GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health Care Finance

MEDICAID MANAGED CARE

PERFORMANCE REPORT

(January 2021–December 2021)

August 19, 2022

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I. EXECUTIVE SUMMARY

A. BACKGROUND

The District of Columbia (DC) Department of Health Care Finance (DHCF) administers the Medicaid program that includes managed care and fee-for-service (FFS) programs available to qualified residents. The Medicaid program is the largest single expenditure in the agency's budget. The managed care program is comprised of the District of Columbia Healthy Families Program (DCHFP) and provides health coverage to individuals who meet the eligibility requirements for the District's Temporary Assistance for Needy Families (TANF) program, Children's Health Insurance Program (CHIP)-funded Medicaid, non-dual Supplemental Security Income (SSI) Adults ages 21+ years, adults who are not in these categories but have incomes that are below prescribed federal poverty thresholds, and children eligible for the Immigrant Children's Program (ICP)[1].

The managed care program also includes the DC Healthcare Alliance (Alliance), which includes healthcare coverage for individuals with incomes at or below 200% of the federal poverty level (FPL) and are ineligible for Medicaid. The Child and Adolescent Supplemental Security Income Program (CASSIP) provides healthcare coverage to children, adolescents and young adults who meet the eligibility requirements for the District's SSI program and choose to enroll in the voluntary managed care program. Healthy children delivered by CASSIP mothers remain in the program through age five years.

As of December 2021, 291,461 Medicaid and ICP beneficiaries and 22,879 Alliance enrollees were assigned to one of the following Managed Care Plans (MCPs):

- **AmeriHealth Caritas DC (AmeriHealth)**
- **CareFirst BlueCross BlueShield Community Health Plan DC (CareFirst)**
- **MedStar Family Choice, Inc. (MedStar)**

As of December 2021, 4,983 Medicaid beneficiaries were voluntarily enrolled to the following MCP:

- **Health Services for Children with Special Needs (HSCSN)**

All MCPs have continued to offer comprehensive benefits during calendar year (CY) 2021. The DCFHP and Alliance MCPs — AmeriHealth, CareFirst, and MedStar — operated under full risk contracts until October 1, 2021, thereafter, the District implemented a risk-sharing arrangement with the contracted MCPs. HSCSN has historically operated under a risk- sharing arrangement with the District and has resulted in no change to the arrangement.

The District spent roughly $1.6 billion[2] on managed care services during 2021. Roughly 89% ($1.5 billion) of this amount funded the DCHFP and Alliance MCPs — AmeriHealth, CareFirst, and MedStar — while approximately 11% ($180 million) funded the risk-sharing contract with HSCSN.

[1] The DCHFP referenced throughout this report includes ICP for purposes of enrollment and expense results.
[2] Total Capitation Revenue and District Exchange/Premium tax revenue based on the Medical Loss Ratio letters and calculations provided by the MCPs and summarized and reported by DHCF's actuaries. For HSCSN, capitation revenue excludes District Exchange/Premium tax revenue and Risk Share amounts.

B. MEDICAID PROGRAM VISION, MISSION, AND VALUES

DHCF continually strives to improve the health and well-being of the residents of the District. 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; provide special incentives to providers to improve access to and quality of care

Strategic Priorities:

- Building a health system that provides whole person care
- Ensuring value and accountability
- Strengthening internal operational infrastructure
- Unwinding from the Public Health Emergency (PHE)

DHCF continues to move towards a fully managed care Medicaid program. This shift transforms 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.

In November 2021, in partnership with the DC Office of Contracting and Procurement (OCP), a solicitation was released for procurement of up to three MCPs to provide healthcare, behavioral health (BH) services, and pharmacy services for the managed care program. The integration of BH services was a significant addition to the managed care program, and integral to servicing whole-person care – physical, behavioral, social factors and services. This will enable health plans to better coordinate care for improved health outcomes and well-being of the qualified and enrolled populations. Integration of BH services is targeted to begin on October 1, 2023.

C. GOALS AND OBJECTIVES

There are three primary goals of this Medicaid Managed Care Performance Report:

- Evaluate the degree to which DHCF's full risk-based MCPs (during CY 2021) 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.
- Offer awareness of the impact of the COVID-19 public health emergency (PHE), pertaining to utilization, costs and performance outcomes.
- Provide objective data on the performance of the MCPs across several domains to inform decision making about possible policy changes for the managed care program.
- Facilitate an assessment of each MCP to help guide oversight activities and prioritize areas for enhanced monitoring and corrective action.

This report illustrates the financial condition of the MCPs during CY 2021, which includes reporting on whether MCP revenues were sufficient to cover claims and operating costs while maintaining a minimum benchmark (85%), or medical loss ratio (MLR) for medical service costs and quality improvement expenses. Administrative functions such as timely claims processing, robust enrollee encounter systems, and appropriate use of claims denial procedures are closely monitored and tracked routinely by DHCF and 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 adults and children, inpatient (IP) admission rates — in addition to MCP performance with coordinating care and services of enrolled populations in comparison to established national quality measures during the review period.

D. KEY FINDINGS

FINANCIAL RESULTS

All MCPs reported healthy financials for the CY 2021 review period. Each of the DCHFP and Alliance MCPs reported risk-based capital (RBC) positions well above the required minimum level of 200%. The MCPs posted profits ranging from roughly 0% – 3%, with ample reserves to meet incurred but not reported (IBNR) claims with liquid assets and alternative short-term investments. All MCPs spent at or above the minimum level of premium revenue on medical and quality improvement costs as reflected in each MCP's MLR. However, as discussed later in this report, the effects of the COVID-19 PHE, and managed care program expansion in late 2020, continued to impact medical service utilization and reported costs in 2021.

Beginning with the fiscal year (FY) 2018 contract year, a disproportionate share of the high-acuity, high-cost population transitioned from two DCHFP and Alliance MCPs – CareFirst and Amerigroup -- to AmeriHealth. This transition led to unforeseeable operating and financial challenges for AmeriHealth throughout 2018 and 2019. With the implementation of new contracts in FY 2021, described earlier in this report, DHCF included a process to distribute or reassign enrollees among the three newly awarded MCPs prior to the contract's start date on October 1, 2020. The new contracts included an

open enrollment period through December 2020, during which MCP enrollees had the option to voluntarily transfer to a different MCP based on the distribution or reassignment.

Additionally, DHCF included new requirements in the FY 2021 contracts (e.g., universal contracting for key providers) designed to help mitigate the adverse selection experienced by AmeriHealth in future contract years. Although AmeriHealth still has the highest per member per month (PMPM) costs for the DCHFP adults, children, SSI, and Alliance populations -- with implementation of a monthly risk-adjustment during the first quarter of the FY 2021 contract year for DCHFP, and in the first quarter of the FY 2022 contract year for Alliance, AmeriHealth's net revenues increased proportionally more than net claims, resulting in an operating gain and healthy capital and liquidity levels for the CY 2021 period.

AmeriHealth and MedStar reported operating profits of $18.5 million and $11.9 million, respectively, in 2021. CareFirst's expenses have risen relative to revenue, resulting in an MLR of 93%, which was a 4% increase from 2020. CareFirst reported strong capital and liquidity levels, partially due to a significant capital contribution from their parent company in 2020 to adjust for the program expansion with the new contracts.

MedStar reported healthy reserves and capital levels resulting in a 93% MLR and notable underwriting gain. As noted earlier, DHCF risk-adjusted the DCHFP base capitation rates quarterly during the FY 2022 contract year, and implemented risk adjustment for Alliance in FY 2022, which is partially responsible for the fluctuations in revenue relative to expenses observed for the MCPs. The impacts of COVID-19, on service utilization and reported costs continued throughout the 2021 reporting period and may have artificially impacted reported costs including reserves for estimated future claims, included in this report.

The financial results for HSCSN, contracted to manage the CASSIP program, are in healthy ranges for the CY 2021 annual review period. HSCSN reported increases in PMPM medical costs across multiple medical service categories due to service utilization returning to pre-COVID-19 levels, resulting in a 4% higher MLR when compared to 2020 levels. HSCSN reported healthy capital and liquidity levels, and a small operating loss in 2021. 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.

MCP FINANCIAL CONDITION — CY 2021

Financial Metric	AmeriHealth	CareFirst	MedStar	HSCSN
Reserves for Estimated IBNR Claims (Months Claims)	2.3	2.9	1.8	2.0
Risk-based Capital	401%	530%	348%	458%
Defensive Interval Ratio (Days)	103	134	121	89

Operating Margin/Loss ($M)	$20.2	$0.8	$11.9	$–0.2
Operating Margin/Loss Percentage	2.8%	0.2%	3.2%	–0.1%
MLR	90%	93%	93%	85%

Notes:
MedStar's IBNR, RBC, and Defensive Interval results are based on the MCP's reported DISBs, which includes a full year of MedStar's State of Maryland line of business.

ADMINISTRATIVE PERFORMANCE

Four areas are typically evaluated to assess MCPs' administrative performance – 1) adequacy of provider network, 2) timely payment of claims, 3) appropriate management of the claims adjudication process, and 4) successful execution of an encounter system. Data from this analysis indicates the MCPs are on balance and properly managing these significant responsibilities:

- The MCPs have maintained comprehensive and diverse provider networks to ensure access to a full range of services, in addition to robust systems to report patient or enrollees' encounters. However, some of the MCPs have historically struggled to contract with all District hospitals, which DHCF has attempted to address through universal contracting requirements for certain providers.
- All the MCPs exceeded the District's timely payment requirement for the period of January 1, 2021 through December 31, 2021, ensuring continuity of operations for their contracting providers.

MCP ADMINISTRATIVE PERFORMANCE — CY 2021

Administrative Metric	AmeriHealth	CareFirst	MedStar*	HSCSN
Acceptance rate for encounter submissions	98.7%	96.2%	98.3%	99.7%
Claims paid within 30 days	97.0%	97.6%	98.5%	95.7%

Source: Mercer and DHCF analysis of Medicaid Management Information System- and MCP-supplied data extracts.

MEDICAL COSTS AND UTILIZATION TRENDS

MEDICAL EXPENSES

All MCPs spent above the required 85% of MCP revenue on medical expenses in 2021. Overall, an increase in PMPM expenses was experienced across the managed care program, driven by increases to the DCHFP Child (27%) and TANF Adult (18%) populations when compared to 2020 levels. The recovery from the effects of the COVID-19 PHE on utilization of services continues to be the primary driver of increasing medical service costs across the managed care program. The full year of coverage for the former Opt-out adults and SSI Adult population in managed care, along with revised reimbursement levels for hospital and other services effective October 2020, are also drivers of the overall increased PMPMs from 2020. Finally, to support States and promote stability of coverage during the COVID-19 PHE, enrollees that would have historically been disenrolled from the DCHFP have received continuous coverage. This primarily impacts TANF and expansion adult populations in the DCHFP, increasing enrollment and dampening PMPMs during CY 2021.

For HSCSN, medical service costs continued to rebound in 2021 from the PHE-driven low expense levels in early to mid-2020, resulting in an overall increase in PMPMs of 3% from 2020 levels and a higher MLR (85%, up from 82% in 2020) for the MCP. HSCSN's total PMPMs have returned to near pre-COVID-19 levels.

The PMPM cost for the Alliance decreased 3% in 2021, following a 13% decrease in CY 2020. This is a notable change from the upward trend in costs over the past few years, including a 3% growth in 2019 and 13% observed in 2018. Past Alliance spending growth was attributed primarily to the 2016 transition of pharmacy benefits into the managed care program. The Alliance population has historically consisted of slightly older individuals with more complex medical conditions, which drove increased spending in outpatient hospital costs. Additionally, to support stability of coverage during the COVID-19 PHE, a maintenance of eligibility was instituted during the District's PHE, which halted eligibility recertification of Alliance enrollees. The maintenance of eligibility has led to increased enrollment (up 16% since February 2020). The overall spending for the Alliance program has increased, but with a lower PMPM for the broader population that is currently covered. Though PMPM costs for the Alliance in 2021 are below levels observed in prior years, this remains driven by the impacts of the COVID-19 PHE and is anticipated to increase with the anticipated end of maintenance of eligibility.

