealth, CareFirst and MedStar, while approximately 14% (\$170 million) funded the risk sharing contract with HSCSN. DHCF continually strives to improve the health and well-being of the residents of the District of Columbia, as described later in this report through the agency's vision, mission, values, and strategic priorities.

Following the award of the contracts for the three full risk-based plans in 2013, DHCF initiated the MCO performance review process as the first step towards reforming a troubled program. Prior to this award, DHCF's MCO program was hampered by ambiguous contract language, financially unstable providers, and de minimis reporting requirements that made it difficult to assess the performance of the plans. Accordingly, to coincide with the new five-year MCO contracts, DHCF initiated the comprehensive review process in 2014 to assess and evaluate the performance of its three full risk-based MCOs. In 2016, DHCF included the Child and Adolescent Supplemental Security Income Program (CASSIP), managed by HSCSN, as part of the MCO performance review.

B. MEDICAID PROGRAM VISION, MISSION, AND VALUES

DHCF continually strives to improve the health and well-being of the residents of the District of Columbia. This is evident through our vision, mission, values, and strategic priorities.

Vision: All residents in the District of Columbia have the supports and services they need to be actively engaged in their health and to thrive.

Mission: The Department of Health Care Finance works to improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services for residents of the District of Columbia.

Values:

1. Professionalism – Treating all recipients and community partners with respect and dignity
2. Accountability – Ensuring that the efficiencies built into the Medicaid managed care program are effective
3. Compassion – For those who are unable to afford comprehensive health insurance
4. Teamwork – Partnering with the community to address social determinants of health
5. Empathy – For those with chronic conditions and provide special incentives to providers to improve access to, and quality of care

⁴ Total Capitation Revenue excluding HIPF payments and DC Exchange/Premium tax revenue based on the MLR letters and calculations provided by the MCOs and summarized and reported by DHCF's actuaries. For HSCSN, capitation revenue excludes DC Exchange/Premium tax revenue and Risk Share amounts.

Strategic Priorities:

- Building a health system that provides whole person care
- Ensuring value and accountability
- Strengthening internal operational infrastructure

To help achieve our vision and mission, DHCF plans to move towards a fully managed care Medicaid program over the next five years. This move aims to transform the managed care program into a more organized, accountable, and person-centered system that best supports the District's Medicaid beneficiaries in managing and improving their health.

C. GOALS AND OBJECTIVES

There are three primary goals of DHCF's Medicaid Managed Care Performance Report:

- Evaluate the degree to which DHCF's full risk-based MCOs and the single risk sharing plan successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of health care services.
- Provide objective data on the performance of the MCOs across several domains to inform decision making about possible policy changes for the managed care program.
- Facilitate an assessment of each MCO to help guide oversight activities and prioritize areas for enhanced monitoring and corrective action.

This report illustrates the financial condition of the MCOs during calendar year 2020, which includes reporting on whether MCO revenues were sufficient to cover claims and operating costs while maintaining a minimum benchmark (85%) Medical Loss Ratio (MLR) for medical service costs and quality improvement expenses. Administrative functions are closely monitored by DHCF - timely claims processing, robust member encounter systems, and appropriate use of claims denial procedures - which DHCF tracks on a regular basis and which are reflected in subsequent sections of this report. This report includes quantitative and qualitative analysis of key service level utilization - primary care visits for both adult and children as well as inpatient admission rates - in addition to MCO performance with member care coordination via progress against established quality measures during the period under review.

D. KEY FINDINGS

FINANCIAL RESULTS

The full risk-based MCOs generally reported healthy financials for the calendar year 2020 review period. Each of the full risk-based MCOs reported risk-based capital (RBC) positions that are well above the required minimum level of 200%. The full risk-based MCOs posted operating margins ranging from roughly 1%-4% with ample reserves to meet incurred but not reported (IBNR) claims with liquid assets and alternative short-term investments. The one exception was for AmeriHealth and

CareFirst, which reported operating margins of roughly 1%, which falls short of the benchmark of 2-4% used by DHCF to evaluate financial strength for this metric. Please reference Section II of this report for more detail on the calculation of operating margin used throughout this report. All MCOs spent at or above the minimum level of premium revenue on medical and quality improvement costs as reflected in each MCO's MLR; however, as discussed later in this report the effects of the coronavirus 2019 (COVID-19) pandemic and managed care program expansion in late 2020, directly impacted medical service utilization and reported costs in 2020.

Beginning with the FY 2018 contract year, a disproportionate share of the high-acuity, high-cost population transitioned from the other full risk-based MCOs to AmeriHealth, leading to unforeseeable operating and financial challenges for AmeriHealth throughout 2018 and 2019. With the implementation of the new contracts in FY 2021 described earlier in this report, DHCF included a process to distribute members among the three MCOs in contract prior to the October 1, 2020 implementation. The new contracts included an open enrollment period through December 2020, during which MCO enrollees had the option to transfer to a different MCO. Additionally, DHCF included new requirements in the FY 2021 contracts – e.g., universal contracting for key providers – that were designed to help mitigate the adverse selection experienced by AmeriHealth in future contract years. Though AmeriHealth still has the highest per member per month (PMPM) costs for the DCHFP Adults, Child, and Alliance populations, with the implementation of monthly risk adjustment during the first quarter of the FY 2021 contract year AmeriHealth's net revenues increased while net claims decreased, resulting in an operating gain and healthy capital and liquidity levels for the calendar-year ending 2020 period.

Amerigroup and CareFirst reported operating profits in 2020, though overall growth in profits have slowed compared to 2019 levels due to the recent program expansion including the transition of the high-cost, high-acuity SSI Adult population from FFS to managed care in October 2020. CareFirst's expenses have risen relative to revenue, resulting in an MLR of 89% which was a 13% increase from 2019. CareFirst reported strong capital and liquidity levels, partially due to a significant capital contribution from their parent company to adjust for the program expansion with the new contracts. Amerigroup reported low reserves and liquidity levels, likely due to their exit from the program in October 2020. MedStar reported healthy reserves and capital levels during their first quarter under contract with the District. MedStar reported higher overall PMPM expenses than the other MCOs driven by the MCO's SSI Adult population, though still ended the period with an operating gain due to relatively low administrative costs. As noted earlier, DHCF risk adjusted the DCHFP base capitation rates monthly during the first quarter of the FY 2021 contract year, which is partially responsible for the fluctuations in revenue relative to expenses observed for the MCOs. Please note that the impacts of COVID-19 on service utilization and reported costs continued throughout the 2020 reporting period and may have artificially impacted reported costs including reserves for estimated future claims, included in this report.

The financial results for the District's risk-sharing MCO – HSCSN – contracted to manage the CASSIP program, are in healthy ranges for the 2020 annual review period. HSCSN continues to report decreases in PMPM medical costs across multiple medical service categories due to the continuing impacts of COVID-19 on service utilization, resulting in a significantly lower MLR when compared to

2019 levels. HSCSN reported healthy capital and liquidity levels, and a notable operating gain in 2020. Additional analysis of service categories and PMPM trends are discussed in Section IV of this report.

The key financial metrics referenced above are summarized in the table below, with more detailed discussion in Section II of this report.

MCO FINANCIAL CONDITION - CY 2020

Financial Metric	Amerigroup ¹	AmeriHealth	CareFirst	MedStar ²	HSCSN
Reserves for Estimated IBNR Claims (Months Claims)	0.4	2.8	4.6	2.1	2.2
Risk-based Capital	2104%	409%	1012%	389%	613%
Defensive Interval Ratio (Days)	7	129	214	157	56.8
Operating Margin/Loss (\$M)	\$5.7	\$3.7	\$1.5	\$4.0	\$7.1
Operating Margin/Loss Percentage	4%	0.6%	0.8%	4%	4%
Medical Loss Ratio	88%	91%	89%	92%	82%

Notes:

1. Amerigroup amounts represent nine months of operation from January 1, 2020 to September 30, 2020 as Amerigroup's contract with the District ended September 30, 2020.

2. MedStar began contracted services as of October 1, 2020. All results shown represent three months of operation from October 1, 2020 to December 31, 2020. MedStar's revenue and expense results are specific to the DC program for October 2020 through December 2020. MedStar's IBNR, RBC, and Defensive Interval results are based on the MCO's reported DISBs, which includes a full year of MedStar's Maryland line of business.

ADMINISTRATIVE PERFORMANCE

Four areas are typically evaluated to assess MCOs' administrative performance – adequacy of provider network, timely payment of claims, appropriate management of the claims adjudication process, and successful execution of an encounter system. Data from this analysis indicates the MCOs are, on balance, properly managing these significant responsibilities:

- The MCOs have maintained comprehensive and diverse provider networks to ensure access to a full range of services as well as robust systems to report patient encounters. However, some of the MCOs have historically struggled to contract with all District hospitals, which DHCF has attempted to address through universal contracting requirements for certain providers.
- All the MCOs exceeded the District's timely payment requirement for the period Jan 1, 2020 – Dec 31, 2020 ensuring the continuity of operations for their contracting providers.
- The overall claims denial rate for District MCOs in CY 2020 was 12.9%. The denial rate is calculated by dividing the count of claims with a final disposition of denied by the sum of all paid and denied non-prescription claims. CareFirst had the highest rate of denied claims with a 21.8% denial rate, followed by Amerigroup at 12.6%, AmeriHealth at 12.1%, MedStar at 8.3% and HSCSN at 4.2%.

Due to changes in the full risk-based MCO contract procurement, Amerigroup’s data represent January 1, 2020 to September 30, 2020 operations and MedStar’s data represent October 1, 2020 to December 31, 2020 operations. DHCF is currently working with the MCOs to improve the agency’s data exchange and update its methods for analyzing denied claims and the reasons for those denials.

MCO ADMINISTRATIVE PERFORMANCE - CY 2020

Administrative Metric	Amerigroup*	AmeriHealth	CareFirst	MedStar*	HSCSN
Acceptance rate for encounter submissions	95.7%	98.4%	95.1%	97.9%	99.6%
Claims paid within 30 days	99.5%	99.9%	99.3%	99.8%	98.8%
Claims denial rate	12.6%	12.1%	21.8%	8.3%	4.2%

Notes: Denial rate reflects claims with a final disposition of denied. * Due to changes in the full risk-based MCO contract procurement, Amerigroup’s data represent January 1, 2020 to September 30, 2020 operations and MedStar’s data represent October 1, 2020 to December 31, 2020 operations.

Source: DHCF analysis of MMIS and MCO-supplied data extracts.

MEDICAL COSTS AND UTILIZATION TRENDS

MEDICAL EXPENSES

All full risk-based MCOs spent above the required 85% of MCO revenue on medical expenses in 2020. Overall, a decline in PMPM expenses were experienced across the managed care program, driven by decreases to the DCHFP Child (29%) and Alliance (13%) populations when compared to 2019 levels. The residual effects of the COVID-19 pandemic on utilization of services continues to be the primary driver of declining medical service costs across the managed care program. The transition of the FFS opt-out and SSI Adult populations into managed care along with revised reimbursement levels for hospital and other services effective October 2020, offset some of the declines in PMPMs observed in the existing managed care program. For DHCF’s risk-sharing MCO – HSCSN, declining medical service costs continued throughout 2020, resulting in an overall drop in PMPMs of 9% from 2019 levels and historically low (82%) MLR for the MCO. HSCSN’s decline in medical service costs are driven by the impacts of COVID-19 on utilization of services, and PMPMs have not yet rebounded to pre-COVID-19 levels.

The reduction in PMPM cost for the Alliance program in 2020 is a notable change from the upward trend in costs over the past few years, including 3% growth in 2019 and 13% observed in 2018. Past Alliance spending growth was attributed primarily to the transition of pharmacy benefits into the managed care program in 2016. The Alliance population consists of slightly older individuals with more complex medical problems. This has driven increased spending in pharmacy, outpatient, and inpatient hospital costs over the past few years. Though PMPM costs for the Alliance program in 2020 are below levels observed in prior years, the impacts of COVID-19 and the inherent short runout period for this report results in a high degree of uncertainty for reported claims reserve estimates and future financial results may vary.

AmeriHealth’s total Alliance PMPM costs remain disproportionately higher than the other MCOs, driven primarily by the plan’s historically disproportionate share of Alliance enrollees and their use of inpatient, outpatient, and pharmacy services. In the past AmeriHealth has attributed this increase in pharmacy spend due to both pharmacy cost and utilization increases for specialty drugs. Specifically, oncology drugs are a major source of disparity for Alliance enrollees, with AmeriHealth spending roughly four times as much on a PMPM basis compared to the other MCOs.

With the start of the FY 2021 managed care contracts in October 2020, as noted previously DHCF transitioned new populations from FFS into managed care and included an open enrollment period during the first quarter of the contract year. To account for potential beneficiary movement between MCOs and impacts on incurred costs, DHCF developed MCO-specific risk scores and budget neutral risk-adjusted rates on a monthly basis during the first three months of the contract. Risk adjustment seeks to align each MCO’s risk as reflected in the disease prevalence of the enrolled population, with the incurred health care costs and associated payment for services provided to enrolled members. Effective October 2020, risk adjustment included the newly transitioned SSI Adult population and new and existing TANF populations, to account for varying levels of costs based on enrollment and acuity of the underlying MCO’s population.

The figure below illustrates the comparison of each MCO’s ranking on enrollee risk scores and their total medical costs, illustrating the distribution of risk and associated costs across the DCHFP program and MCOs. As illustrated below, there was some variation in alignment of risk and PMPM cost among the MCOs likely due to the transitioning of beneficiaries among the MCOs. In general, AmeriHealth’s populations generally exhibit greater risk and associated costs compared to the other MCOs, with CareFirst generally showing lower risk and costs and MedStar falling somewhere in between the other two MCOs. While risk adjustment improves the alignment of payment to projected cost, it does not capture all observed variation between MCO populations and utilization, and in particular does not currently apply to the Alliance program.

RANKING OF ENROLLEE RISK SCORE & MEDICAL COSTS

		Ranking on Enrollee Risk Scores		
		Low	Medium	High
Ranking on Medical Cost	Low	CareFirst - Child CareFirst – TANF Adult CareFirst – SSI Adult		
	Medium	MedStar – Child MedStar – TANF Adults		AmeriHealth – SSI Adult
	High		MedStar – SSI Adult	AmeriHealth – Child AmeriHealth – TANF Adult

Notes: Enrollee risk scores based off risk-adjustment study period of January 2019 - December 2019 and enrollment snapshot as of December 2020. Expenses incurred from January 1, 2020 to December 31, 2020 and paid as of January 31, 2021. IBNR is estimated based on historical payment lags.

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

MENTAL HEALTH SERVICE UTILIZATION

DHCF is currently undertaking a variety of transformation efforts related to behavioral health (BH) care services for both mental health and substance use disorders. These include the implementation of

a Section 1115 waiver that expands the array of BH services and providers covered under the Medicaid program, as well as planning for a future managed care carve-in of certain BH services now paid under fee-for-service (FFS). DHCF is working with a variety of stakeholders on these issues and in a future managed care report will provide data that aligns with related analyses currently under way.