AmeriHealth's total Alliance PMPM costs remain disproportionately higher than the other MCPs, driven primarily by the plan's historically disproportionate share of Alliance enrollees and their use of IP, 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 MCPs.

A risk-adjustment reimbursement model seeks to align each MCP'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 populations. The DCHFP rates have been risk-adjusted since the start of the FY 2021 managed care contracts in October 2020. As noted previously, DHCF transitioned new populations from fee-for-service (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 MCPs and impacts on incurred costs, DHCF developed MCP-specific risk scores and budget neutral risk-adjusted rates monthly during the first six months of the contract year, and on a quarterly basis starting in April 2021. Effective October 2020, risk-adjustment included the newly transitioned SSI Adult population and new and existing TANF populations. With the start of the FY 2022 contract year in October 2021, the Alliance rates are also risk-adjusted each quarter to account for varying levels of costs based on enrollment and acuity of the underlying MCP's population.

The Figure below illustrates the comparison of each MCP's ranking on enrollee risk scores and their total medical costs, illustrating the distribution of risk and associated costs across the DCHFP and Alliance programs and MCPs. In general, AmeriHealth's populations generally exhibit greater risk and associated costs compared to the other MCPs, with CareFirst generally showing lower risk and costs and MedStar falling somewhere in between the other two MCPs. While risk-adjustment improves the alignment of payment to projected cost, it does not capture all observed variation between MCP populations and utilization.

RANKING OF ENROLLEE RISK SCORE & MEDICAL COSTS

Ranking on Medical Cost	Ranking on Enrollee Risk Scores: Low	Medium	High
Low	MedStar — Child MedStar — Alliance CareFirst — Child CareFirst — TANF Adult CareFirst — SSI Adult CareFirst — Alliance		
Medium	MedStar — TANF Adults	MedStar — SSI Adult	
High			AmeriHealth — Child AmeriHealth — TANF Adult AmeriHealth — SSI Adult AmeriHealth — Alliance

Notes: Enrollee risk scores based off risk-adjustment study period of July 2020–June 2021 and enrollment snapshot as of December 2021. Expenses incurred from January 1, 2021 to December 31, 2021 and paid as of January 31, 2022. IBNR is estimated based on historical payment lags.
Source: Enrollment and expense data are based on self-reported MCP Quarterly Financial Data and encounter data submitted directly to DHCF.

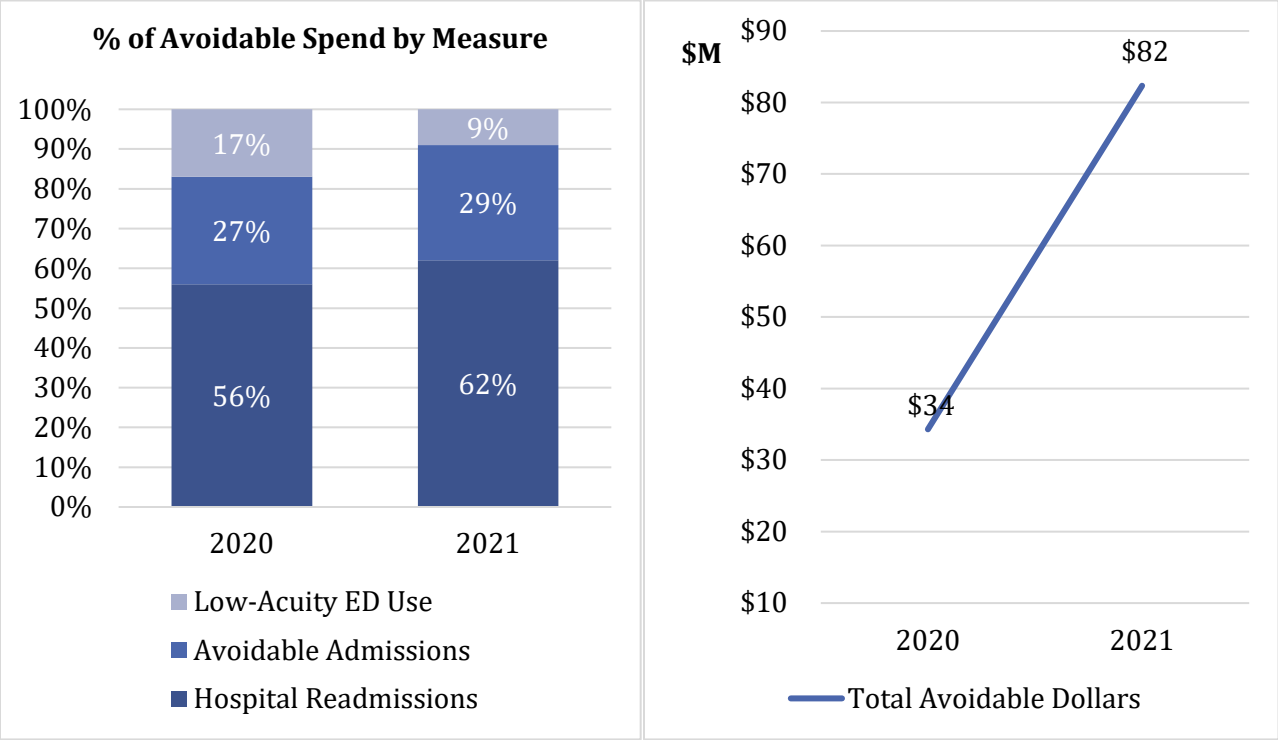
MENTAL HEALTH SERVICE UTILIZATION

DHCF is currently undertaking a variety of transformation efforts related to behavioral health (BH) care services for both mental health (MH) and substance use disorders (SUDs). These include the implementation of a Section 1115 waiver in 2020 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 through FFS. DHCF is working with a variety of stakeholders, including the DC Department of Behavioral Health, on transition and other matters related to delivery and administration of BH services. A future managed care report will provide data that aligns with related analyses currently under way.

CARE COORDINATION

The historic care coordination challenges that plagued the District's three DCHFP and Alliance MCPs have been well documented – enrollees' use of the emergency room (ER) for routine care, repeated occurrences of potentially avoidable hospital admissions, and the problem of hospital readmissions – remain stubborn challenges, but with some improvement. With the approval of the Centers for Medicare and Medicaid Services (CMS), DHCF implemented a MCP pay-for-performance (P4P) program in FFY 2017. For the period reflecting 2021 reporting, the MCPs have spent approximately $82 million on patient care that may have been avoided using more aggressive care coordination strategies. These amounts are notably higher than FY 2020 reported results, as seen in the Figure below, which illustrates both the percentage of avoidable spend by utilization metric and total avoidable spend so far in 2021 compared to 2020. The data period representing 2021 and the reported results reflect new DCHFP populations, increased populations due to the maintenance of eligibility, and contractual requirements that greatly impact IP and outpatient hospital claim expenses. DHCF will continue to work closely with the MCPs on identifying opportunities for continued improvement in implementing effective care coordination interventions.

AVOIDABLE HOSPITALIZATION SPEND — FFY 2020 TO FFY 2021



Notes: Current annual (2021) results reflect data incurred October 2020 through September 2021 with payment runout through December 31, 2021, compared to FY 2020 (October 2019 through September 2020) results. Total avoidable costs include Health Home enrollees.
Source: Mercer analysis of MCP encounter data for DCHFP reported by the MCPs to DHCF.

See Section V of this report for further details on MCPs performance on P4P metrics. DHCF postponed the P4P withhold in FY 2021 due to changes in the payment rates for the MCPs. However, the withhold incentive will be reinstituted in future years.

II. FINANCIAL PERFORMANCE

A. INTRODUCTION

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

- MLR — represents the portion of total revenue used by the MCPs to fund medical expenses, including expenses for cost containment.
- Administrative Loss Ratio (ALR) — represents the portion of total revenue used by the MCPs to fund both claims processing and general administrative expenses.
- Operating Margin (OM) — also referred to as profit margin and 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), as part of Mercer Health & Benefits LLC, established a benchmark for the OM needed to sustain a strong financial position that is approximately 2 – 4% annually over a three year to five year time horizon.

- RBC — represents a measure of the financial solvency of managed care plans and reflects the proportion of the required minimum capital maintained by a managed care plan as of the annual filing.

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

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

- **Risk-adjusted Payment Rates:** Risk-adjustment ensures financial viability and operational sustainability for MCPs whose enrollment represents a disproportionate share of high-acuity, high-cost beneficiaries. With DHCF's payment model, MCPs whose enrollees evince greater medical risk in the form of disease prevalence receive higher risk scores and greater payments. MCPs with lower-risk enrollees receive reduced rates. Therefore, health plans that properly align enrollment 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 2021 contract year, risk-adjustment was applied monthly for the first six months to the actuarially sound base capitation rates established during rate setting, transitioning to quarterly risk-adjustment for the last six months of the contract period. With the start of the new FY 2022 contract, quarterly risk-adjustment was implemented. Additionally, with the FY 2022 contracts effective October 2021, risk-adjustment was implemented for the Alliance program.

- **Provider Contract Rates:** Health 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 health plans in the degree to which their enrollees unnecessarily access high-end care as an alternative to less expensive treatment will drive variations in OMs. In addition, differences in the application of medical necessity requirements may directly impact utilization and incurred costs observed between MCPs.

The Table below reflects enrollment growth for both the DCHFP and Alliance populations, as well as the CASSIP population enrolled in HSCSN, from December 2020 to December 2021. As illustrated, enrollment increases were substantial for the DCHFP and Alliance MCPs due to contract changes made at the start of FY 2021 (October 2020) and the COVID-19 related maintenance of eligibility discussed earlier in this report. There was a moderate decrease in enrollment observed for HSCSN.

ENROLLMENT GROWTH — DECEMBER 2020 TO DECEMBER 2021

MCP	Enrollment December 2020	Enrollment December 2021	Net Change
AmeriHealth	104,348	121,491	16.4%

CareFirst	67,762	68,876	1.6%
MedStar	67,346	67,514	0.2%
HSCSN	5,056	4,965	−1.2%
Total DCHFP & Alliance MCPs	239,456	257,881	7.7%
Total MCPs	244,515	262,879	7.5%

Notes: AmeriHealth, CareFirst and MedStar enrollment results reflect both DCHFP and Alliance populations. HSCSN's results reflect enrollment for the CASSIP population for the referenced reporting period.
Source: Enrollment data extracted from Mercer's Q4 2021 Financial monitoring report.

The Table below illustrates the total revenue, medical and administrative costs, and OM for each of the MCPs as of December 2021. DHCF reports total capitation revenue by excluding District Exchange/Premium tax revenue based on letters and reports containing the MLR and calculations provided by the MCPs. For HSCSN, capitation revenue excludes District Exchange/Premium tax revenue and risk-share amounts. Total incurred claims (including IBNR) and cost containment expenses as of December 31, 2021, 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 District Exchange/Premium taxes as reported in the MLR report and calculations provided by the MCPs. OM is derived by subtracting net claims and administrative costs from MCP revenue.

- AmeriHealth's revenue and net claims increased relative to the prior year, resulting in the MCP's MLR holding steady and a reported operating profit in 2021.
- CareFirst experienced increased revenues relative to expenses, offset by an increase in administrative expenses, which resulted in a small operating gain for the MCP and an increased MLR.
- MedStar reported a notable operating gain, driven by low administrative costs relative to revenues.

All DCHFP MCPs are reporting operating profits for 2021, undoubtedly driven at least in part by the continued impacts of the COVID-19 PHE -- medical service utilization and enrollment -- and offset by the impact of the DCHFP program expansion and risk-adjusted rates.

MCP REVENUE AND EXPENSE DATA — CY 2021

MCP	Revenue	Claims	Administrative Cost	OM (Loss)
AmeriHealth	$720.4M	$650.2M	$50.0M	$20.2M
CareFirst	$376.8M	$349.1M	$26.9M	$0.8M
MedStar	$370.8M	$346.6M	$12.3M	$11.9M
HSCSN	$177.9M	$152.0M	$26.1M	$−0.2M

Notes:
Source: MCP Annual Statement as of December 31, 2021 filed by the MCPs with the DISB.

B. RISK-BASED CAPITAL

The MCP's RBC levels can be seen as a proxy for whether an MCP has the assets to pay claims and withstand the risks associated with a managed care contract. MCPs conduct this complicated calculation annually for each MCP using end-of-year financial data (as well as some information that is not publicly disclosed) provided to the DISB for review. MCPs with RBC levels that fall below 200% face greater scrutiny from DISB and DHCF to ensure 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.

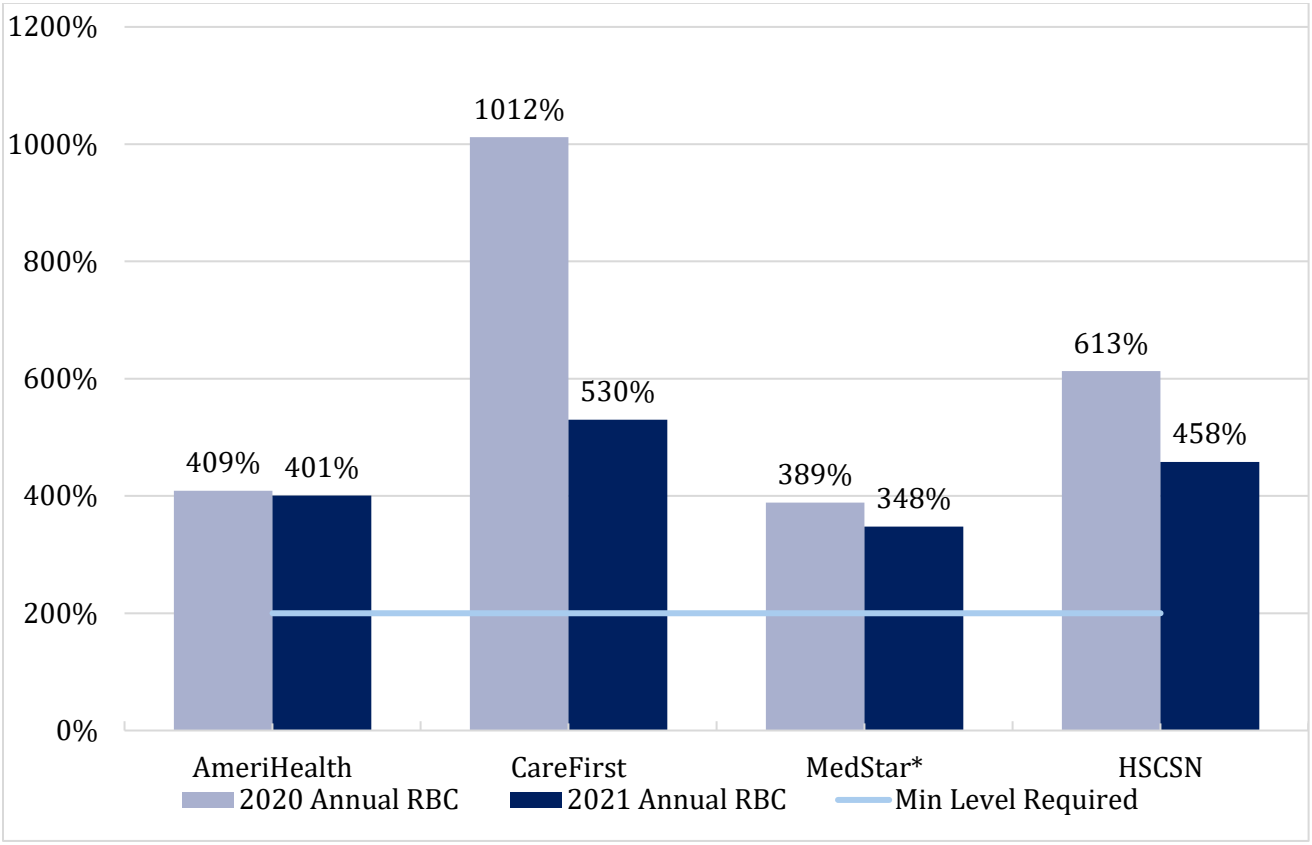
3. Regulatory Action Level — Total Adjusted Capital of 100% – 150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems.

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 2021 RBC for each MCP compared to the 2020 filings with DISB. Positive trends are indicated by results at or above the stated 200% threshold. As illustrated below, all MCPs maintained risk-based capital levels that exceeded recommended standards for the annual 2021 period. The impacts of COVID-19 on service utilization and increases in costs have likely resulted in lower realized profits and decreased retained capital and reserves for the MCPs in 2021, as seen in the following Exhibits below.

RBC — CY 2021 COMPARED TO CY 2020



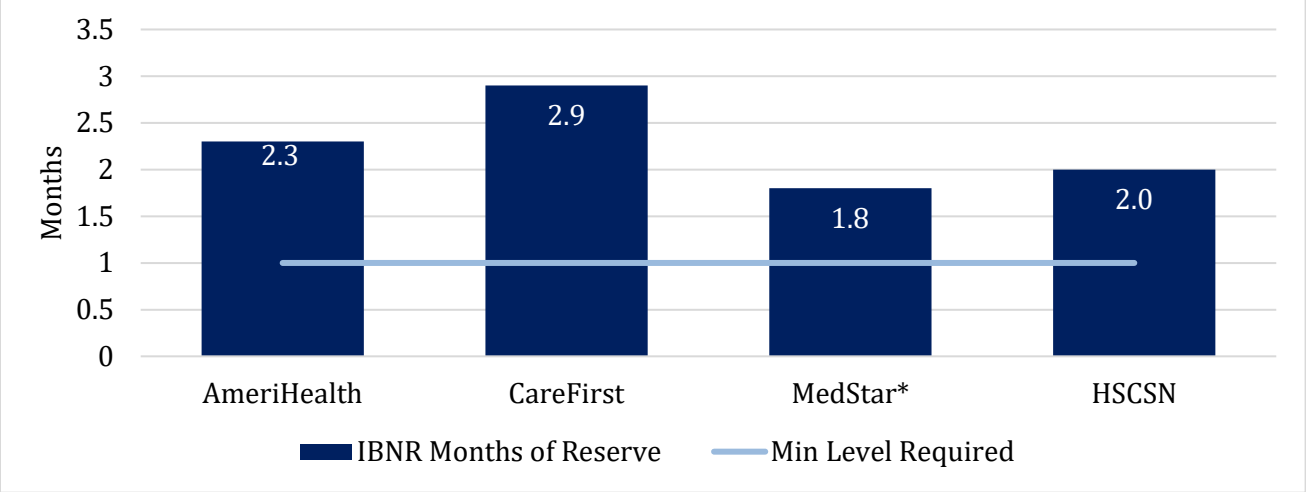
Notes: HSCSN is not subject to DISB RBC reporting requirements for the period under review. The reported numbers are calculated and included in this report for monitoring and informational purposes.
*MedStar began contracted services as of October 1, 2020. CY 2020 results shown represent three months of operation from October 1, 2020 to December 31, 2020. MedStar's IBNR, RBC, and Defensive Interval results are based on the MCP's reported DISBs, which includes a full year of MedStar's State of Maryland line of business.
Source: Reported figures are from the MCPs' annual 2020 and 2021 financial statements reported to DISB.

C. RESERVE AND LIQUIDITY METRICS

It is paramount in managed care that MCPs 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 MCPs each month and MCPs that fail to build a sufficient reserve may not be able to pay claims when they eventually clear the billing pipeline. Typically, MCPs 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 MCP's have available to satisfy IBNR claims for the CY 2021 Q1–Q4 reporting period.

IBNR MONTHS CLAIMS — CY 2021

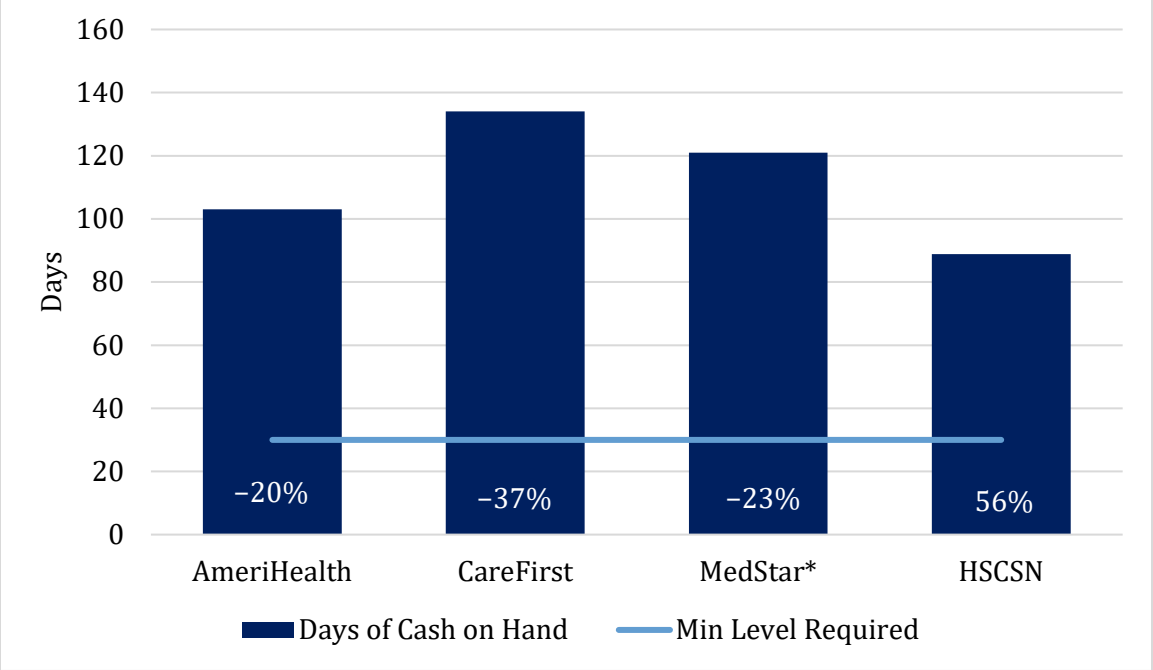


Notes: Estimated number of months of reserves compared to average monthly incurred claims.
*MedStar's IBNR, RBC, and Defensive Interval results are based on the MCPs' reported DISBs, which includes a full year of MedStar's State of Maryland line of business.
Source: IBNR is based on amounts reported on the MCPs' annual filings.

Based on the results illustrated in the Figure above, all MCPs have a sufficient number of months in reserve for estimated IBNR claims. All MCPs decreased their IBNR reserves compared to historical levels, likely due to the uncertainty of future costs correlated with the COVID-19 PHE. 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 MCP, by reporting on the number of days the MCPs can operate without accessing long-term assets for the annual 2021 period, along with trends (percentages included in the Table below) when comparing to 2020 levels. This is described as a Defensive Interval Ratio (DIR) which is, in essence, a liquidity measure -- the degree to which the MCPs can survive on liquid assets without having to access long-term assets. DHCF derives the liquidity metric by taking the cash, cash equivalents, and short-term investments as reported in the MCPs' DISB submissions, 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.

DIR — CY 2021 AND TRENDS



Notes: *MedStar's IBNR, RBC, and Defensive Interval results are based on the MCP's reported DISBs, which includes a full year of MedStar's State of Maryland line of business.
Source: Mercer calculated the DIR as cash, cash equivalents, and short-term investments divided by daily operating expenses for the period from January 2021 to December 2021.

All MCPs met the standard liquidity benchmark for the annual 2021 period, based on the formula used for this report to calculate the cash, cash equivalents, and short-term investments component of the DIR.

III. ADMINISTRATIVE PERFORMANCE

A. INTRODUCTION

There are several administrative requirements critical to the successful operation of MCPs. As a part of its core mission, MCPs 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 MCP enrollees with special or chronic health care issues and ensure that each of these enrollees 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 MCP. The five-year MCP 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 MCPs to the agency's Medicaid Management Information System (MMIS) and tracks the number of recorded encounters and the accuracy of encounter submissions to the agency's MMIS. As seen in the Table below, all MCPs met or exceeded the DHCF established target of a 95% acceptance rate, therefore continuing to maintain accurate encounter data file submissions for the CY 2021 reporting period. DHCF continues to work closely with the MCPs to enhance their internal encounter reporting and oversee processes to improve encounter submissions for accuracy and completeness.