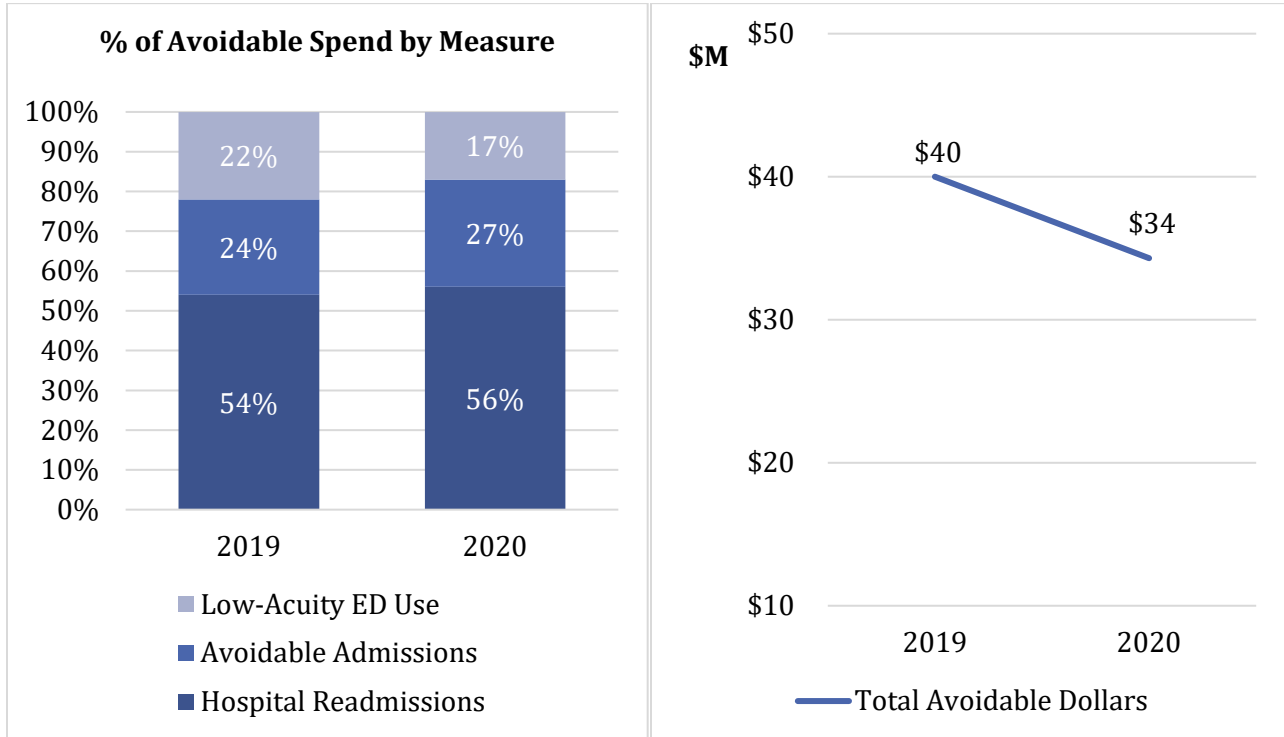
WELL-CHILD AND OTHER AMBULATORY CARE VISIT RATES

Well-child visit rates vary by plan and year. After holding relatively steady or increasing in recent years, the District experienced a large drop in well-child visits in FY 2020, with the MCO average falling from 71 percent in FY 2019 to 57 percent in FY 2020. The FY 2020 figures for individual MCOs ranged from 49% for Amerigroup to 65% for HSCSN. Based on the District's analysis of MCO encounter data, the drop coincides with the start of the COVID-19 pandemic, consistent with findings for other states. With regard to preventive and other ambulatory care for adults, visit rates also vary by plan and time period. Adult visit rates for MCOs overall decreased between 2015 and 2018, then remained steady in 2019. The overall rate for 2020 increased but is not directly comparable to earlier years due to the entry of MedStar, exit of Amerigroup, and MCO reassignments that occurred October 1, which reduced the number of beneficiaries meeting the 11-month enrollment threshold for calculation of the metric. See Section IV of this report for detailed information on MCO utilization rates and DHCF's strategies to oversee utilization of these services.

CARE COORDINATION

The historic care coordination challenges that plagued the District's three full risk-based MCOs have been well documented – members' use of the emergency room for routine care, the repeated occurrences of potentially avoidable hospital admissions, the problem of hospital readmissions – and remain stubborn challenges, but with some improvement. With CMS approval, DHCF implemented the MCO pay-for-performance (P4P) program in 2017. For the period reflecting 2020 reporting, the MCOs have spent approximately \$34 million on patient care that may have been avoided using more aggressive care coordination strategies. These amounts are notably below FY 2019 reported results as seen in the figure below which illustrates both the percentage of avoidable spend by utilization metric and total avoidable spend thus far in 2020 compared to 2019. Note, the data period representing 2020 and the reported results may have been impacted by COVID-19 similar to other utilization and expense metrics reported elsewhere in this report. DHCF will continue to work closely with the MCOs on identifying opportunities for continued improvement in implementing effective care coordination interventions in the future.

AVOIDABLE HOSPITALIZATION SPEND - 2019 TO 2020



Notes: Current annual (2020) results reflect data incurred October 2019 through September 2020 with payment runout through December 31, 2020, compared to FY 2019 (October 2018 through September 2019) results. Total avoidable costs include Health Home enrollees
 Source: Mercer analysis of MCO encounter data for DCHFP reported by the MCOs to DHCF.

When comparing the representative period for 2020 to the P4P baseline period, all three risk-based MCOs currently meet or surpass the target on all three quality measures. See Section V of this report for further details on MCOs performance on P4P metrics. Please note DHCF postponed the P4P withhold in FY 2020 due to changes in the payment rates for the MCOs; however, DHCF plans to reinstitute the withhold incentive in future years.

II. FINANCIAL PERFORMANCE

A. INTRODUCTION

DHCF focuses on four key metrics when evaluating the financial stability of MCOs:

- Medical Loss Ratio (MLR) – represents the portion of total revenue used by the MCOs to fund medical expenses, including expenses for cost containment.
- Administrative Loss Ratio (ALR) – represents the portion of total revenue used by the MCOs to fund both claims processing and general administrative expenses.
- Operating Margin (OM) – also referred to as profit margin and is defined as the sum of MLR and ALR subtracted from 100%. A positive OM indicates a financial gain while a negative indicates a loss. DHCF's actuary, Mercer Government Human Services Consulting (Mercer), established a benchmark for the operating margin needed to sustain a strong financial position is approximately 2-4% annually over a 3-5-year time horizon.
- Risk-based Capital (RBC) – represents a measure of the financial solvency of managed care plans and reflects the proportion of the required minimum capital that is maintained by a managed care plan as of the annual filing.

Traditional concerns that patient care is being sacrificed are often expressed when MCOs report significant operating margins. Accordingly, DHCF routinely tracks the MCOs' performance against a target minimum MLR of 85% for the full risk-based plans and an MLR target established during rate setting for the shared risk plan. MCOs that fall short of this standard face detailed scrutiny and possible financial penalties if warranted. MCOs can also artificially (and temporarily) inflate operating margins by repeatedly denying claims that should be paid. DHCF began monitoring denied claims in 2016 starting with CY 2015 denial rates. This report provides an analysis of CY 2020 denial rates only.

Assuming adequacy in the base capitated payment rate, there are typically three important factors that impact whether an MCO will experience positive operating margins:

- Risk-adjusted payment rates: Risk adjustment ensures financial viability and operational sustainability for MCOs whose membership represent a disproportionate share of high-acuity, high-cost beneficiaries. With DHCF's payment model, MCOs whose enrollees evince greater medical risk in the form of disease prevalence, receive higher risk scores and greater payments. MCOs with lower risk enrollees receive reduced rates. Thus, plans that properly align membership risk based on enrollee disease prevalence with utilization of appropriate services based on the acute needs of their population, can gain a considerable advantage over others that do not. For the FY 2020 contract year, risk adjustment was applied on a quarterly basis to the actuarially sound base capitation rates established during rate setting, transitioning to monthly risk adjustment with the start of the new FY 2021 contracts.
- Provider contract rates: Plans that negotiate contract rates that are adequate to build a solid network but lower than their competitors can realize significantly higher surpluses.

- Patient utilization management: Relative differences across plans in the degree to which their enrollees unnecessarily access high-end care as an alternative to less expensive treatment will drive variations in operating margins. In addition, differences in the application of medical necessity requirements may directly impact utilization and incurred costs observed between MCOs.

The table below reflects enrollment growth for both the DCHF and Alliance populations served by the full risk-based MCOs, as well as the CASSIP population enrolled in HSCSN, from December 2019 to December 2020. As illustrated in the table below, enrollment shifts were substantial for the risk-based MCOs due to contract changes made at the start of FY 2021 (October 2020) discussed earlier in this report, and there was a moderate increase observed for HSCSN.

ENROLLMENT GROWTH – DECEMBER 2019 TO DECEMBER 2020

MCO	Enrollment December 2019	Enrollment December 2020	Net Change
Amerigroup*	46,938	0	-100.0%
AmeriHealth	125,296	104,439	-16.6%
CareFirst	34,985	67,745	93.6%
MedStar*	0	67,319	NA
HSCSN	5,013	5,056	0.9%
Total Full Risk-Based MCOs	207,219	239,503	15.6%
Total MCOs	212,232	244,559	15.2%

Notes: Full risk-based MCOs enrollment results reflect both DCHF and Alliance populations. HSCSN's results reflect enrollment for the CASSIP population for the referenced reporting period. *Amerigroup ceased contracted services as of September 30, 2020. MedStar began contracted services as of October 1, 2020.

Source: Enrollment data extracted from DCHF's Medicaid Management Information System (MMIS) on April 27, 2021.

The table below illustrates the total revenue, medical and administrative costs, and operating margin for each of the MCOs as of December 2020. DCHF reports total capitation revenue by excluding Health Insurance Providers Fee (HIPF) payments and DC Exchange/Premium tax revenue based on the MLR letters and calculations provided by the MCOs. For HSCSN, capitation revenue excludes DC Exchange/Premium tax revenue and risk share amounts. Total incurred claims (including IBNR) and cost containment expenses as of December 31, 2020, net of reinsurance recoveries, are included in the calculation of MLR. Administrative expenses include all claims adjustment expenses as reported in quarterly filings to the Department of Insurance, Securities and Banking (DISB), excluding cost containment expenses and DC Exchange/Premium taxes as reported in MLR report and calculations provided by the MCOs. For HSCSN, administrative expenses are reported based on MCO submitted balance sheet and income statement. Operating margin is derived by subtracting net claims and administrative costs from MCO revenue.

AmeriHealth's revenue increased relative to the prior year, and net claims decreased, resulting in reductions in the MCO's MLR and a reported operating profit in 2020. CareFirst experienced increased expenses relative to revenues due to the program expansion, offset by a decrease in administrative expenses, which resulted in an operating gain for the MCO. MedStar reported a notable operating gain

in the first three months under contract with DHCF, driven by low administrative costs relative to revenues. All MCOs are reporting operating profits for 2020, undoubtedly driven at least in part by the impacts of COVID-19 on medical service utilization and offset by the impact of the DCHFP program expansion and risk adjusted rates during the last quarter of CY 2020.

MCO REVENUE AND EXPENSE DATA - CY 2020

MCO	Revenue	Claims	Administrative Cost	Operating Margin (Loss)
Amerigroup ¹	\$129.4M	\$113.5M	\$10.2M	\$5.7M
AmeriHealth	\$586.1M	\$531.4M	\$51M	\$3.7M
CareFirst	\$192.4M	\$171.2M	\$19.7M	\$1.5M
MedStar ²	\$97.7M	\$90M	\$3.7M	\$4M
HSCSN	\$170.1M	\$139.6M	\$23.4M	\$7.1M

Notes:

1. Amerigroup amounts represent nine months of operation from January 1, 2020 to September 30, 2020 as Amerigroup's contract with the District ended September 30, 2020.

2. MedStar began contracted services as of October 1, 2020. All results shown represent three months of operation from October 1, 2020 to December 31, 2020.

Source: MCO Annual Statement as of December 31, 2020 filed by the MCOs with the Department of Insurance, Securities, and Banking (DISB) and self-reported financials for HSCSN.

B. RISK-BASED CAPITAL

The MCO's Risk-based Capital (RBC) levels can be seen as a proxy for whether an MCO has the assets to pay claims and withstand the risks associated with a managed care contract. MCOs conduct this complicated calculation annually for each MCO using end-of-year financial data (as well as some information that is not publicly disclosed) that is provided to the Department of Insurance, Securities and Banking (DISB) for review. MCOs with RBC levels that fall below 200% face greater scrutiny from DISB and DHCF to ensure that they raise their capital level above the 200% RBC minimum threshold.

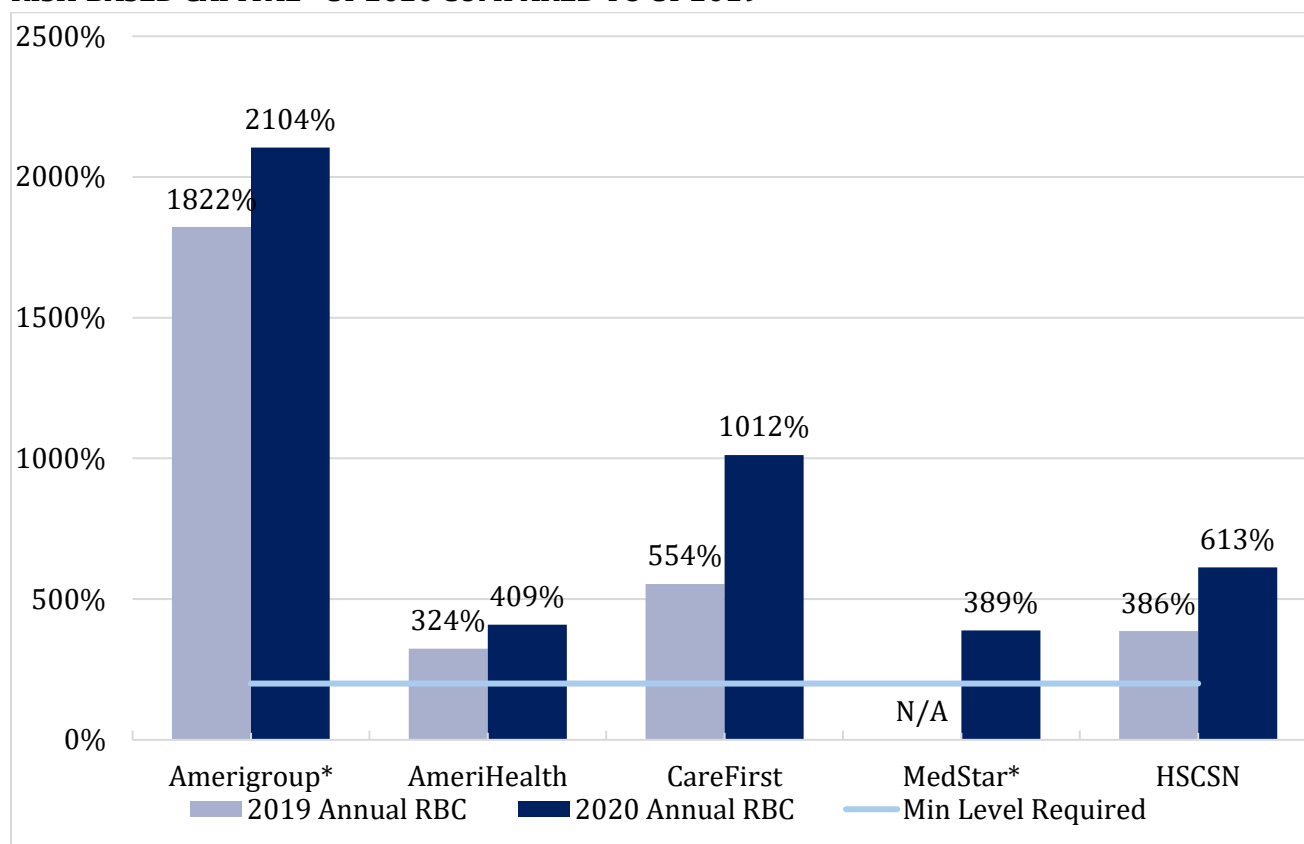
Based on the level of reported risk, the National Association of Insurance Commissioners (NAIC) indicates that several actions (described below) are available if warranted:

1. No action – Total Adjusted Capital of 200% or more of Authorized Control Level.
2. Company Action Level – Total Adjusted Capital of 150%-200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.
3. Regulatory Action Level – Total Adjusted Capital of 100%-150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems.