NUMBER OF RECORDED ENCOUNTERS AND ACCURACY RATE — CY 2021

MCP	Total Submitted Encounters*	Acceptance Rate of Encounter Submissions
AmeriHealth	1,528,429	98.7
CareFirst	618,696	96.2
MedStar	656,856	98.3
HSCSN	335,488	99.7

Notes: * Gross count can include originals, voids, and resubmissions. All MCPs Acceptance Rates are calculated based on submissions through the end of the CY 2021.
Source: DHCF MMIS each month January 2021 through December 2021.

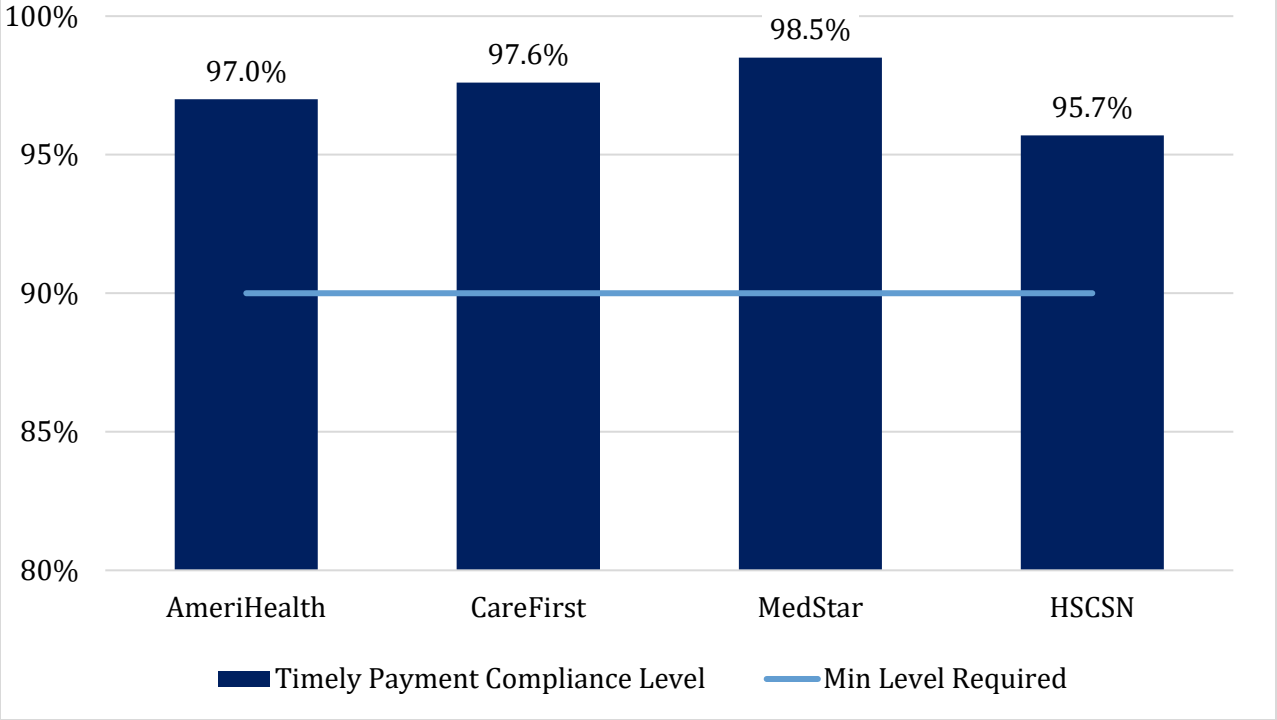
C. TIMELY PAYMENT OF CLAIMS

Timely payment of health care claims is a core requirement for the District's Medicaid MCPs. Claims processing is a central administrative function that MCPs must efficiently perform to avoid payment problems for providers. Through electronic claims processing, the District's MCPs are required to pay clean claims within 30 days to satisfy timely processing requirements. Like most MCPs, the District's MCPs utilize a series of automated edit-checks on all claims submitted for payment by health care 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/Enrollees

DHCF monitors compliance with timeliness requirements by comparing the MCPs' submissions to a target goal of 90% compliance of payment of all clean claims, as part of regular oversight reporting from each contracted MCP. Compliance with the timeliness requirement is measured by calculating the lag between the date the MCP receives a clean provider claim and the date of payment for that claim. As seen in the Figure below, each MCP exceeded DHCF's timely payment requirement for the CY 2021 reporting period.

TIMELY PAYMENT COMPLIANCE — CY 2021



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 MCP.
Source: Data is self-reported by MCPs on the DHCF's Claims Monthly Payment Report.

The District currently relies on MCP reporting of timely payment of their claims. Internal projects have begun to receive 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 MCP provided data outside DHCF's MMIS.

IV. MEDICAL SPENDING AND UTILIZATION TRENDS

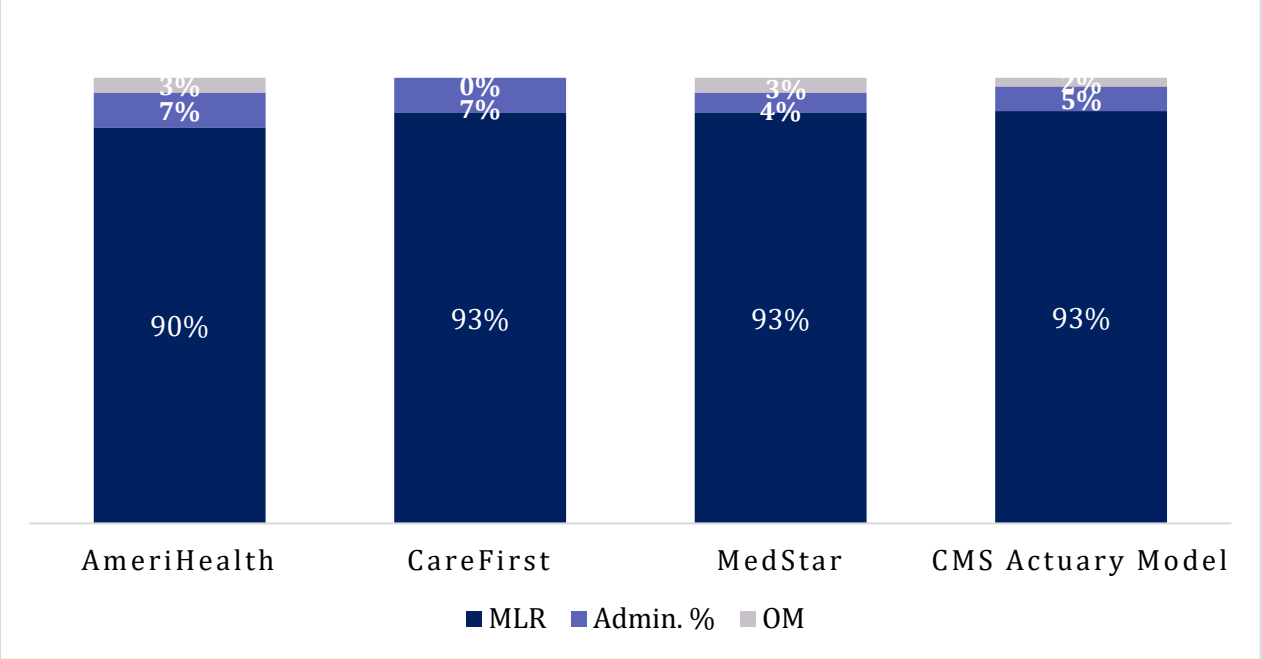
A. INTRODUCTION

This report provides an overview of the financial status of the MCPs during the current period (CY 2021) under review, and the underlying medical service cost trends and utilization driving the financial results for the four MCPs.

DCHFP and Alliance MCPs

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

MLR, ADMINISTRATIVE AND OM — CY 2021



Source: MCP Annual Statements as of December 31, 2021 filed by the MCPs with the DISB.

As illustrated in the above Figure, all DCHFP and Alliance MCPs posted operating profits for the 2021 calendar-year ending period, ranging from roughly 0% – 3% of total premium revenue. All MCPs spent at or above the minimum level of premium revenue on medical and quality improvement costs as reflected in each MCP's reported MLR; however, as discussed throughout this report, the effects of the COVID-19 PHE and managed care program expansion in late 2020 directly impacted medical service utilization and reported costs for the current period.

- AmeriHealth and MedStar reported operating profits in 2021, though overall growth in profits have slowed compared to 2020 levels.
- CareFirst's expenses have risen relative to revenue, resulting in an MLR of 93% which was a 4% increase from 2020.
- AmeriHealth reported higher overall PMPM expenses than the other MCPs, driven by the acuity of the population.

As noted earlier, DHCF risk-adjusted the DCHFP base capitation rates quarterly during the FY 2022 contract year, which is partially responsible for the fluctuations in revenue relative to expenses observed for the MCPs. 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.

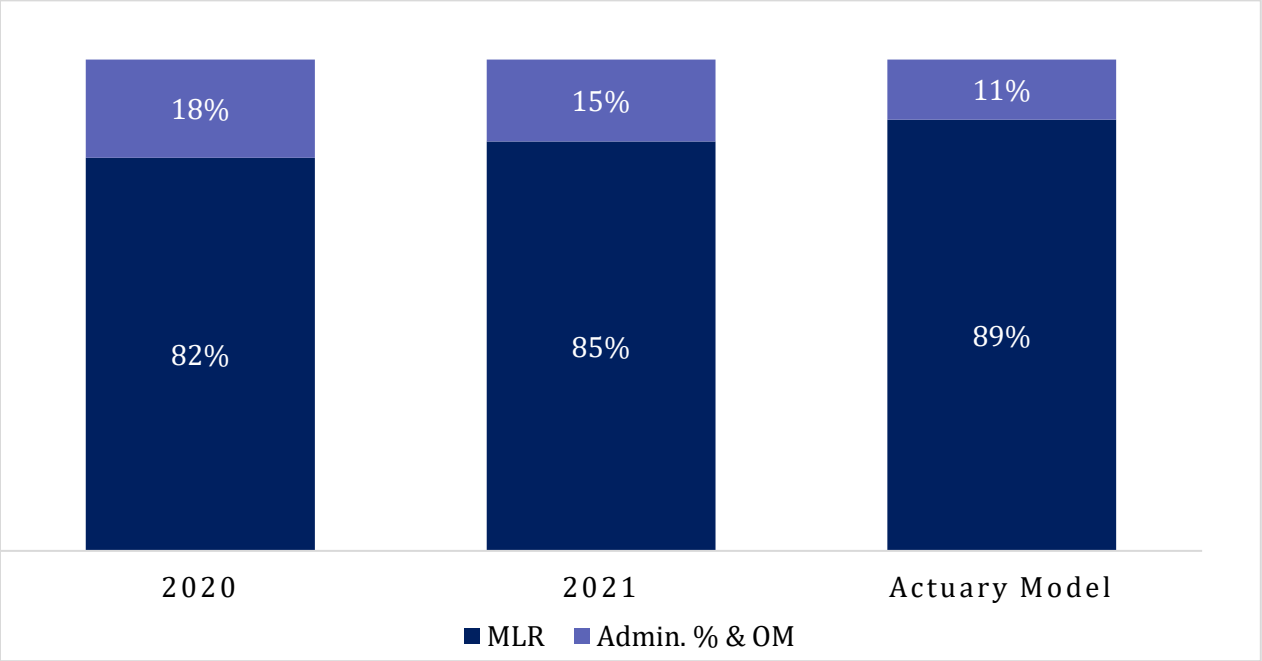
CASSIP

This report also provides a financial overview and medical service cost analysis of DHCF's CASSIP MCP contracted to manage the program. DHCF and the MCP 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 targeted 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%. Therefore, if the MCP experiences cost below 87%, the District shares in the financial gain. Conversely, if the MCP incurs cost above 91%, the District absorbs a portion of the cost.