4. Authorized Control Level – Total Adjusted Capital 70%-100% of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.
5. Mandatory Control Level – Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

The figure below illustrates the results of the annual 2020 RBC for each MCO compared to the 2019 filings with DISB. Positive trends are indicated by results at or above the stated 200% threshold. As illustrated below, all MCOs maintained risk-based capital levels that exceeded recommended standards for the annual 2020 period, with increases in RBC across all applicable MCOs from 2019 levels. Note, the impacts of COVID-19 on service utilization and reductions in costs have likely resulted in greater realized profits and increased retained capital and reserves for the MCOs in 2020, as seen in the following exhibits below.

RISK-BASED CAPITAL - CY 2020 COMPARED TO CY 2019



Notes: HSCSN is not subject to DISB Risk-Based Capital reporting requirements for the period under review. The reported numbers are calculated and included in this report for monitoring and informational purposes. *Amerigroup amounts represent nine months of operation from January 1, 2020 to September 30, 2020 as Amerigroup’s contract with the District ended September 30, 2020.

MedStar began contracted services as of October 1, 2020. All results shown represent three months of operation from October 1, 2020 to December 31, 2020. MedStar’s IBNR, RBC, and Defensive Interval results are based on the MCO’s reported DISBs, which includes a full year of MedStar’s Maryland line of business.

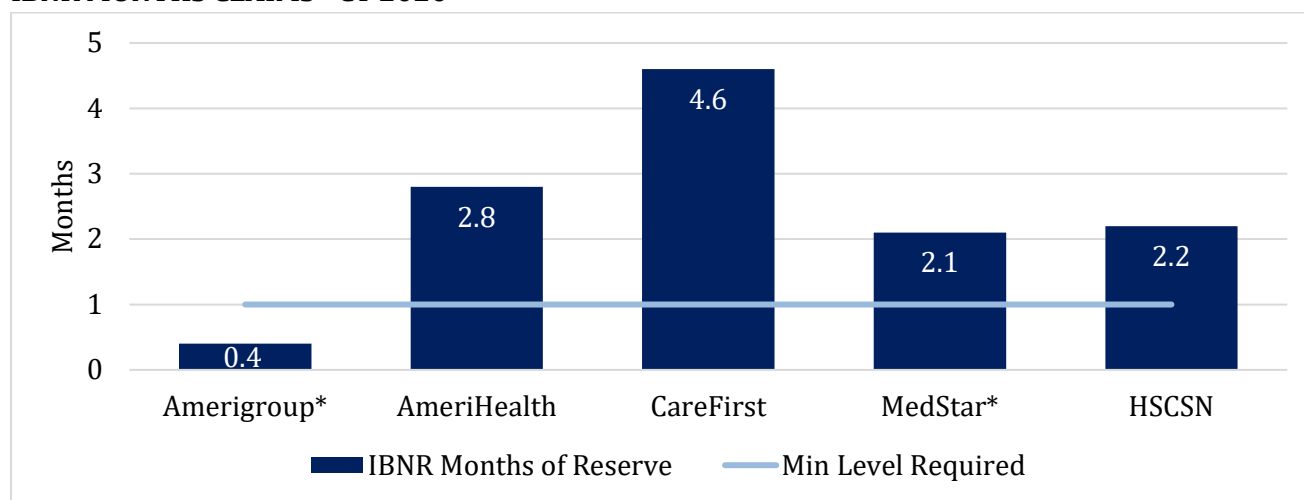
Source: Reported figures are from the full risk-based MCO’s annual 2019 and 2020 financial statements reported to DISB and self-reported financials for the shared risk MCO.

C. RESERVE AND LIQUIDITY METRICS

It is paramount in managed care that MCOs maintain a reserve to pay for services that have been provided but not yet reimbursed. This claims liability represents an accrued expense or short-term liability for the MCOs each month and MCOs that fail to build a sufficient reserve may not be able to pay claims when they eventually clear the billing pipeline. Typically, MCOs are expected to retain a reserve equal to between one to two months' worth of claims, depending on how quickly claims are processed.

The figure below illustrates the level of reserves MCO's have available to satisfy incurred but not reported claims (IBNR) for the CY 2020 Q1-Q4 reporting period.

IBNR MONTHS CLAIMS - CY 2020



Notes: Estimated number of months of reserves compared to average monthly incurred claims. *Amerigroup amounts represent nine months of operation from January 1, 2020 to September 30, 2020 as Amerigroup's contract with the District ended September 30, 2020.

MedStar began contracted services as of October 1, 2020. All results shown represent three months of operation from October 1, 2020 to December 31, 2020. MedStar's IBNR, RBC, and Defensive Interval results are based on the MCO's reported DISBs, which includes a full year of MedStar's Maryland line of business.

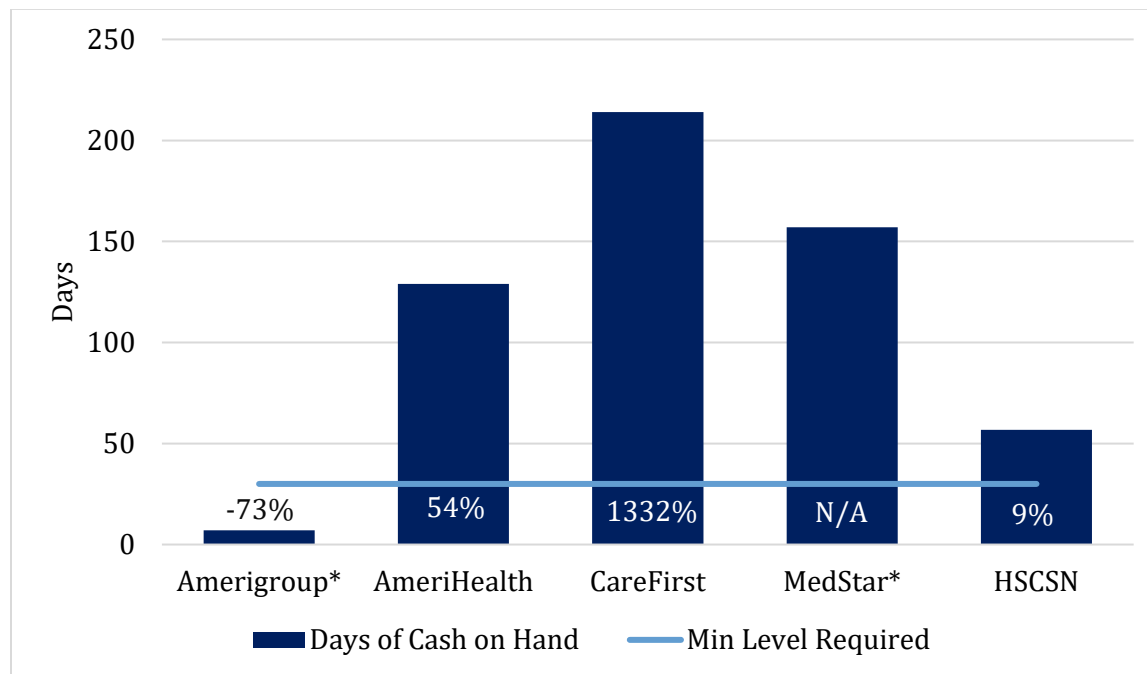
Source: IBNR is based on amounts reported on the MCO's annual filings for the three full risk-based plans and self-reported financials for the shared risk plan.

Based on the results illustrated in the figure above, all MCOs except for Amerigroup have a sufficient number of months in reserve for estimated incurred but not reported claims. Amerigroup's drop in reserves was expected due to the ending of their contract with the District in September 2020. Both AmeriHealth and CareFirst increased their IBNR reserves compared to historical levels, likely due to the expansion of the program and uncertainty of future costs correlated with the transitioning FFS populations with the start of the new managed care contracts in FY 2021. These IBNR estimates may impact other financial results reported in the following sections of this report.

The figure below illustrates the level of liquidity for each MCO, by reporting on the number of days the MCOs can operate without accessing long-term assets for the annual 2020 period, along with trends (percentages included in the table below) when comparing to 2019 levels. This is described as a Defensive Interval Ratio (DIR) which is, in essence, a liquidity measure – the degree to which the MCOs can survive on liquid assets without having to access long-term assets. DDCF derives the liquidity metric by taking the cash, cash equivalents and short-term investments as reported in the MCOs DISB

submissions, or balance sheet and income statement for HSCSN, divided by total daily operating expenses. DHCF uses the NAIC's definition of cash, cash equivalents and short-term investments which aligns with the reported line items included in the statutory filings based on statutory accounting principles.

DEFENSIVE INTERVAL RATIO - CY 2020 AND TRENDS



Notes: *Amerigroup amounts represent nine months of operation from January 1, 2020 to September 30, 2020 as Amerigroup's contract with the District ended September 30, 2020. MedStar began contracted services as of October 1, 2020. All results shown represent three months of operation from October 1, 2020 to December 31, 2020. MedStar's IBNR, RBC, and Defensive Interval results are based on the MCO's reported DISBs, which includes a full year of MedStar's Maryland line of business.

Source: Mercer calculated the Defensive Interval Ratio as cash, cash equivalents, and short-term investments divided by daily operating expenses for the period from January to December 2020.

All MCOs, except Amerigroup, met the standard liquidity benchmark for the annual 2020 period, based on the formula used for this report to calculate the cash, cash equivalents, and short-term investments component of the Defensive Interval Ratio. As noted previously, Amerigroup exited the program in September 2020 and correspondingly moved a large portion of cash into bonds which likely impacted their reported results.

III. ADMINISTRATIVE PERFORMANCE

A. INTRODUCTION

There are several administrative requirements which are critical to the successful operation of MCOs. As a part of its core mission, MCOs must accomplish the following:

1. Build an adequate network of providers and pay health care claims to service providers on time and through an electronic claims process with documentation to facilitate reconciliation of payments.
2. Create an accurate electronic record of all patient health care encounters and transmit the files containing this information to DHCF with a minimal error rate.
3. Establish a system of care management and care coordination to identify MCO enrollees with special or chronic health care issues and ensure that these enrollees each receives access to appropriate care, while managing the delivery of health care services for all enrollees.

Certain contractual requirements exist to ensure adequate health care provider networks exist, which DHCF continually monitors for compliance by each MCO. The five-year MCO contracts contain specific provisions to ensure Medicaid and Alliance enrollees have reasonable access to care – primary care physician-to-enrollee ratios, number of hospitals that specialize in pediatric care, pharmacy, and laboratory accessibility standards, etc. – which are outlined in detail in the managed care contracts.

B. ENCOUNTER DATA

DHCF monitors encounter submissions from MCOs to the agency's Medicaid Management Information System (MMIS), and tracks number of recorded encounters and the accuracy of encounter submissions to the agency's MMIS. As seen in the table below, all MCOs met or exceeded the DHCF established target of 95% acceptance rate, thus continuing to maintain accurate encounter data file submissions for the CY 2020 reporting period. DHCF continues to work closely with the MCOs to enhance their internal encounter reporting and oversight processes to improve encounter submissions for accuracy and completeness.

NUMBER OF RECORDED ENCOUNTERS AND ACCURACY RATE - CY 2020

MCO	Total Submitted Encounters*	Acceptance Rate of Encounter Submissions
Amerigroup	317,797	95.7%
AmeriHealth	1,355,773	98.4%
CareFirst	258,998	95.1%
MedStar	42,800	97.9%
HSCSN	345,131	99.6%

Notes: *Gross count can include originals, voids, and resubmissions. Reported numbers are currently abnormally high due to correction and resubmission of historical encounters to support the Federally Qualified Health Center (FQHC) Wrap process. The District expects this number to remain higher than normal for one to two more reporting periods. All MCOs Acceptance Rates are calculated based on submissions through the end of the CY 2020. Amerigroup and Medstar only include partial year data, (January 2020-September 2020 for Amerigroup; October 2020-December 2020 for Medstar).

Source: Department of Health Care Finance MMIS each month January through December 2020.

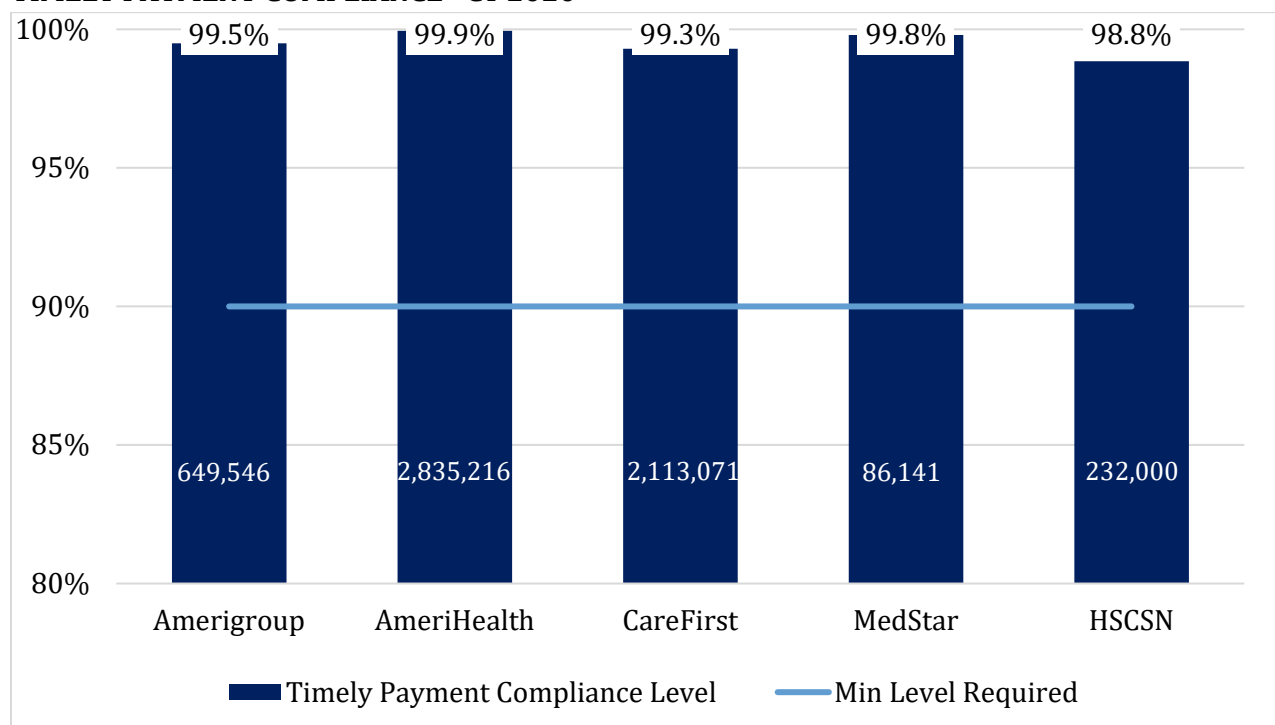
C. TIMELY PAYMENT OF CLAIMS

Timely payment of health care claims is a core requirement for the District's managed care plans. Claims processing is a central administrative function that MCOs must efficiently perform to avoid payment problems for providers. Through electronic claims processing, the District's managed care organizations are required to pay clean claims within 30 days to satisfy timely processing requirements. Like most MCOs, the District's MCOs utilize a series of automated edit checks on all claims submitted for payment by healthcare providers in the Medicaid and Alliance programs. Included among the numerous potential problems this system of edit checks is designed to eliminate are:

- Duplicate claims
- Payments to ineligible providers
- Payments for services delivered to non-eligible patients

DHCF monitors compliance with timeliness requirements by comparing the MCOs' submissions to a target goal of 90% compliance of payment of all clean claims, as part of regular oversight reporting from each contracted MCO. Compliance with the timeliness requirement is measured by calculating the lag between the date the MCO receives a clean provider claim, and the date of payment for that claim. As seen in the figure below, each MCO exceeded DHCF's timely payment requirement for the CY 2020 reporting period.