The Figure and Table below exhibits the percent of MCP revenue spent on medical service costs and administrative costs, and how the financial gains or losses are shared between the MCPs and DHCF for the current reporting period.

MLR, ADMINISTRATIVE AND OM FOR CASSIP — CY 2020 TO CY 2021



Source: Annual statements as of December 31, 2021 submitted to DHCF by HSCSN.

RISK SHARE BASED ON TARGET MLR — CY 2020

Risk Share Based on 89% MLR	2020	2021
Total (At Risk) or Underspend[1]	$11.8M	$6.3M
Amount Due to MCP[2]	$0	$0
Amount Due to District[3]	$4.2M	$1.4

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

For CY 2021, HSCSN's medical expenses as a percentage of its revenue was below the threshold for the target MLR (~89%) established during annual rate development. This will likely trigger the risk-sharing provision if these results are reflected in the final settlement reporting period. HSCSN reported a small operating loss of roughly $(200,000), primarily driven by medical and administration costs rising relative to revenue.

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

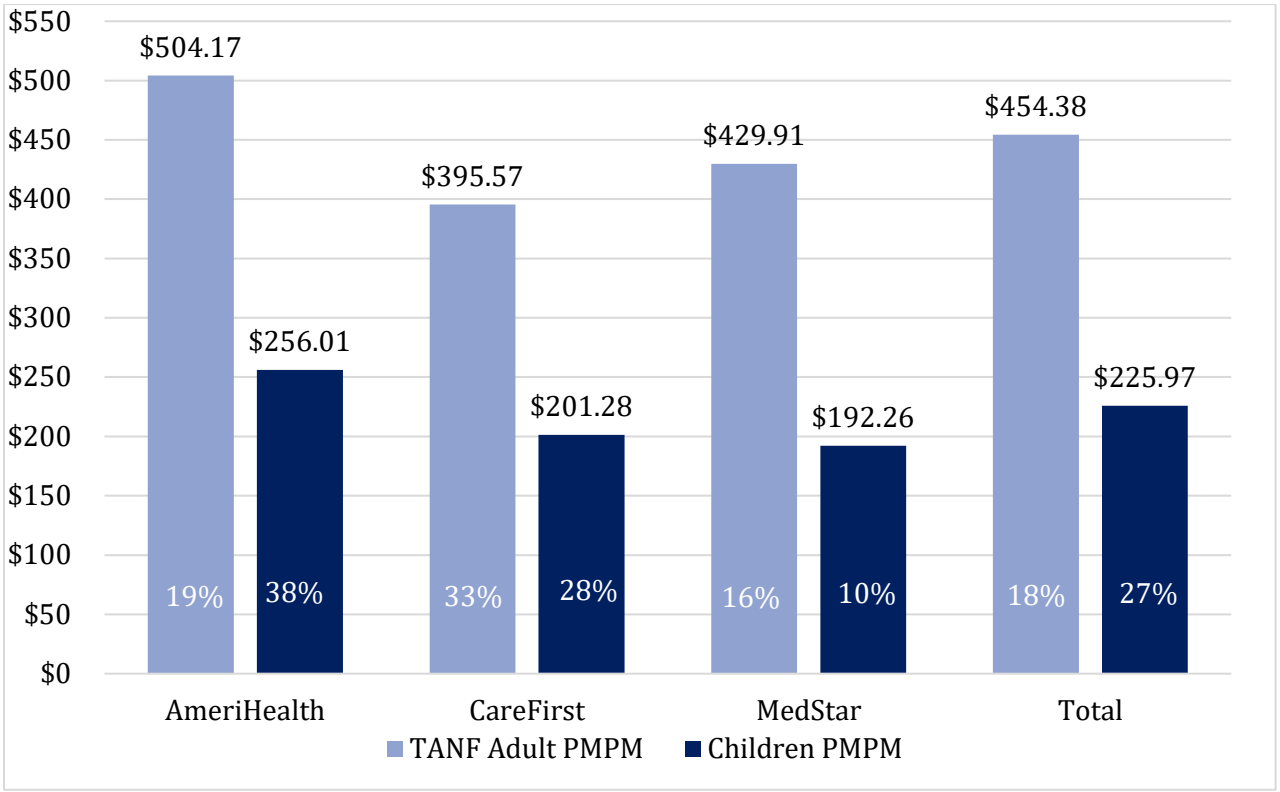
B. PMPM MEDICAL COSTS

This report presents an analysis of the PMPM medical service costs for the DCHFP, Alliance, and CASSIP — both the Well Child population and the children who have special health care needs and receive SSI benefits — programs and populations. DHCF and its contracted actuaries review quarterly financial data submitted by the MCPs for expenses incurred from January 1, 2021 to December 31, 2021 and paid as of January 31, 2022. The Figures below also provide an analysis of changes in average PMPM expenses, January 1, 2021 to December 31, 2021 compared to January 1, 2020 to December 31, 2020, for major high-cost medical service categories for the four MCPs.

IBNR included in the following expense figures is estimated based on historical payment lags. The relatively short run-out 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 the COVID-19 PHE that reflect the best estimate of DHCF and DHCF's contracted Actuaries as of the date of this report. These estimates may change, potentially rapidly and to a significant degree, as more experience and information emerges.

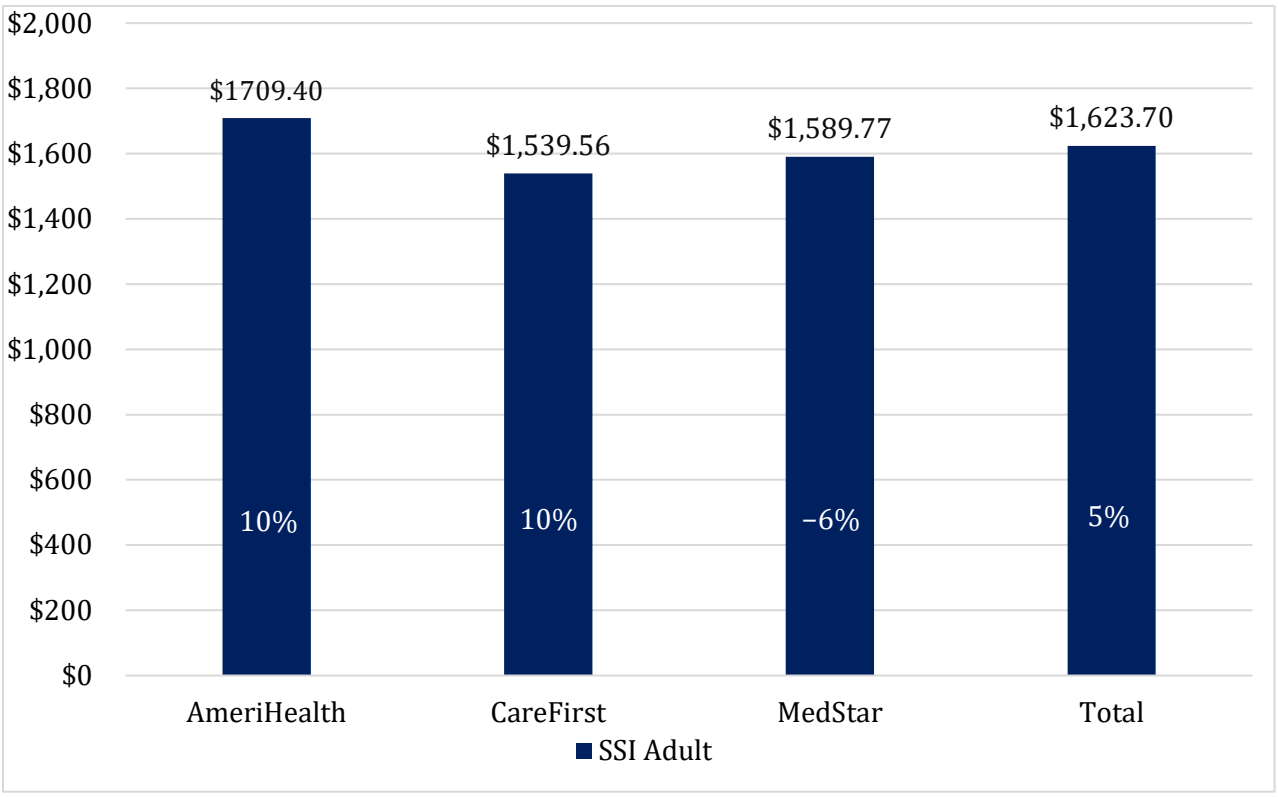
The Figure below illustrates the total PMPM costs associated with the DCHFP TANF Adult, SSI, and Child populations, along with trends in PMPM costs when comparing to a similar period during the prior year. A similar Exhibit is provided below for the Alliance PMPMs and cost trends when comparing to 2020 levels.

DCHFP TANF ADULT AND CHILD PMPM — CY 2021 AND TRENDS



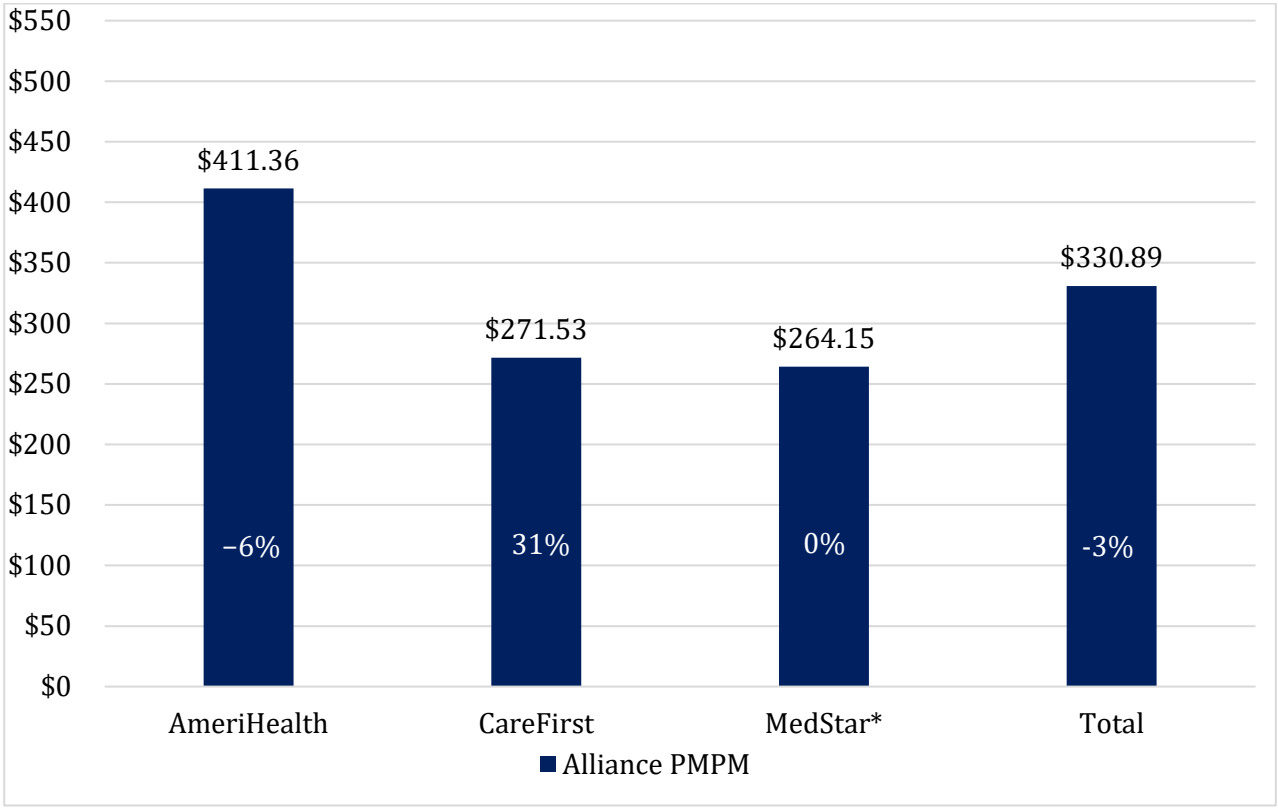
Notes: Children defined as person up to age 21 years in this analysis for the MCPs.
*MedStar began contracted services as of October 1, 2020. All results represent twelve months of operation from January 1, 2021 to December 31, 2021 compared to October 1, 2020 through December 31, 2020
Source: Enrollment and expense data are based on self-reported MCP Quarterly Financial Data submitted directly to DHCF.