TIMELY PAYMENT COMPLIANCE - CY 2020



Notes: The 30-day timely payment requirement only applies to “clean claims” that meet the requirement for payment. Total adjudicated claims are included in the figure for each MCO. Due to changes in the full risk-based MCO contract procurement, Amerigroup’s data represent January 1, 2020 to September 30, 2020 operations and MedStar’s data represent October 1, 2020 to December 31, 2020 operations. Source: Data is self-reported by MCOs on the Department of Health Care Finance’s Claims Monthly Payment Report.

The District currently relies on MCO reporting of timely payment of their claims. Internal projects have begun to ingest the necessary data elements into DHCF’s MMIS to enable better validation of this core requirement internally, increase agency analytical capabilities, and reduce reliance on MCO provided data outside DHCF’s MMIS.

D. DENIED CLAIMS

Due to the fact that the District’s 30-day timely payment requirement does not apply to claims that are initially denied, some providers expressed concern that managed care plans were unjustifiably denying a high rate of claims as a cash management strategy. Such a practice would obviously violate the tenets of good faith claims processing, create significant revenue issues for some of the providers in the MCOs’ networks, and potentially cause access to care issues. As a result, DHCF has analyzed data on MCO denied claims for the past several years to monitor plan performance in this area.

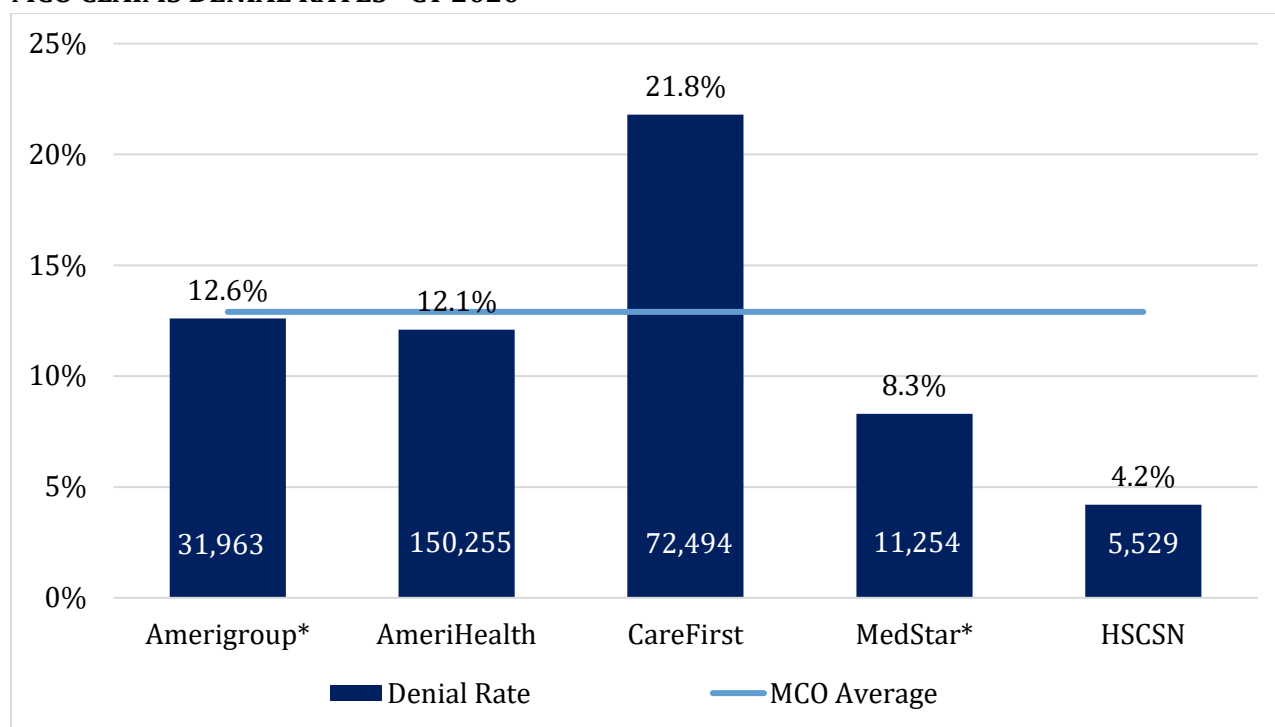
This report provides information on the incidence of CY 2020 managed care claims with a final disposition of denied. DHCF is currently working with the health plans to improve the agency’s data exchange and update its methods for analyzing denied claims and the reasons for denials.

METHODOLOGY

The key steps executed to obtain CY 2020 denial rates as reported in the figure below, were as follows:

- Using DHCF’s MMIS, all paid claims with dates of service during the report calendar year were extracted for each MCO.
- All MCO claims with a final disposition as “denied” and a date of service during the report calendar year were obtained directly from the District’s MCOs.
- Due to discrepancies in adjudication practices among MCO pharmacy benefit managers (PBMs), all pharmacy claims were excluded from both the paid and denied claims data sets.
- After removing all pharmacy claims, the denial rate was calculated as the number of claims with a final disposition of denied (numerator) divided by the sum of paid plus final disposition denied claims (denominator).

MCO CLAIMS DENIAL RATES - CY 2020



Note: Due to discrepancies in adjudication practices among the MCO’s pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims. Total number of denied claims are included in the figure for each MCO.

Source: Patient encounters with January 1-December 31, 2020 dates of service from DHCF’s MMIS system were merged with MCO files containing denied claims for the same period. *Due to changes in the full risk-based MCO contract procurement, Amerigroup’s data represent January 1, 2020 to September 30, 2020 operations and MedStar’s data represent October 1, 2020 to December 31, 2020 operations.

The overall claims denial rate for District MCOs in CY 2020 was 12.9%. CareFirst had the highest rate of denied claims with a 21.8% denial rate, followed by Amerigroup at 12.6%, AmeriHealth at 12.1%, MedStar at 8.3% and HSCSN at 4.2%. Due to changes in the full risk-based MCO contract procurement, Amerigroup’s data represent January 1, 2020 to September 30, 2020 operations and MedStar’s data represent October 1, 2020 to December 31, 2020 operations. DHCF is currently working with the health plans to improve the agency’s data exchange and update its methods for analyzing denied claims later paid and the reasons for denials, to augment future reporting including observed trends and underlying operational drivers for denials.

IV. MEDICAL SPENDING AND UTILIZATION TRENDS

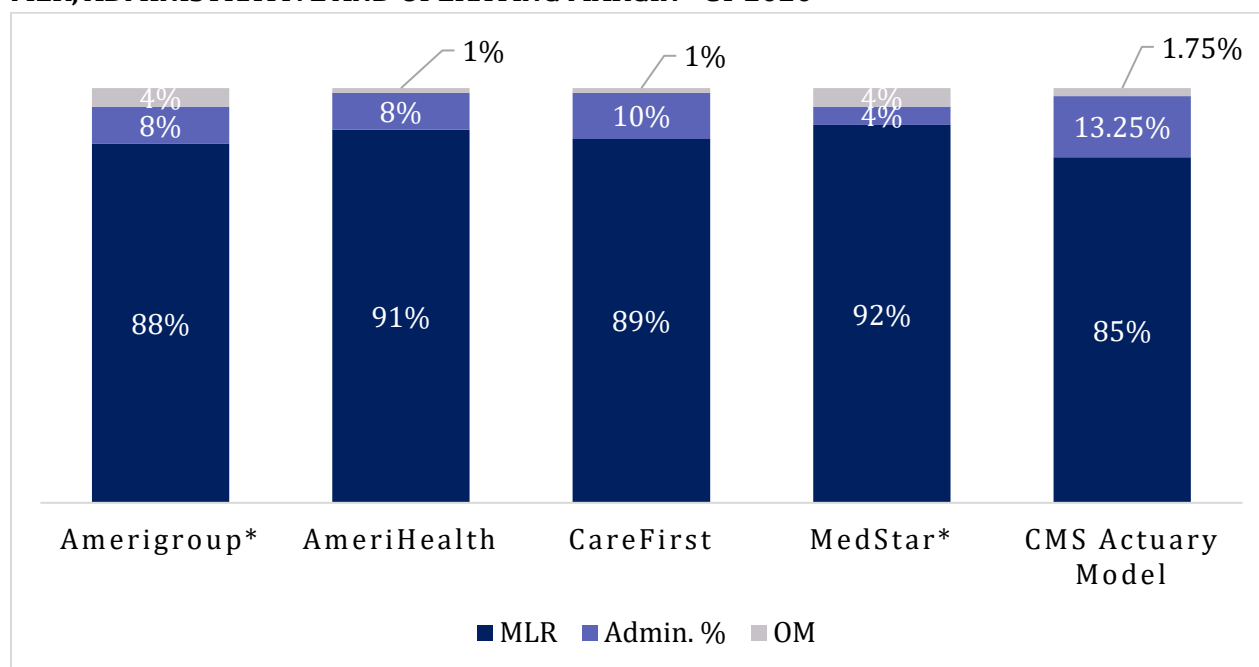
A. INTRODUCTION

This report provides an overview of the financial status of the MCOs during the current period under review, and the underlying medical service cost trends and utilization driving the financial results for the four MCOs.

FULL RISK MCOS

The figure below illustrates the portion of MCO revenue spent on medical service costs (MLR), administrative costs, and the portion of MCO revenue remaining as operating margin. For detailed information regarding calculation of MCO revenue, MLR and administrative costs, please see Section II of this report.

MLR, ADMINISTRATIVE AND OPERATING MARGIN - CY 2020



Notes: *Amerigroup amounts represent nine months of operation from January 1, 2020 to September 30, 2020 as Amerigroup's contract with the District ended September 30, 2020. MedStar began contracted services as of October 1, 2020. All results shown represent three months of operation from October 1, 2020 to December 31, 2020.

Source: MCO Annual Statements as of December 31, 2020 filed by the MCOs with the Department of Insurance, Securities, and Banking.

As illustrated in the above figure, all full risk-based MCOs posted operating profits for the 2020 calendar-year ending period, ranging from roughly 1%-4% of total premium revenue. All MCOs spent at or above the minimum level of premium revenue on medical and quality improvement costs as reflected in each MCO's reported MLR; however, as discussed throughout this report the effects of the coronavirus 2019 (COVID-19) pandemic and managed care program expansion in late 2020, directly impacted medical service utilization and reported costs for the current period. Amerigroup and CareFirst reported operating profits in 2020, though overall growth in profits have slowed compared to 2019 levels due to the recent program expansion, particularly, the transition of the high-cost, high-acuity SSI Adult population from FFS to managed care in October 2020. CareFirst's expenses have risen relative to revenue, resulting in an MLR of 89% which was a 13% increase from 2019. MedStar

reported higher overall PMPM expenses than the other MCOs driven by the newly enrolled SSI Adult population, though still reported an operating gain due to relatively low administrative costs during their first three months of operation. As noted earlier, DHCF risk adjusted the DCHFP base capitation rates monthly during the first quarter of the FY 2021 contract year, which is partially responsible for the fluctuations in revenue relative to expenses observed for the MCOs. Please note AmeriHealth and CareFirst continue to hold relatively high levels of IBNR reserves due to uncertainty related to the recent program expansion, which directly impacts expense levels and reported profits.

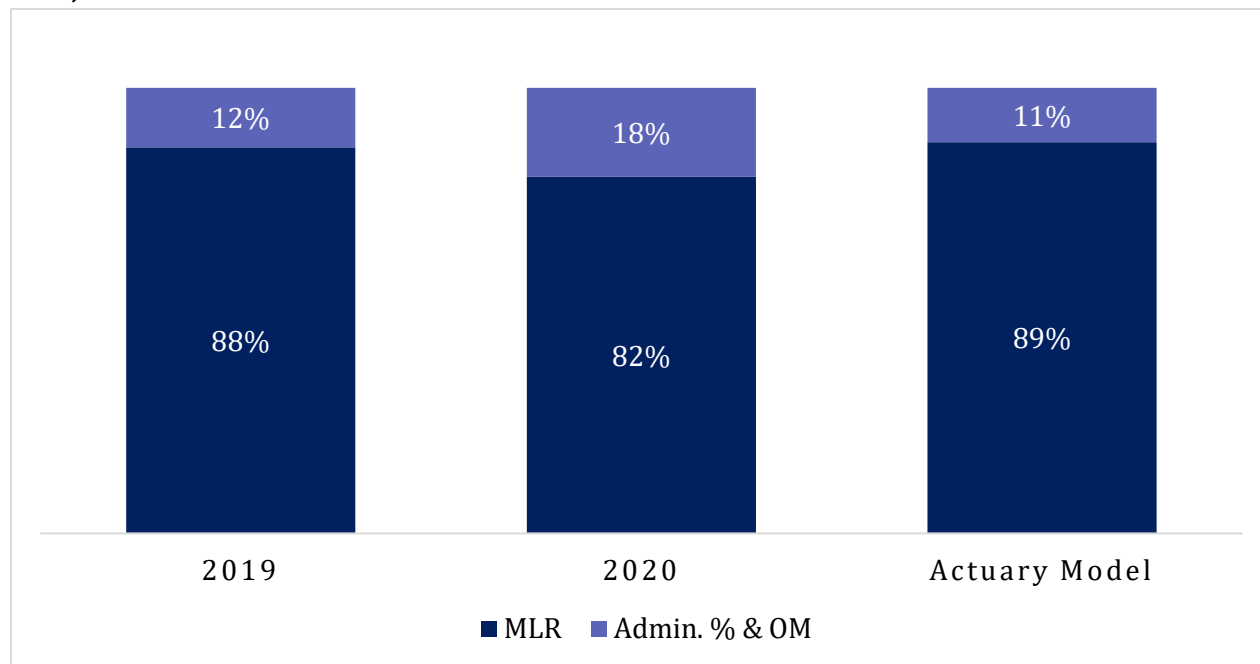
The underlying trends in medical service costs are discussed below in Section IV.B of this report.

SHARED RISK MCO

This report also provides a financial overview and medical service cost analysis for HSCSN – DHCF’s shared-risk MCO contracted to manage the CASSIP program. DHCF and HSCSN operate a risk sharing arrangement to limit the financial gains and losses under the contract through the application of risk corridors. The arrangement sets risk corridors around an annual target MLR established during rate setting. For the current rate setting period, the target MLR is approximately 89%, with the risk corridors applying to gains and losses of more than 2%. Thus, if the MCO experiences cost below 87%, the District shares in the financial gain. Conversely, if HSCSN incurs cost above 91%, the District absorbs a portion of the cost.

The figure and table below exhibit the percent of MCO revenue spent on medical service costs and administrative costs, and how the financial gains or losses are shared between HSCSN and DHCF for the current reporting period.

MLR, ADMINISTRATIVE AND OPERATING MARGIN FOR CASSIP - CY 2020 TO CY 2019



Source: Self-reported annual statements as of December 31, 2020 submitted to DHCF by HSCSN.

RISK SHARE BASED ON TARGET MLR - CY 2020

Risk Share Based on 89% MLR	2019	2020
Total (At Risk) or Underspend ¹	\$1.8M	\$11.8M
Amount Due to MCO ²	\$0	\$0
Amount Due to District ³	\$0	\$4.2M

Notes:

1. Estimated amount spent over level (At Risk) or under level (Underspend) set by target Medical Loss Ratio.
2. Estimated amount payable to MCO based on allocation of at-risk amount to District.
3. Estimated amount of surplus due to the District.

For calendar year 2020, HSCSN's medical expenses as a percent of its revenue was below the threshold for the target Medical Loss Ratio (89%) established during annual rate development, which will likely trigger the risk-sharing provision if these results are reflected in the final settlement reporting period. HSCSN reported strong operating profits of roughly \$7M primarily driven by lower medical service costs as a result of the depressed serviced utilization from COVID-19.

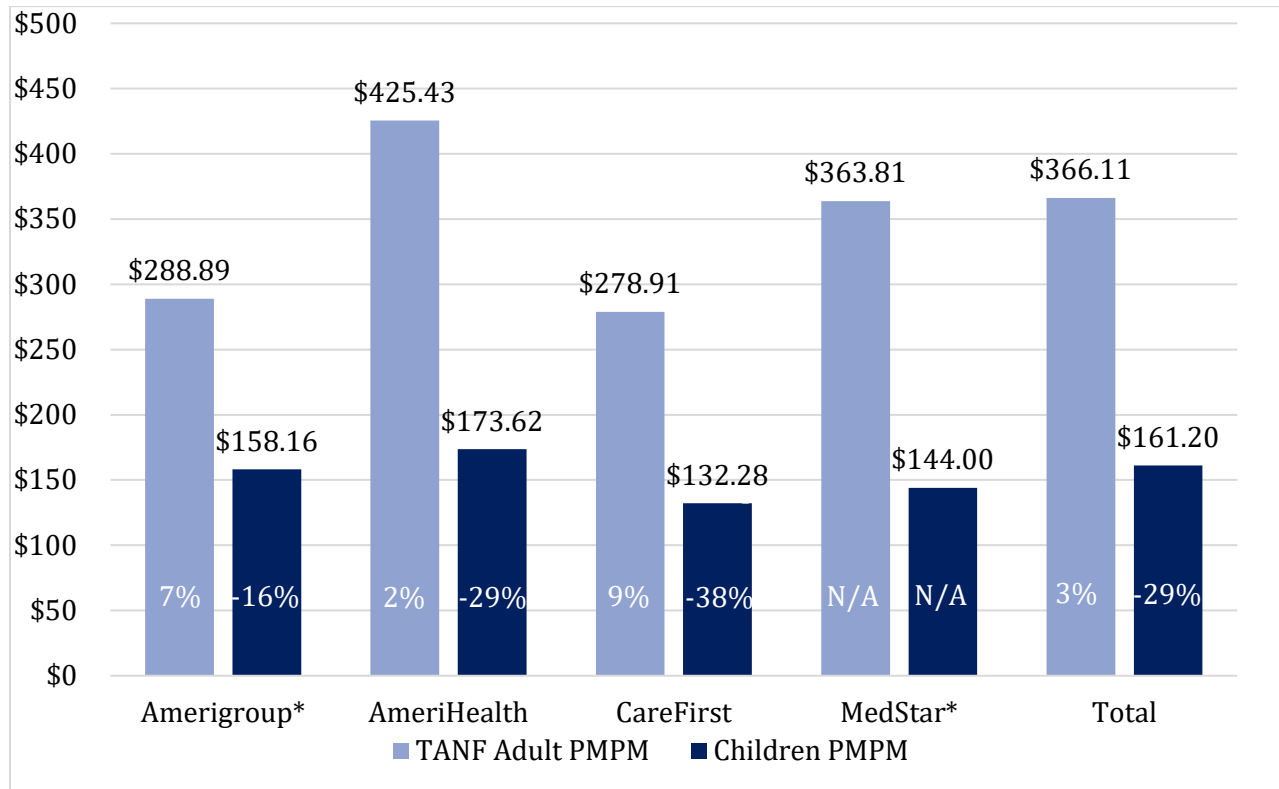
The underlying trends in medical service costs are discussed below in Section IV.B of this report.

B. PER MEMBER PER MONTH MEDICAL COSTS

This report presents an analysis of the per member per month (PMPM) medical service costs for the DCHFP, Alliance, and CASSIP – both the Well and children who have special health care needs and receive Supplemental Security Income (SSI) benefits – programs and populations. DHCF and its contracted actuaries review quarterly financial data submitted by the MCOs for expenses incurred from January 1, 2020 to December 31, 2020 and paid as of January 31, 2021. The figures below also provide an analysis of changes in average PMPM expenses, January 1, 2020 to December 31, 2020 compared to January 1, 2019 to December 31, 2019, for major high-cost medical service categories for the four MCOs. Please note Amerigroup ceased contracted services as of September 30, 2020. All results represent nine months of operation from January 1, 2020 to September 30, 2020 compared to a similar period in 2019. Correspondingly, MedStar began contracted services as of October 1, 2020. All results represent three months of operation from October 1, 2020 to December 31, 2020. Note, IBNR included in the following expense figures is estimated based on historical payment lags. The relatively short runout period for this report results in a high degree of uncertainty for IBNR estimates, and actual medical service costs may differ from those reported below. In addition, IBNR estimates recognize financial impact estimates related to COVID-19 that reflect DHCF and DHCF's contracted actuaries best estimate as of the date of this report. These estimates may change, and potentially rapidly and to a significant degree, as more experience and information emerges.

The figure below illustrates the total PMPM costs associated with the DCHFP TANF Adult, SSI and Child populations, along with trends in PMPM costs when comparing to a similar period during the prior year. Please note that trends are not included for the DCHFP SSI Adult population as this population transitioned to managed care effective October 1, 2020. A similar exhibit is provided below for the Alliance PMPMs and cost trends when comparing to 2019 levels.

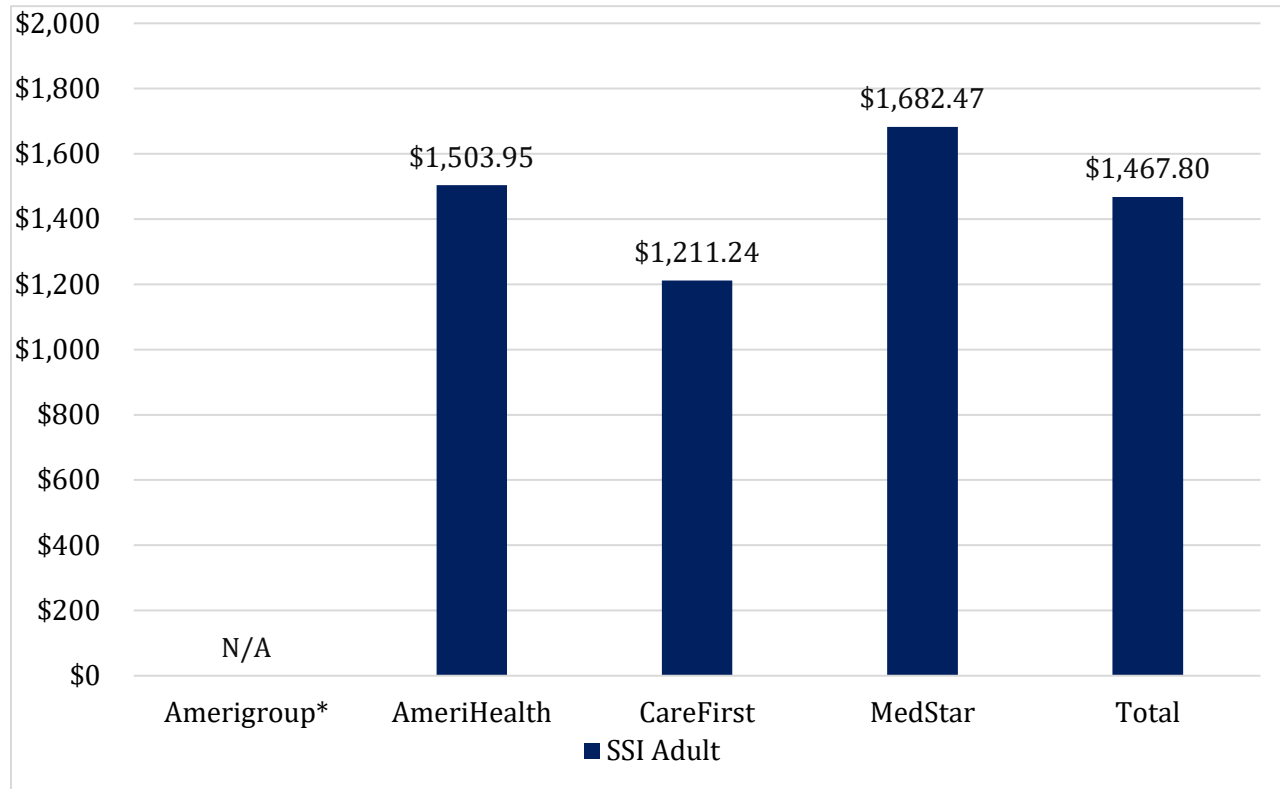
DCHFP TANF ADULT AND CHILD PMPM - CY 2020 AND TRENDS



Notes: Children defined as person up to age 21 in this analysis for the full risk-based MCOs. *Amerigroup ceased contracted services as of September 30, 2020. All results represent nine months of operation from January 1, 2020 to September 30, 2020 compared to a similar period in 2019. Correspondingly, MedStar began contracted services as of October 1, 2020. All results represent three months of operation from October 1, 2020 to December 31, 2020, with no prior period comparisons.

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

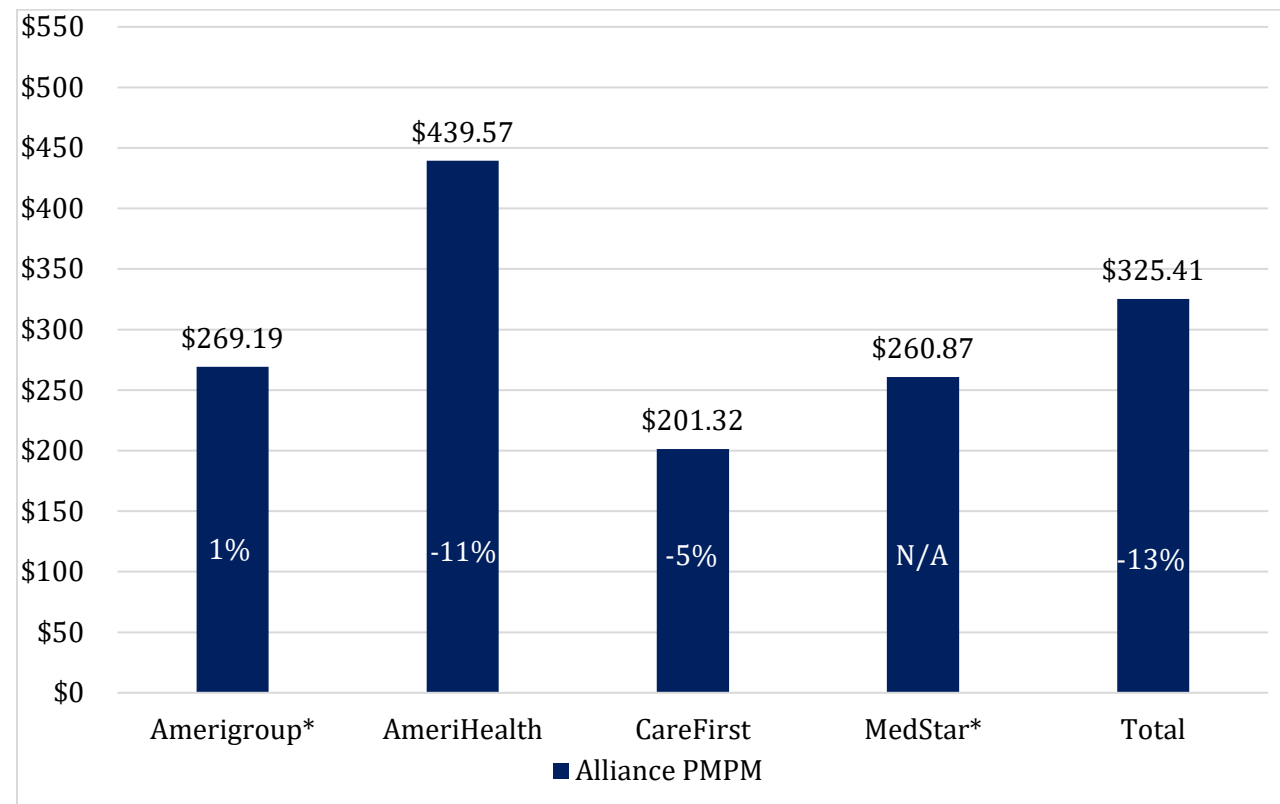
DCHFP SSI ADULT PMPM - CY 2020



Notes: *Amerigroup ceased contracted services as of September 20, 2020. The SSI Adult population transitioned into managed care effective October 1, 2020.

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

ALLIANCE PMPM - CY 2020 AND TRENDS



Notes: *Amerigroup ceased contracted services as of September 30, 2020. All results represent nine months of operation from January 1, 2020 to September 30, 2020 compared to a similar period in 2019. Correspondingly, MedStar began contracted services as of October 1, 2020. All results represent three months of operation from October 1, 2020 to December 31, 2020.