DCHFP SSI ADULT PMPM — CY 2021 AND TRENDS



Note: All results represent twelve months of operation from January 1, 2021 to December 31, 2021 compared to October 1, 2020 through December 31, 2020.
Source: Enrollment and expense data are based on self-reported MCP Quarterly Financial Data submitted directly to DHCF.

ALLIANCE PMPM — CY 2021 AND TRENDS



Note: *MedStar began contracted services as of October 1, 2020. All results represent twelve months of operation from January 1, 2021 to December 31, 2021 compared to October 1, 2020 through December 31, 2020
Source: Enrollment and expense data are based on self-reported MCP Quarterly Financial Data submitted directly to DHCF.

Overall, increases in PMPM expenses were experienced for both the DCHFP TANF Adults, SSI Adults, and Child populations in 2021, primarily as a result of recovery from the impacts of the COVID-19 PHE, depressing medical service utilization, as well as new contractual requirements for hospital reimbursement.

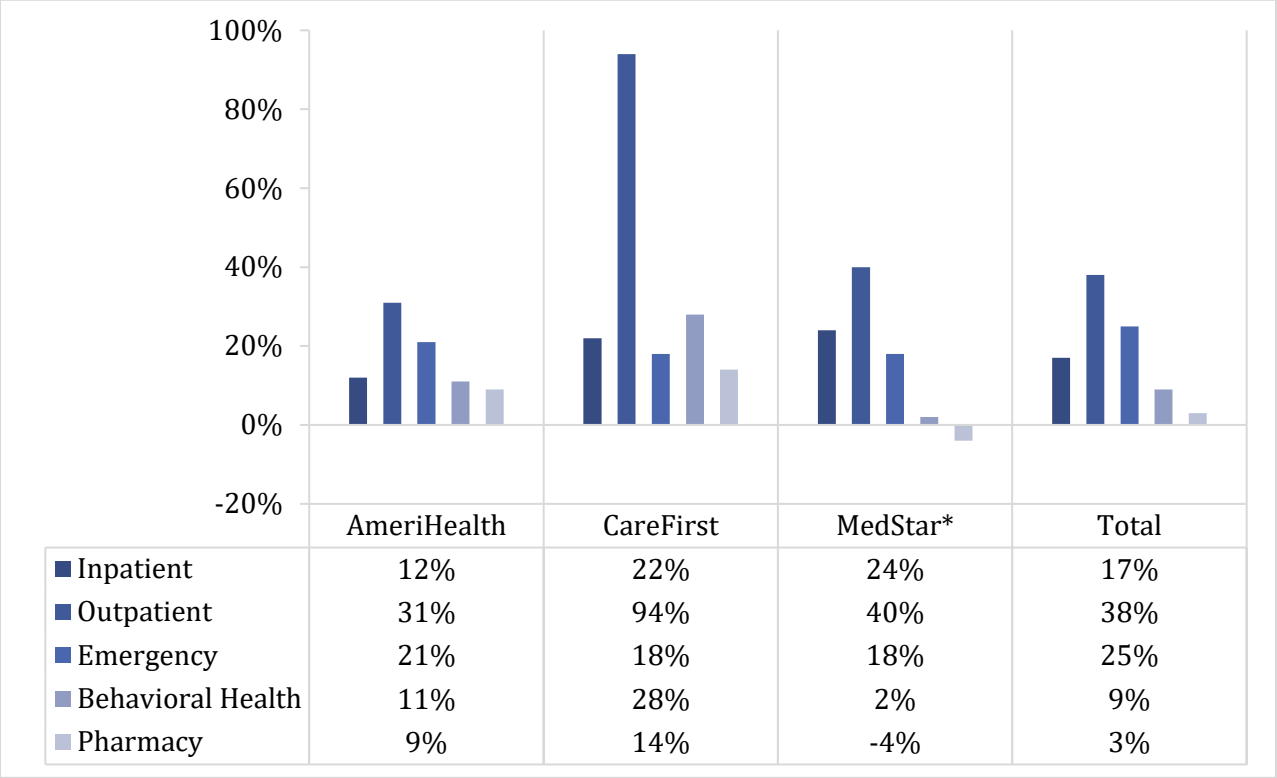
The DCHFP TANF Adult population experienced an 18% increase in PMPMs when comparing to a similar period in 2020, likely driven by the impacts of COVID-19 on service utilization. The DCHFP SSI Adult PMPMs remained relatively consistent, experiencing a 5% increase from 2020 driven by IP. The DCHFP Child PMPMs experienced significant increases (27%), driven primarily by IP, outpatient, physician, Federally Qualified Health Centers (FQHCs), and dental services.

The Alliance program experienced PMPMs decreasing by roughly 3%, driven primarily by offsetting IP and outpatient costs. Pharmacy reported a large decline (14%) for the Alliance compared to 2020 levels, which is a notable change compared to the relatively flat growth in pharmacy medical service costs in the past year.

Notable disparities in total PMPMs remain for AmeriHealth when compared to the MCPs, both for Alliance and the DCHFP TANF Adult and Child populations. Consistent with 2020, CareFirst reported the lowest overall PMPM across programs and populations, and the largest overall increase in PMPM expenses of 33% for -- the TANF Adult population, 10% for SSI Adults, and 28% for Children -- driven primarily by IP, outpatient, emergency department (ED), pharmacy, and physician medical service costs. AmeriHealth reported the highest PMPM for the newly transitioned SSI Adult population. See the Figures below for PMPM trends by high-cost medical service categories for DCHFP TANF Adult, Child, and CASSIP populations.

For HSCSN, PMPM expenses remained fairly stable compared to 2020 levels, increasing by 3% in total. These trends were driven by offsetting costs in IP and home health services. The Well Child population group experienced a 7% 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 a 2% increase in PMPMs during 2021. See the Figures below for overall trends in CASSIP cost growth and high-cost medical service categories.

DCHFP TANF ADULT PMPM TRENDS — CY 2020 TO CY 2021

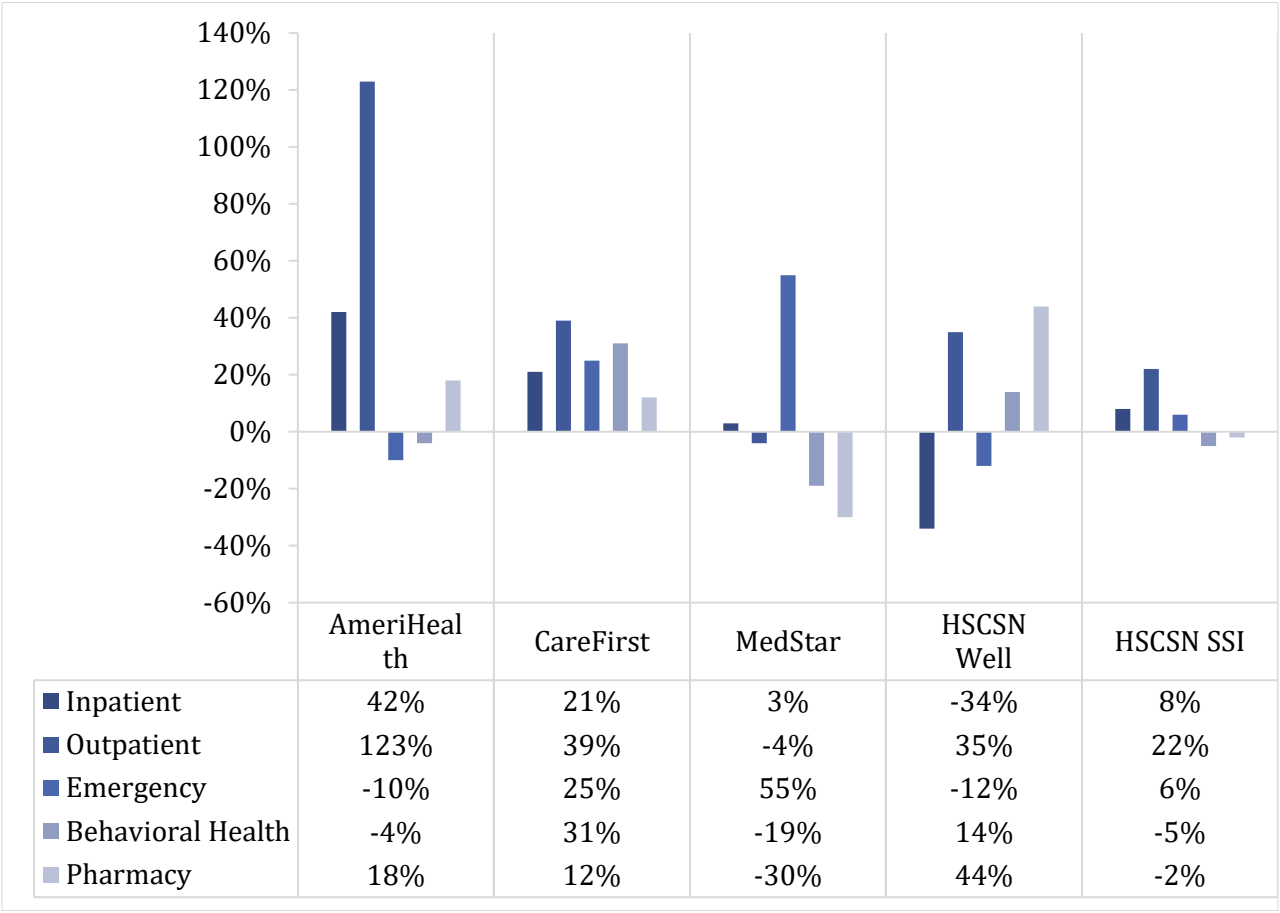


	AmeriHealth	CareFirst	MedStar*	Total
Inpatient	12%	22%	24%	17%
Outpatient	31%	94%	40%	38%
Emergency	21%	18%	18%	25%
Behavioral Health	11%	28%	2%	9%
Pharmacy	9%	14%	-4%	3%

Note: *MedStar began contracted services as of October 1, 2020. All results represent twelve months of operation from January 1, 2021 to December 31, 2021 compared to October 1, 2020 through December 31, 2020

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

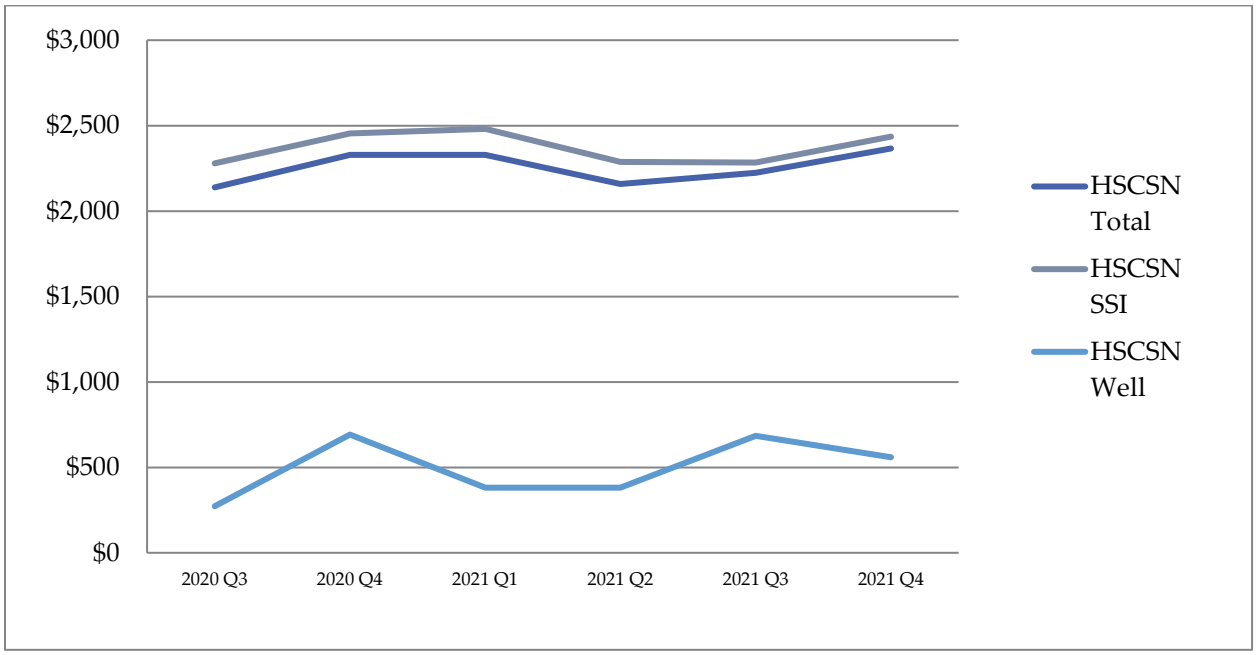
DCHFP & CASSIP CHILDREN PMPM TRENDS — CY 2020 TO CY 2021



	AmeriHealth	CareFirst	MedStar	HSCSN Well	HSCSN SSI
Inpatient	42%	21%	3%	-34%	8%
Outpatient	123%	39%	-4%	35%	22%
Emergency	-10%	25%	55%	-12%	6%
Behavioral Health	-4%	31%	-19%	14%	-5%
Pharmacy	18%	12%	-30%	44%	-2%

Notes: HSCSN's financial results are reported for both the Well Child population and the children who have special health care needs and receive SSI benefits.
*MedStar began contracted services as of October 1, 2020. All results represent twelve months of operation from January 1, 2021 to December 31, 2021 compared to October 1, 2020 through December 31, 2020
Source: Enrollment and expense data are based on self-reported MCP Quarterly Financial Data submitted directly to DHCF.

CASSIP PMPM TRENDS — CY 2020 Q3 TO CY 2021 Q4

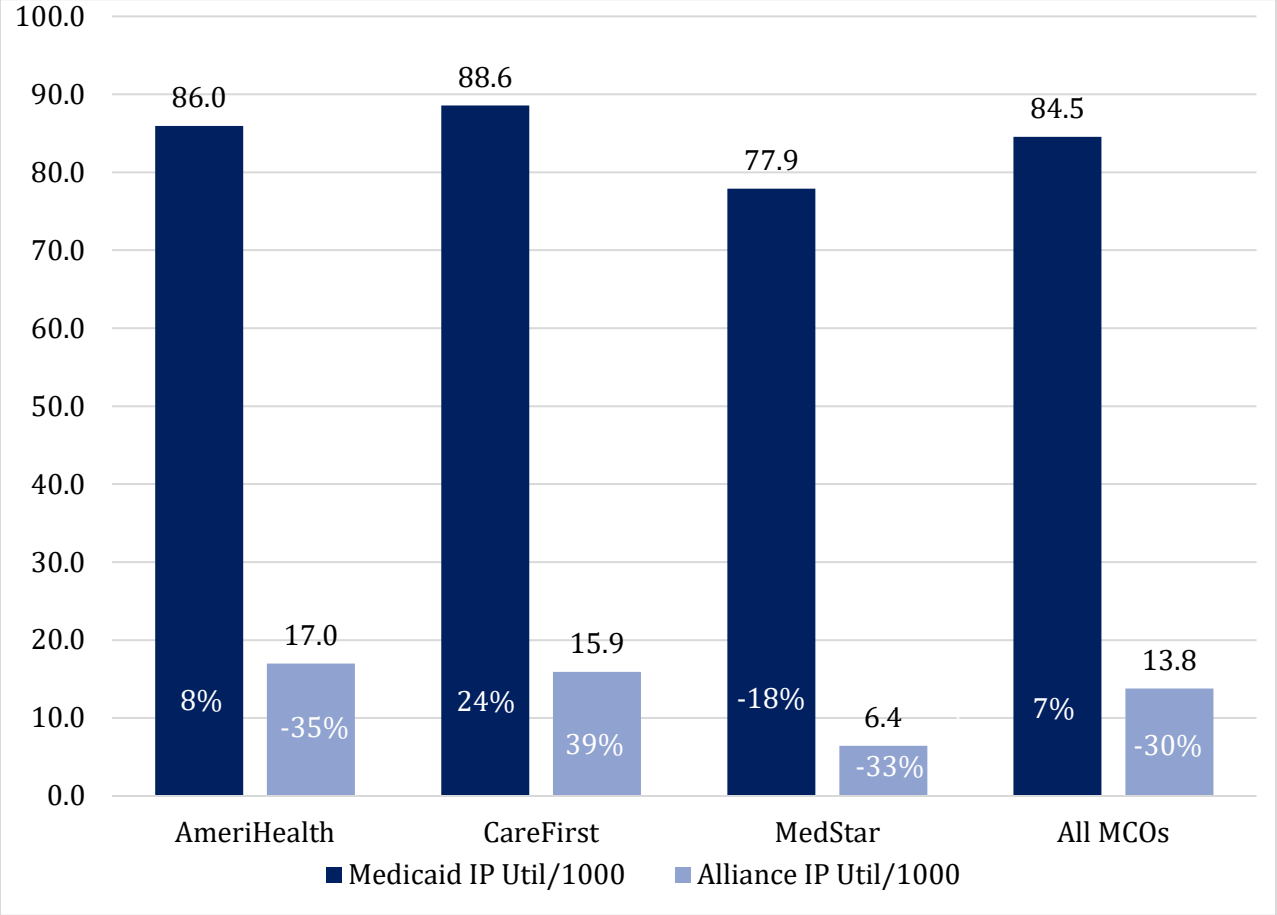


Source: Enrollment and expense data are based on self-reported MCP Quarterly Financial Data submitted directly to DHCF.

IP ADMISSIONS RATES

In addition to providing an analysis of primary and preventative care utilization, this report also includes an analysis of IP admission rates, expressed as utilization per 1000 member months (util/1000), which reflect more costly health care utilization. The Figure below illustrates the current indexed IP admission rates for the period CY 2021 based on MCP-encounter claims from DHCF's MMIS, data and trends when comparing to those for CY 2020.

IP ADMISSION RATES AND TRENDS — CY 2020 TO CY 2021



Noted:
*MedStar began contracted services as of October 1, 2020. All results represent twelve months of operation from January 1, 2021 to December 31, 2021 compared to October 1, 2020 through December 31, 2020
Source: Data based on MCP encounter data submitted to MMIS.

For the current performance period, IP utilization for the DCHFP program increased by 7% from 2020 levels, driven by AmeriHealth and CareFirst's experience. MedStar began operations with the District on October 1, 2020, and their utilization change is affected by significant enrollment changes between Q4 2020 and CY 2021.

Further analysis of the numerators (IP stays) and the denominators (enrollment sizes) shows that for the AmeriHealth population, increases in IP stays (8% for Medicaid) resulted in an 8% increase in IP rates from CY 2020 levels for the Medicaid population. For CareFirst, increases in IP stays (24% for Medicaid) and in enrollment (56% in Medicaid) resulted in a 40% increase in IP util/1000 from

CY 2020. Both the impacts of the COVID-19 PHE, 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. For MedStar, large decreases to IP stays along with increased enrollment resulted in an 18% decrease to IP rates.

Alliance enrollment rose from 2020 to 2021 due to the maintenance of eligibility, which drives the overall decrease in IP admissions relative to member months. The Chart above is limited to IP admissions within managed care, and thus excludes IP stays that are covered under the District's FFS program. As a result, the admissions for Alliance beneficiaries are more volatile and result in large percent changes from year to year.

V. PAY FOR PERFORMANCE AND CARE COORDINATION

A. INTRODUCTION

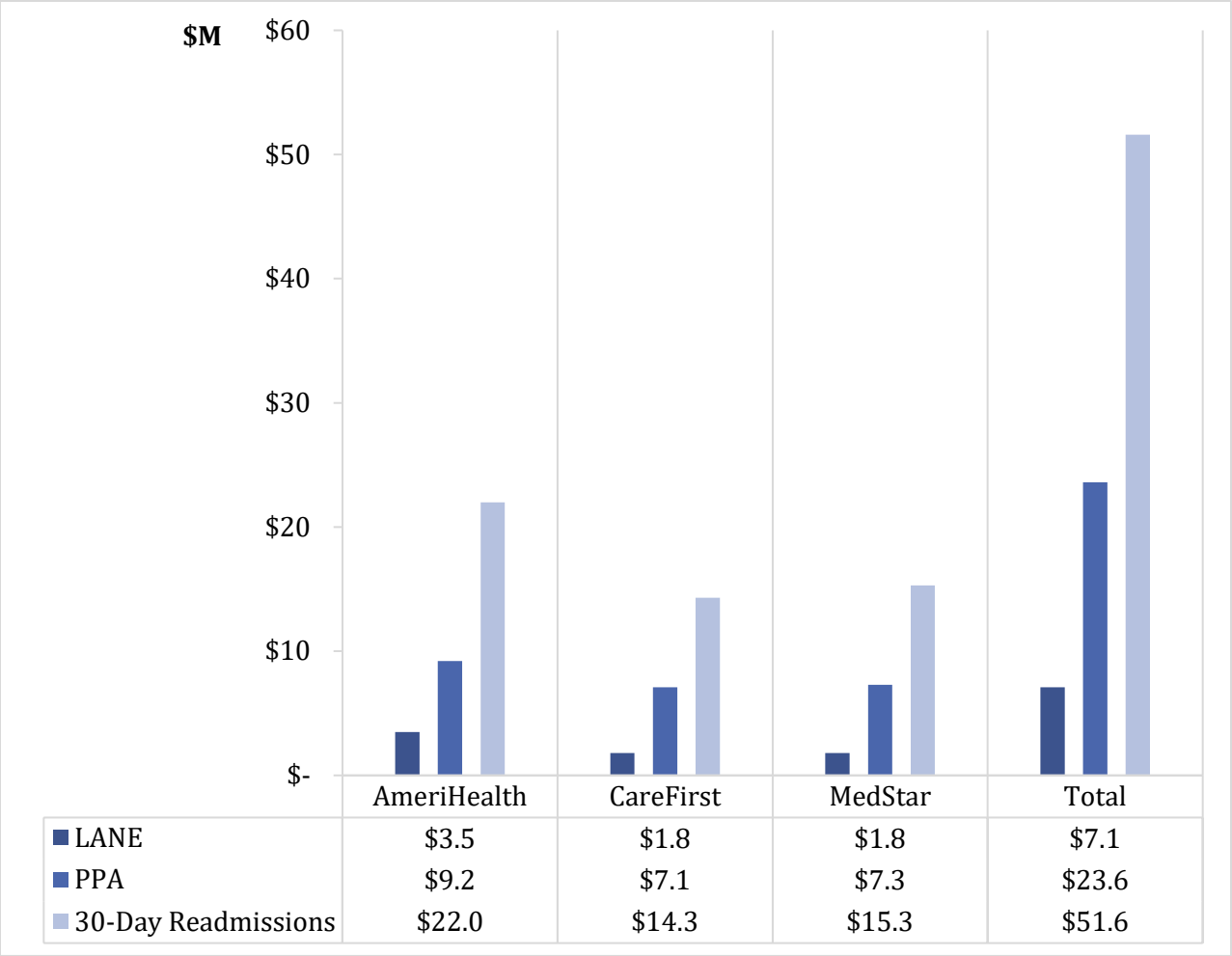
Achieving high value in health care for Medicaid beneficiaries is a preeminent goal of DHCF's managed care program. The District's MCPs are expected to advance their enrollees' health care and improve outcomes per dollar spent through aggressive care coordination and health care management. From October 2016 to September 2018, DHCF's three MCPs serving the DCHFP program 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 MCPs 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 MCPs:

- Low Acuity Non-emergent (LANE) Visits — emergency room utilization for non-emergency conditions[3]
- Potentially Preventable Admissions (PPAs) — admissions to the hospital which could have been avoided with access to quality primary and preventative care[4]
- 30-Day All-Cause Readmissions — hospital readmissions for problems related to the diagnosis which prompted a previous and recent (within 30 days) hospitalization[5]

The MCPs could potentially save millions by reducing their enrollees' use of the emergency room 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 MCPs for potentially avoidable emergency room visits and hospitalizations. The amounts listed as potentially avoidable would likely be offset by other costs if the MCPs improved their care management, such as increased outpatient costs due to increased use of ambulatory care.