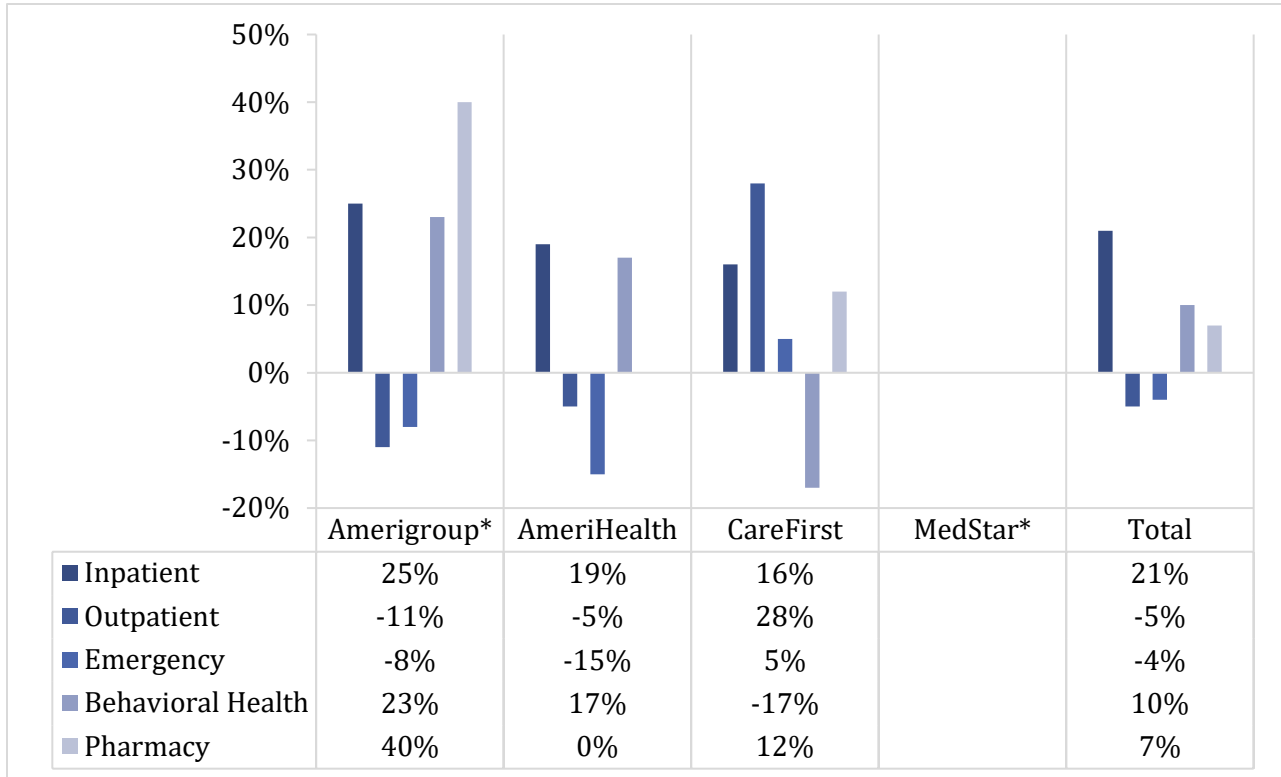
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

Overall, declines in PMPM expenses were experienced for both the DCHFP Child, and Alliance populations in 2020 primarily as a result of the impacts of COVID-19 on medical service utilization. The DCHFP Adult population showed relatively consistent PMPMs (3% increase) when comparing to a similar period in 2019, likely driven by the impacts of COVID-19 on service utilization offset by the addition of the opt-out FFS population in late 2020. The DCHFP Child PMPMs experienced significant decreases (29%), driven primarily by inpatient, outpatient, emergency department, behavioral health, and pharmacy services. Similar results were observed in the Alliance program, with overall PMPMs decreasing by roughly 13%, driven primarily by outpatient, emergency department, physician, FQHC, behavioral health and dental services. Pharmacy reported a slight decline (1%) for the Alliance program compared to 2019 levels, which is a notable change compared to the relatively high historical growth in pharmacy medical service costs in prior years.

Notable disparities in total PMPMs remain for AmeriHealth when compared to the other full risk-based MCOs, both for Alliance and the DCHFP TANF Adult and Child populations; however, AmeriHealth's growth in PMPM costs have continued to subside and even decline for certain population segments in 2020. Amerigroup's overall PMPM growth for 2020 is relatively flat for the MCO's corresponding nine-month period under contract compared to a similar period in 2019, driven by increases in the Adult PMPMs and offsetting decreases in Child PMPMs across multiple major medical categories of service. CareFirst reported the lowest overall PMPM across programs and populations, and the largest overall decrease in PMPM expenses (38%) for the Child population, driven primarily by inpatient, outpatient, emergency department and physician medical service costs. MedStar reported the highest PMPM for the newly transitioned SSI Adult population; however, as MedStar began contracted services in October 2020 no trend data is available for comparison to prior periods for the other population segments within the DCHFP and Alliance programs. See the figures below for PMPM trends by high-cost medical service categories for DCHFP TANF Adult, Child, and CASSIP populations.

For DHCF's risk-sharing MCO – HSCSN, notable decreases in PMPM expenses (9% across the total CASSIP program) were observed compared to 2019 levels. These trends were driven by sharp declines in inpatient, outpatient, emergency department and non-emergent medical transportation (NEMT), primarily due to the residual service impacts of COVID-19 throughout 2020. The Well Child population group experienced a 48% decline in PMPM expenses; however, this population is relatively small and inherently volatile in terms of service cost trends. The remainder of the CASSIP population experienced an 8% decline in PMPMs during 2020. See the figures below for overall trends in CASSIP cost growth and high-cost medical service categories.

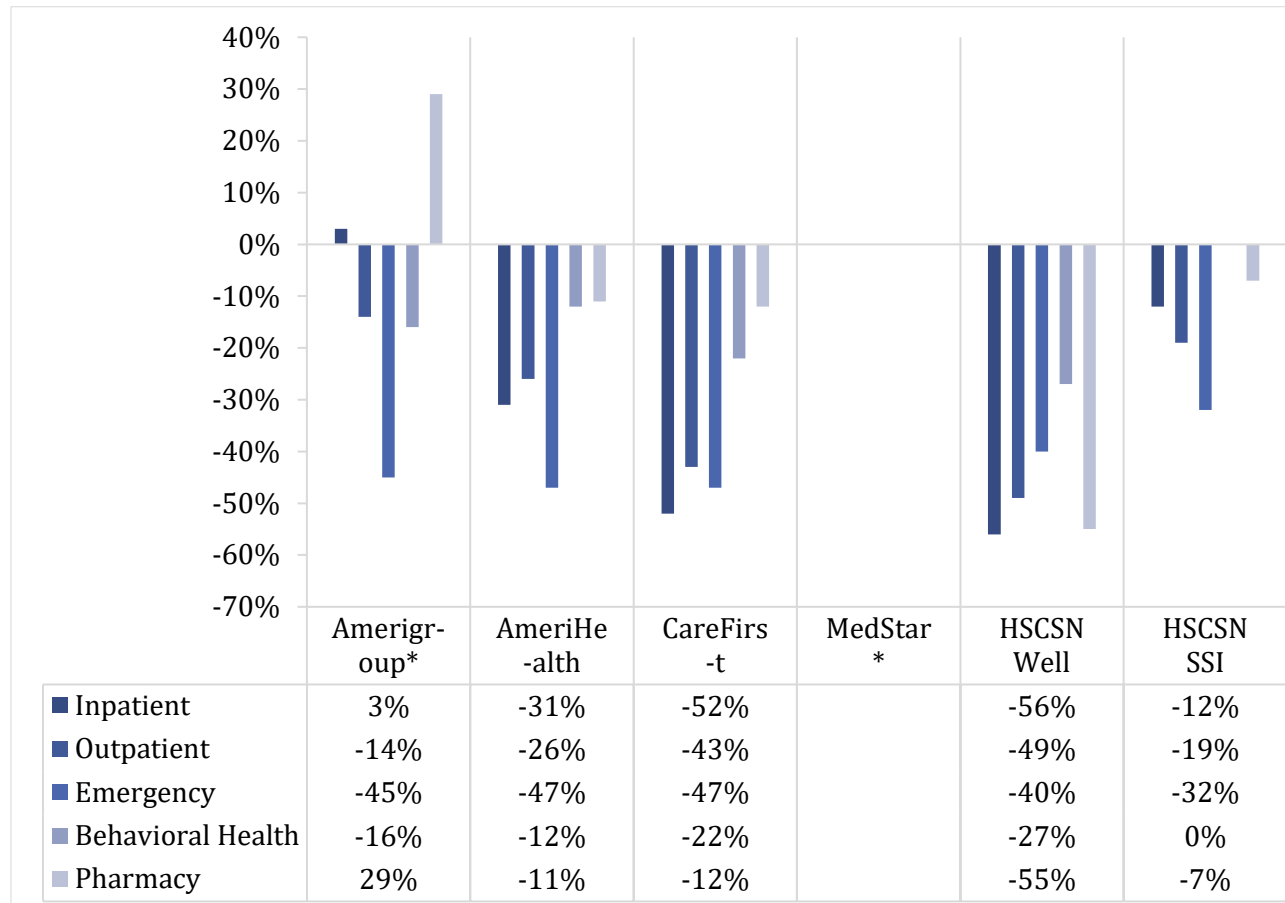
DCHFPTANF ADULT PMPM TRENDS - CY 2019 TO CY 2020



Notes: *Amerigroup ceased contracted services as of September 30, 2020. All results represent nine months of operation from January 1, 2020 to September 30, 2020 compared to a similar period in 2019. Correspondingly, MedStar began contracted services as of October 1, 2020. All results represent three months of operation from October 1, 2020 to December 31, 2020.

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

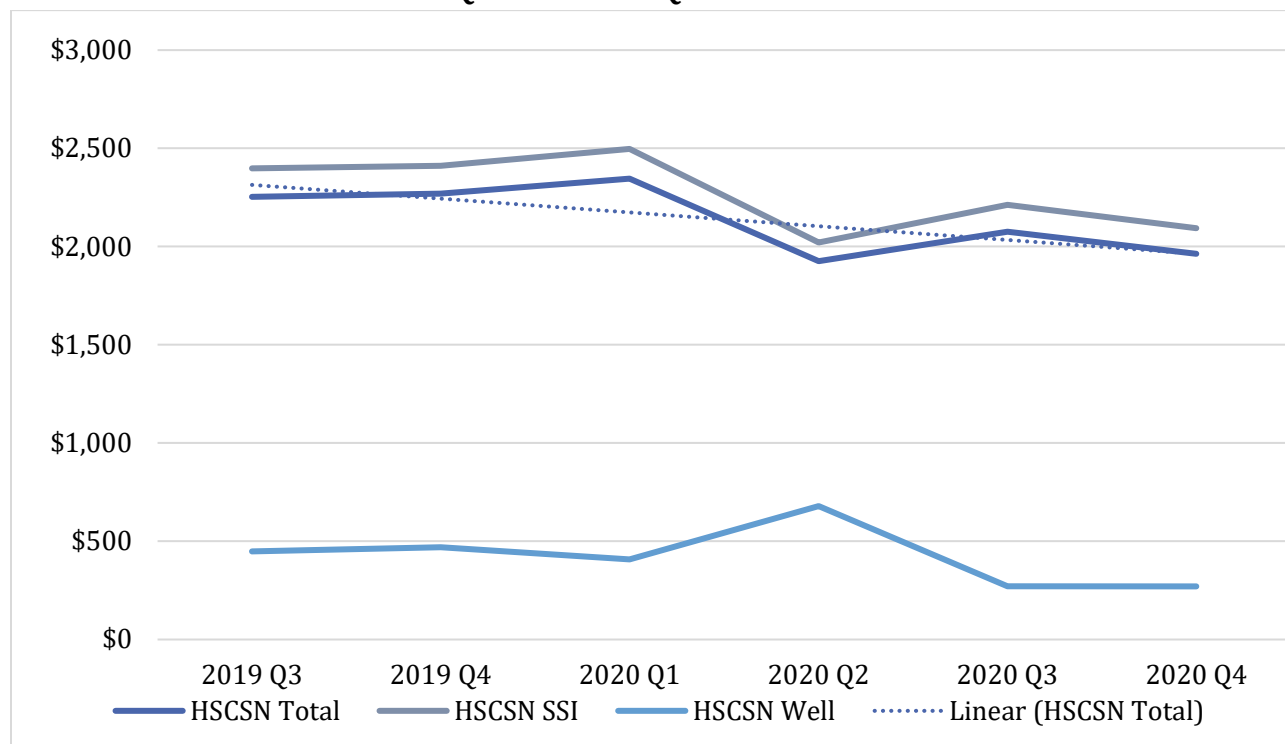
DCHF & CASSIP CHILDREN PMPM TRENDS - CY 2019 TO CY 2020



Notes: HSCSN's financial results are reported for both the Well and children who have special health care needs and receive Supplemental Security Income (SSI) benefits. *Amerigroup ceased contracted services as of September 30, 2020. All results represent nine months of operation from January 1, 2020 to September 30, 2020 compared to a similar period in 2019. Correspondingly, MedStar began contracted services as of October 1, 2020. All results represent three months of operation from October 1, 2020 to December 31, 2020.

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

CASSIP PMPM TRENDS - CY 2019 Q3 TO CY 2020 Q4



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

C. UTILIZATION TRENDS

WELL-CHILD AND OTHER AMBULATORY CARE VISIT RATES

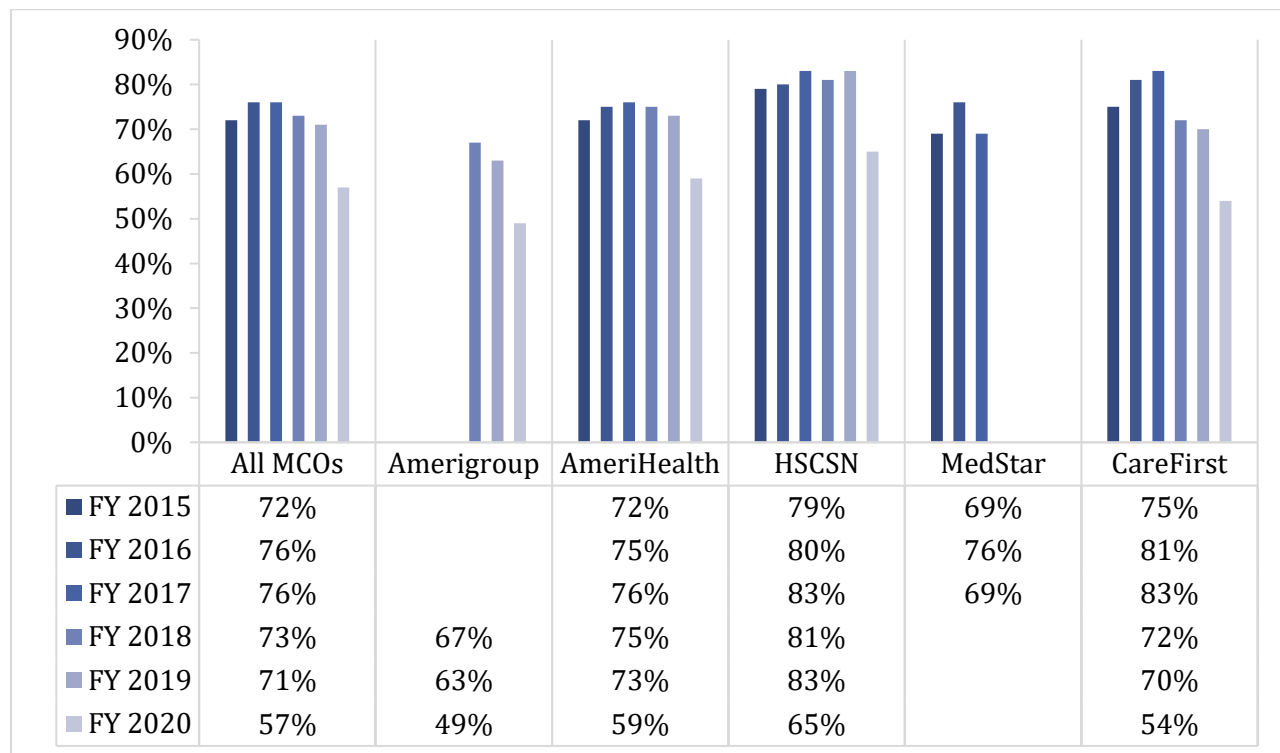
Well-child visit (WCV) rates vary by plan and year, based on data reflecting information reported by each MCO in accordance with Centers for Medicare & Medicaid Services (CMS) Form CMS-416 specifications for WCV and other child utilization measures. After holding relatively steady or increasing in recent years, the District experienced a large drop in well-child visits in FY 2020, with the MCO average falling from 71 percent in FY 2019 to 57 percent in FY 2020. The FY 2020 figures for individual MCOs ranged from 49% for Amerigroup to 65% for HSCSN. Based on the District’s analysis of MCO encounter data, the drop coincides with the start of the COVID-19 pandemic, with substantial decreases in well-child utilization during March-May 2020 when compared to the same months in 2019, consistent with findings for other states.⁵ The drops were not as substantial for June-September 2020, but “catch up” visits to offset the drops seen in March-May also did not occur, leading to the overall FY 2020 decrease in well-child visits.

DHCF’s Division of Children’s Health Services (DCHS) works closely with the MCOs to monitor WCVs, dental utilization and lead screening on the Form CMS-416. Through the MCO EPSDT Working Group and EPSDT 1:1s, DCHS monitors the MCO’s beneficiary outreach and activities to increase utilization (e.g., clinic wellness days, incentives, etc.). MCOs also work with their provider networks on EPSDT training and WCV billing practices. Finally, DCHS shares data quarterly with the MCOs to identify noncompliant children for MCO targeted outreach.

⁵ <https://www.medicare.gov/state-resource-center/downloads/covid19-data-snapshot.pdf#page=13>

With regard to preventive and other ambulatory care for adults, visit rates also vary by plan and time period. For example, 68% of adult MCO enrollees had a visit in CY 2020, but rates ranged from 48% for CareFirst to 73% for AmeriHealth. Adult visit rates for MCOs overall decreased between 2015 and 2018, then remained steady in 2019. The overall rate for 2020 increased but is not directly comparable to earlier years due to the entry of MedStar, exit of Amerigroup, and MCO reassignments that occurred October 1, which reduced the number of beneficiaries meeting the 11-month enrollment threshold for calculation of the metric. This data excludes emergency department care and reflects a visit definition based on HEDIS measure specifications for Adults' Access to Preventive/Ambulatory Health Services (AAP). In DHCf MCO reports for years prior to CY 2019, adult visits were reported at somewhat lower rates based on specifications that differ from HEDIS, but both approaches produce rates with similar trajectories over time. As with WCV rates, DHCf will continue to monitor MCO performance and will work with plans to address observed trends with adult visit rates.

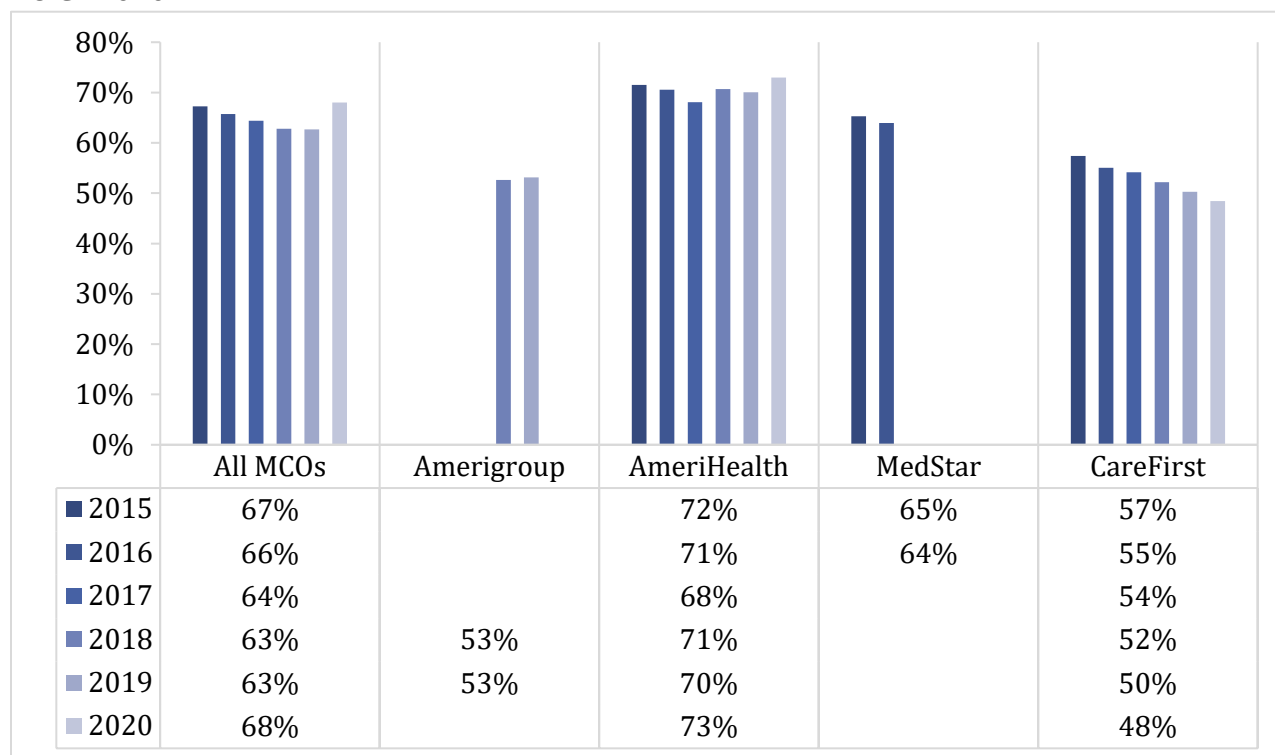
PERCENTAGE OF CHILDREN WITH A WELL-CHILD VISIT - FY 2015 TO FY 2020



Notes: Reflects Medicaid beneficiaries under age 21 with at least 90 days of continuous enrollment. Average for all MCOs is weighted by the number of children in each plan.

Source: Line 10 Participant Ratio from Form CMS-416 reports submitted by MCOs.

PERCENTAGE OF ADULTS WITH A PREVENTIVE OR OTHER AMBULATORY CARE VISIT - CY 2015 TO CY 2020



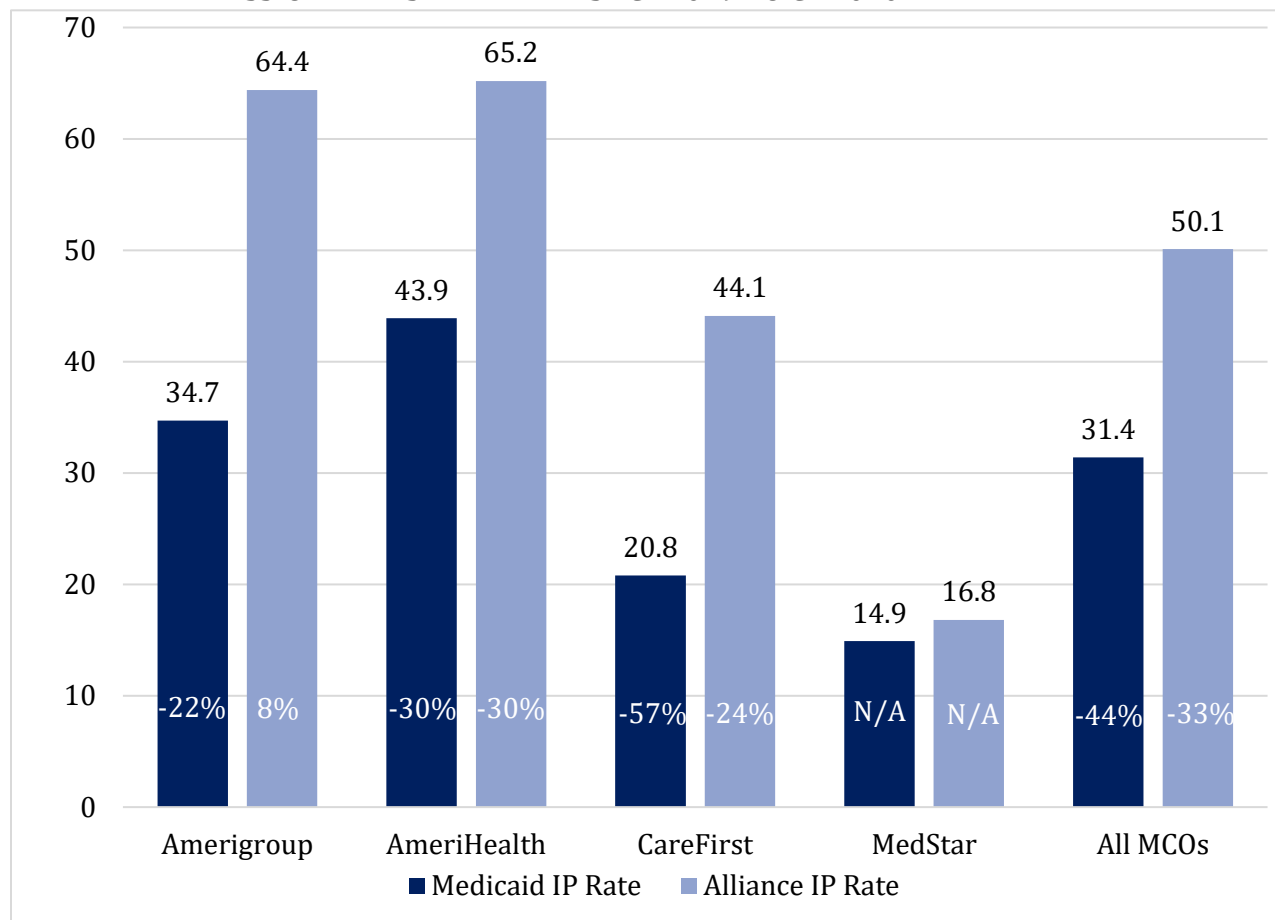
Notes: Reflects Medicaid beneficiaries age 21 or older with at least 11 months of coverage during the calendar year with a given MCO. CY 2020 figures are limited to AmeriHealth and CareFirst due to the entry of MedStar and exit of Amerigroup as of October 1; they also reflect smaller denominators due to plan reassignments as of October 1 that reduced the number of beneficiaries continuously enrolled with a given MCO for at least 11 months. Average for all MCOs is weighted by the number of adults in each plan. Includes both MCO encounters from DHCF’s MMIS system and any fee-for-service use by MCO beneficiaries. Visit definition reflects HEDIS measure specifications for Adults’ Access to Preventive/Ambulatory Health Services (AAP).

Source: DHCF Medicaid Management Information System data as of July 13, 2020 (CYs 2015-2019) and September 7, 2021 (CY 2020).

INPATIENT ADMISSIONS RATES

In addition to providing an analysis of primary and preventative care utilization, this report also includes an analysis of inpatient admission rates which reflect more costly health care utilization. The figure below illustrates the current indexed inpatient admission rates for the period CY 2020 based on MCO encounter claims from DHCF’s MMIS data and trends when comparing to those for CY 2019.

INPATIENT ADMISSION RATES AND TRENDS - CY 2019 TO CY 2020



Noted: Encounters include Medicare crossover claims in the above reported results.
Source: Data based on MCO encounter data submitted to MMIS.

For the current performance period, except for Amerigroup’s Alliance population, inpatient admission rates for all MCOs decreased significantly from 2019 levels, ranging from 22% to 57% across MCOs and programs. For the overall MCO populations, decreases of 44% and 33% were observed in CY 2020 for the Medicaid and Alliance programs, respectively. MedStar began operations with the District on October 1, 2020, with unusually low rates likely due to the short coverage period,

Further analysis of the numerators (inpatient stays) and the denominators (enrollment sizes) shows that for the Amerigroup Alliance population, slight decreases (3%) in IP stays and along with a 10% decrease in enrollment lead to an 8% overall increase in IP rates from CY2019, whereas a 22% decrease in the Medicaid IP rate was almost entirely due to the decrease in IP stays. For AmeriHealth, reductions in IP stays (18% for Alliance and 12% for Medicaid) combined with changes in enrollment (18% in Alliance and 26% in Medicaid) resulted in a 30% decrease in IP rates from CY2019 levels for both Alliance and Medicaid populations. AmeriHealth’s inpatient admissions rates continue to be higher than the other two full risk-based MCOs, which is likely due to the disproportionate share of higher acuity members enrolled in the MCO. For CareFirst, increases in IP stays (17% for Alliance and 12% for Medicaid) being offset by large changes in enrollments (54% in Alliance and 161% in Medicaid) resulted in a 57% decrease in IP rates from CY2019 for Medicaid and a 24% decrease in Alliance IP rates. Both the impacts of the COVID-19 pandemic as well as the District’s transition of

additional FFS populations into managed care, potentially impacted the reported IP rates and trends for the current reporting period.

V. PAY FOR PERFORMANCE AND CARE COORDINATION

A. INTRODUCTION

Achieving high value in health care for Medicaid beneficiaries is a preeminent goal of DHCF's managed care program. The District's MCOs are expected to increase their members' health care and improve outcomes per dollar spent through aggressive care coordination and health care management. From October 2016 to September 2018, DHCF's three full risk-based MCOs were required to meet performance goals in order to receive their full capitated payment rate. DHCF relies upon several metrics to quantitatively assess the efforts by the MCOs to coordinate enrollee care. After reviewing several years of data, DHCF can now more closely examine the following performance indicators for each of the District's MCOs:

- Low acuity non-emergent (LANE) visits - emergency room utilization for non-emergency conditions⁶;
- Potentially preventable admissions (PPA) – admissions to the hospital which could have been avoided with access to quality primary and preventative care⁷; and
- 30-Day All-Cause Readmissions - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days – hospitalization⁸.

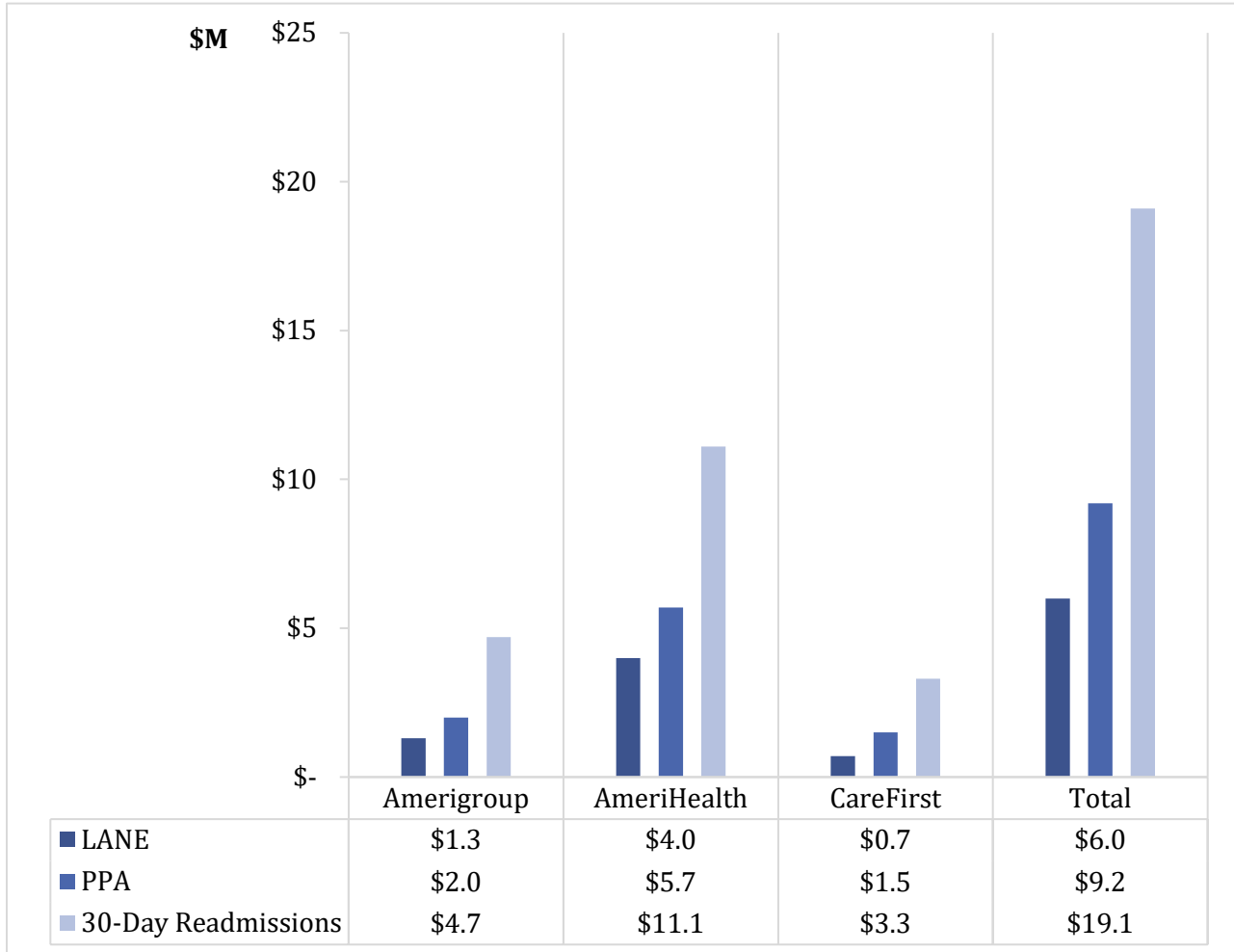
The MCOs could potentially save millions by reducing their enrollees use of the ER for non-emergent reasons, reducing potentially avoidable hospitalizations, and slowing the rate of hospital readmissions. The figure below illustrates the aggregate avoidable costs incurred by the MCOs for potentially avoidable emergency room visits and hospitalizations. Note, the amounts listed as potentially avoidable would likely be offset by other costs if the MCOs improved their care management, such as increased outpatient costs due to increased use of ambulatory care. MedStar was not under contract with the District during the FY 2020 contract period associated with the P4P program, thus no results for MedStar are included in the following exhibits.