[3] LANE visits are emergency room visits that could have been potentially avoided, identified using a list of diagnosis applied to outpatient data.
[4] Avoidable admissions are identified using a set of prevention quality measures applied to discharge data.
[5] Readmissions represent IP visits within 30 days of a qualifying initial IP admission.

AVOIDABLE SPEND ON MANAGED CARE SERIVCES — CY 2021



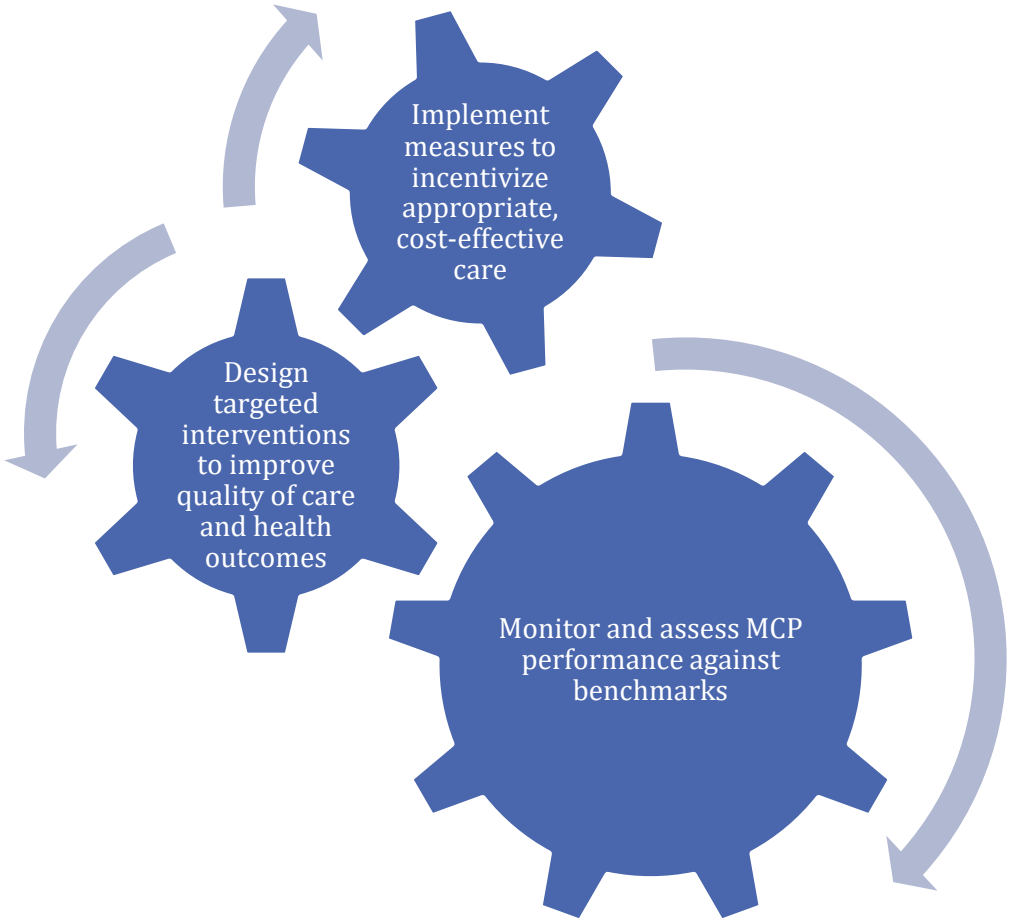
	AmeriHealth	CareFirst	MedStar	Total
LANE	$3.5	$1.8	$1.8	$7.1
PPA	$9.2	$7.1	$7.3	$23.6
30-Day Readmissions	$22.0	$14.3	$15.3	$51.6

Notes: Current annual results for 2021 reflect data incurred during the 12-month period (October 2020 through September 2021) with payment runout through December 31, 2021. Total avoidable costs include Health Home enrollees.
Source: Mercer analysis of MCP Encounter data for DCHFP reported by the MCPs to DHCF.

B. METHODOLOGY

When previously active, the managed care P4P program was funded through a 2% withhold of each MCP's actuarially sound capitation payments for non-delivery DCHFP rate cells for the corresponding period. The 2% withhold was approximately the profit margin for each MCP factored into the base PMPM payment rate. Actual P4P results are based on MCP 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 run-out through September 2016. MCPs 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 2021 or FY 2022 (CY 2021) measurement years, 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 MCPs. LANE and PPA quality metrics are weighted at 33% of the capitation withhold. The MCPs have an opportunity to earn back the full 33% based on performance as follows:

- 10% reduction (improvement) in LANE ED utilization and PPAs from the baseline will result in the MCP 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 MCP earning 50% of the 33% withhold attributed to these measures.

- 5% reduction in LANE ED utilization and PPAs from the baseline will result in the MCP 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 MCPs 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 MCPs 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 MCPs' performance on the targeted quality measures. Since a run-out period must be allowed to ensure a more complete picture of claims activity, payments

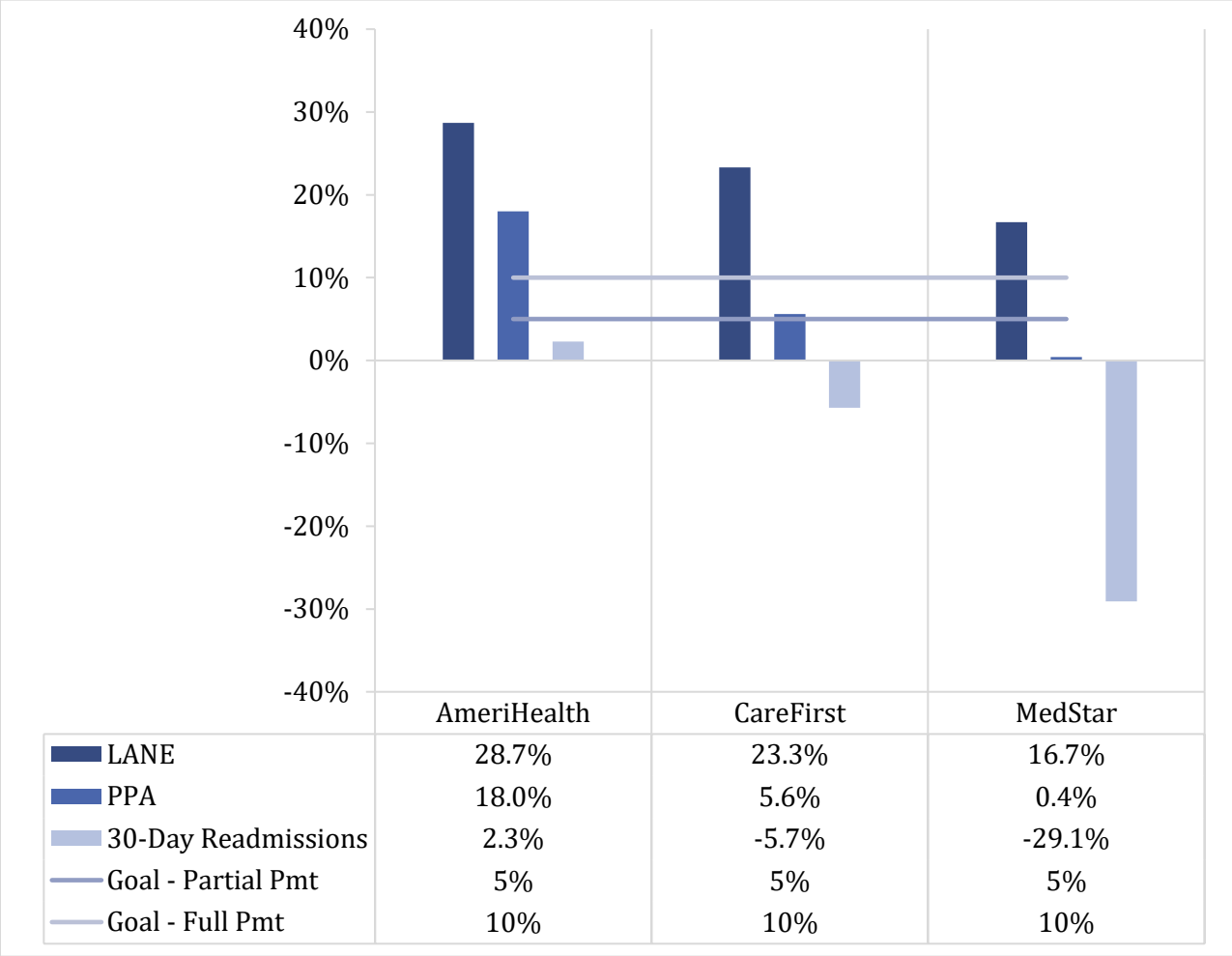
will likely occur four to seven months after the measurement period closes in years when the withhold is in effect.

DHCF is reassessing the P4P program for FY 2023, and may modify requirements (e.g., performance measures, targets, incentive structure) for future contract years. DHCF seeks to move MCPs towards a greater focus on interventions and will require each MCP 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 2021 reporting period for the three MCPs providing services to the DCHFP population.

PERCENTAGE IMPROVEMENT ON P4P — FY 2021 COMPARED TO BASELINE



	AmeriHealth	CareFirst	MedStar
LANE	28.7%	23.3%	16.7%
PPA	18.0%	5.6%	0.4%
30-Day Readmissions	2.3%	-5.7%	-29.1%
Goal - Partial Pmt	5%	5%	5%
Goal - Full Pmt	10%	10%	10%

Notes: Current annual results for 2020 reflect data incurred during the 12-month period (October 2020 through September 2021) with payment runout through December 31, 2021. Final metrics are net of Health Home enrollees.
Source: Mercer analysis of MCP Encounter data for DCHFP reported by the MCPs to DHCF.

All three MCPs are currently meeting the historical target improvement thresholds for LANE — 10% reduction in avoidable visits compared to the baseline — for the representative period of 2021 compared to the baseline period of the P4P program. Improvement of the PPA and IP Readmission

from the baseline is mixed. The current measurement period includes reductions in utilization of ER and other medical services due to the impacts of the COVID-19 PHE, which likely artificially impacted the reported P4P results, as well as the inclusion of SSI adults who were not covered under managed care during the baseline period. Please note the capitation withhold is not in effect for the FFY 2021 or FFY 2022 measurement year, although DHCF plans to reinstitute quality incentive requirements in the upcoming 10-year managed care contracts.

VI. CONCLUSION

Each MCP'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 COVID-19 pandemic on medical service utilization, costs for the District's contracted MCPs, 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 MCPs, their growth in medical service costs have continued to subside in 2021 resulting in positive operating margins for the MCP. 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 MCPs 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 and 2021, including Alliance risk-adjustment, the District has observed better alignment of cost and associated payment across the DCHFP and Alliance.

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 of the COVID-19 PHE on hospital utilization and associated medical service cost is still unknown, and the District will continue to monitor MCP experience for future reporting periods.

Moving forward, as the health care landscape continues to evolve, DHCF is focused on strategic initiatives targeted to improve the health outcomes of Medicaid beneficiaries by imagining perfect programs. Programs that are simpler and easier to navigate for beneficiaries and administer for staff –

- Where beneficiaries understand their benefits and are supported to engage in the management of their health.
- Where the services are paid for to support cost-effectiveness and higher quality.
- That are designed and operated so that beneficiaries can access the services they need to manage and improve their health and to address inequities in health.
- Where quality of care is a focus which should improve beneficiary health and address health inequities.
- Where our energies are focused on improving a few things, and where we are more focused on driving strategic changes and getting the core operations of the program right.

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.