⁶ Low acuity non-emergent visits are emergency room visits that could have been potentially avoided, identified using a list of diagnosis applied to outpatient data.

⁷ Avoidable admissions are identified using a set of prevention quality measures that are applied to discharge data.

⁸ Readmissions represent inpatient visits that are within 30 days of a qualifying initial inpatient admission.

AVOIDABLE SPEND ON MANAGED CARE SERVICES - 2020



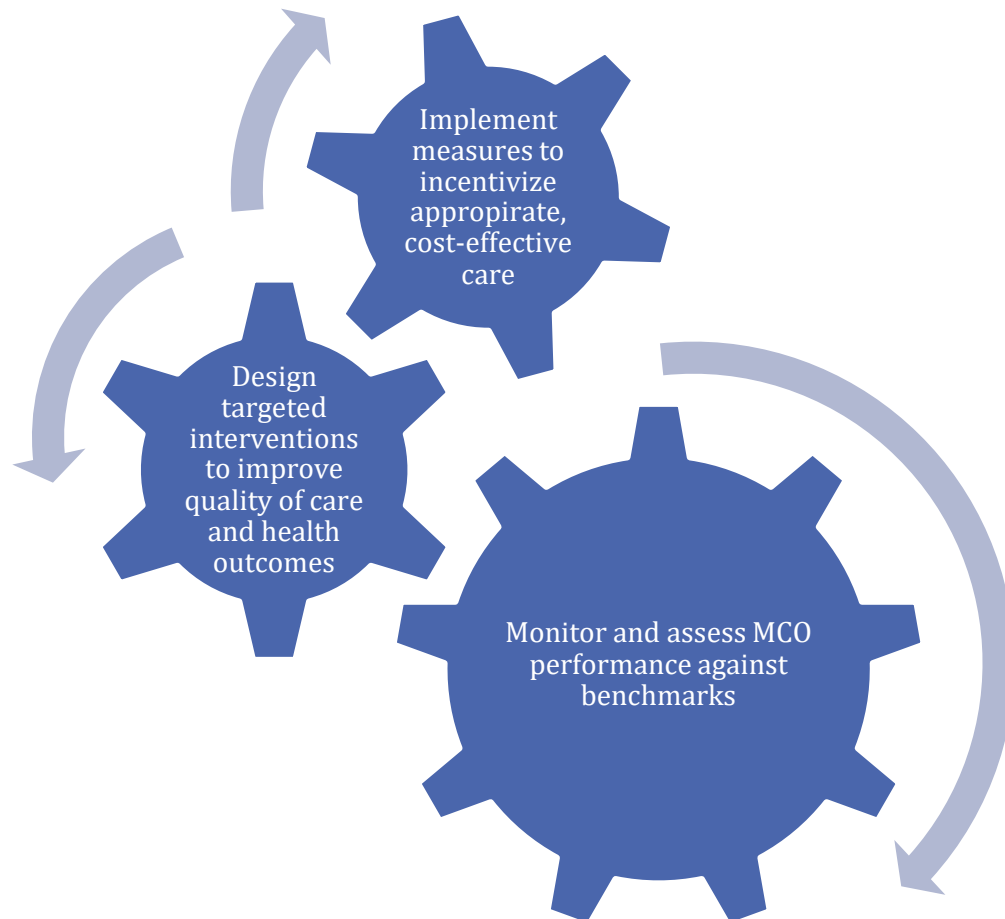
Notes: Current annual results for 2020 reflect data incurred during the 12-month period – October 2019 through September 2020 - with payment runout through December 31, 2020. Total avoidable costs include Health Home enrollees.

Source: Mercer analysis of MCO Encounter data for DCHFP reported by the MCOs to DHCF.

B. METHODOLOGY

The managed care P4P program is funded through a 2% withhold of each MCO’s actuarially sound capitation payments for non-delivery DCHFP rate cells for the corresponding period. The 2% withhold is the profit margin for each MCO that is factored into the base per member per month payment rate. Actual P4P results are based on MCO experience during a performance year compared to the baseline. The baseline period used to set the target remains April 1, 2015 through March 31, 2016, with runout through September 2016. MCOs must meet the minimum threshold for improvement for all three performance measures in order to earn any portion of the withhold.

The capitation withhold was not in effect for the FY 2020 measurement year, though DHCF plans to reinstitute quality incentive requirements in future years.



DHCF set performance goals for the P4P program based on reasonable and attainable improvement thresholds and implemented a scoring system to determine the distribution of payment incentives for the MCOs. LANE and PPA quality metrics are weighted at 33% of the capitation withhold. The MCOs have an opportunity to earn back the full 33% based on performance as follows:

- 10% reduction (improvement) in LANE Emergency Department (ED) utilization and PPAs from the baseline will result in the MCO earning 100% of the 33% withhold attributed to each of these measures.
- 7.5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 50% of the of the 33% withhold attributed to these measures.
- 5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCO earning 25% of the 33% withhold attributed to these measures.

If reduction in LANE utilization and PPAs are less than the minimum 5% standard from the baseline, the MCOs do not earn any portion of the 33% withhold attributed to the relevant measure. The scoring system is the same for the third measure – 30-Day All-Cause Hospital Readmissions - but this outcome is weighted at 34% of the capitation withhold. The MCOs can earn back 25%, 50% or 100% of the 34% withhold attributed to the measure by demonstrating reductions at 5%, 7.5% and 10% respectively. DHCF relies upon claims data to measure the MCOs’ performance on the targeted quality measures. Since a run-out period must be allowed to ensure a more complete picture of claims activity, payments

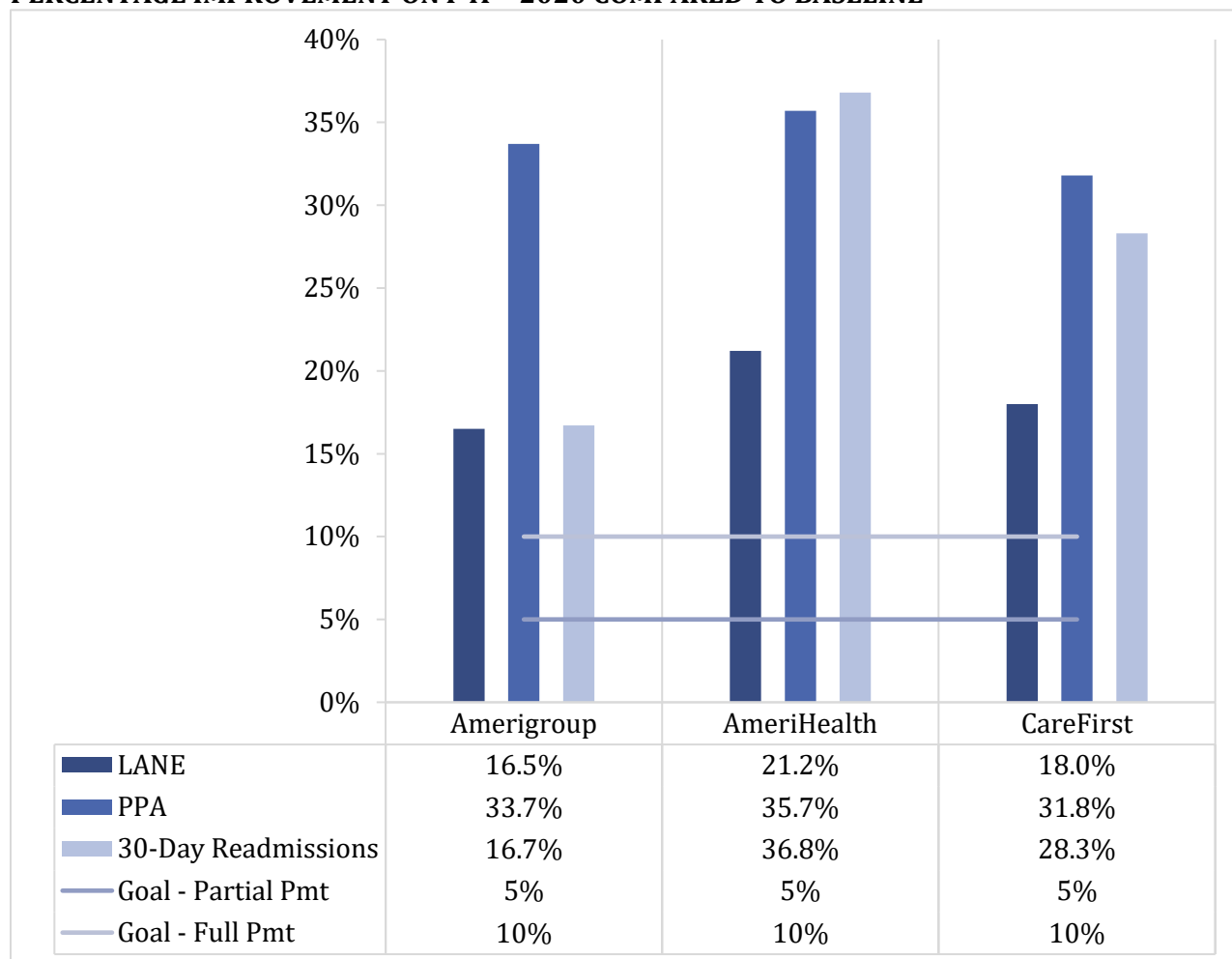
will likely occur 4 to 7 months after the measurement period closes in years when the withhold is in effect.

DHCF is reassessing the P4P program for FY 2021, and may modify requirements (e.g., performance measures, targets, incentive structure, etc.) for future contract years. DHCF would like to move MCOs towards a greater focus on interventions and will require each MCO to develop and report on targeted interventions and impacts on attributed populations, which should result in improved performance on the established P4P metrics.

C. P4P RESULTS

The figure below illustrates the improvement on the three P4P quality measures from the baseline to the current 2020 reporting period, for the three full risk-based MCOs providing services to the DCHFP population.

PERCENTAGE IMPROVEMENT ON P4P - 2020 COMPARED TO BASELINE



Notes: Current annual results for 2020 reflect data incurred during the 12-month period – October 2019 through September 2020 - with payment runout through December 31, 2020. Final metrics are net of Health Home enrollees.

Source: Mercer analysis of MCO Encounter data for DCHFP reported by the MCOs to DHCF.

All three full risk-based MCOs are currently meeting the target improvement thresholds – 10% reduction in avoidable visits compared to the baseline – for the representative period for 2020 compared to the baseline period of the P4P program. The current measurement period includes reductions in utilization of emergency room and other medical services due to the impacts of COVID-19, which likely artificially impacted the reported P4P results. Please note the capitation withhold is not in effect for the FY 2020 measurement year, though DHCF plans to reinstitute quality incentive requirements in future years.

VI. CONCLUSION

Each MCO's financial, operational, and utilization management results were assessed as part of this report. This current review highlighted a number of key observations in the District's managed care program, predominately the preliminary effects of the coronavirus 2019 (COVID-19) pandemic on medical service utilization and costs for the District's contracted MCOs, and preliminary impacts of the addition of the newly transitioned FFS populations to the DCHFP program. While AmeriHealth's total PMPM medical costs continue to remain the highest of the full risk-based MCOs, their growth in medical service costs have continued to subside in 2020 resulting in positive operating margins for the MCO. The District has observed an overall decline in PMPM medical service costs for both the DCHFP Child and Alliance programs in 2020, with substantial enrollment shifts amongst the MCOs due to contract changes and reassignment of enrollees as part of the FY 2021 managed care procurement. With the implementation of new risk adjustment methodologies in 2020 including increased frequency of enrollment review, the District has observed better alignment of cost and associated payment across the DCHFP program.

The District continues to monitor avoidable hospitalization utilization and expenditures tied to avoidable admissions, readmissions, and ED utilization as part of the managed care P4P program and has observed largely positive trends in reducing these unnecessary services and health care costs during the current reporting period. However, the impact COVID-19 on hospital utilization and associated medical service cost is still unknown and the District will continue to monitor MCO experience for future reporting periods.

For preventative care, DHCF updated its methodology beginning with the annual 2019 report for both well-child and adult preventative care measures to be more aligned with CMS regulatory and other authoritative measure reporting standards. After holding relatively steady or increasing in recent years, the District experienced a large drop in well-child visits in FY 2020, which coincides with the start of the COVID-19 pandemic. With regard to preventive and other ambulatory care for adults, adult visit rates for MCOs overall decreased between 2015 and 2018, then remained steady in 2019. The overall rate for 2020 increased but is not directly comparable to earlier years due to MCO changes that occurred October 1, which reduced the number of beneficiaries meeting the 11-month enrollment threshold for calculation of the metric. As described earlier in this report, DHCF has mechanisms in place to monitor utilization of critical primary and preventative care and will continue working with MCOs to develop strategies to encourage utilization of these services.

Moving forward, as part of the District's health system redesign, DHCF continues to focus and work towards implementing the following Medicaid reform activities in the near and long-term, to improve health outcomes of Medicaid beneficiaries and create a sustainable healthcare delivery system:

- More value over volume: Increase expectations for value-based purchasing through managed care, including a greater focus on aligning payment with improved outcomes and reduction in avoidable health care spending.
- Increased access to care: Require universal contracting for key providers to mitigate adverse selection in managed care and prevent MCOs from falling short of medical spending requirements.

- Better alignment of payment with underlying health conditions: Continue application of diagnostic and pharmacy combined risk-adjustment model to better assess beneficiary risk and curtail growing costs for MCOs with high-acuity, high-cost enrollees.
- More coordinated care: Transition additional FFS Medicaid population and services to managed care and expand care management requirements for highly vulnerable populations.

As these strategic initiatives are implemented, DHCF will continue to monitor the impact on service utilization and the use of appropriate cost-effective care, to promote population health and quality care for the District's managed care enrollees.