GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

MEDICAID MANAGED CARE PERFORMANCE REPORT

(January 2022 – December 2022)

February 12, 2024

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I. EXECUTIVE SUMMARY

A. BACKGROUND

The District of Columbia (DC) Department of Health Care Finance (DHCF) is the single State/District agency responsible for administering Title XIX of the Social Security Act, the Medicaid program. This Performance Report is specific to the Medicaid managed care program during calendar year (CY) 2022 or January 1, 2022 through December 31, 2022. The DC Medicaid managed care program consists of the following categories:

District of Columbia Healthy Families Program (DCHFP), covering individuals who meet the eligibility requirements of the Temporary Assistance for Needy Families (TANF) program, the Children's Health Insurance Program (CHIP), adults ages 21 years and older designated as non-dual Supplemental Security Income (SSI) beneficiaries.

Child and Adolescent Supplemental Security Income Program (CASSIP) covers children and young adults who meet the eligibility requirements for the District's SSI program and choose to voluntarily enroll in the managed care program. Additionally, the District allows healthy children of CASSIP mothers to remain in the CASSIP through age 5 years.

Immigrant Children's Program (ICP) covers children less than 21 years who are ineligible for Medicaid due to citizenship or immigration status but meet pre-determined income guidelines. The beneficiaries enrolled in the ICP are only eligible for medical services.[1]

DC Healthcare Alliance Program (Alliance) covers adults 21 years and older with incomes at or below 210% of the federal poverty level (FPL) and are ineligible for Medicaid.

Enrollment as of December 2022

Health Program	Total Enrollment
DCHFP and ICP	250,173
Alliance	14,208
CASSIP	5,070

Throughout the CY, all enrollment was attributed amongst the following Managed Care Plans (MCPs):

<u>Alliance, DCHFP, and ICP</u>

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

<u>CASSIP</u>

- Health Services for Children with Special Needs (HSCSN)

The DCHFP and Alliance enrollment is directly influenced by the maintenance of eligibility (MOE) associated with the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE). Specifically, DCHFP experienced continued enrollment increases to the TANF adult population. Alliance enrollment increased until disenrollments for persons not eligible resumed in

[1] The DCHFP referenced throughout this report includes ICP for purposes of enrollment and expense results.

September 2022. Thereafter, the program observed a significant number of disenrollments through the end of 2022.

All MCPs continued to offer comprehensive benefits during CY 2022. The DCHFP and Alliance MCPs — AmeriHealth, CareFirst, and MedStar — operated under full -risk contracts until September 30, 2021. On October 1, 2021, the District added a risk-sharing arrangement to the three managed care contracts. HSCSN has historically operated under a risk-sharing arrangement through its managed care contract with the District.

In 2022, the District of Columbia spent roughly $1.8 billion[2] on services administered by the MCPs. Roughly 90% ($1.6 billion) of this amount funded the DCHFP and Alliance MCPs, while approximately 10% ($179 million) funded the risk-sharing contract with HSCSN. DHCF continually strives to improve the health and well-being of the residents of the District through an articulation of the agency's vision, mission, values, and strategic priorities, described later in this report.

The ***Medicaid Managed Care Performance Report*** illustrates the financial condition of the MCPs during CY 2022, which includes reporting on whether MCPs' 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 — such as timely claims processing, robust enrollee encounter systems, and appropriate use of claims denial procedures — are closely monitored and tracked by DHCF on a regular basis and are reflected in subsequent sections of this report. Lastly, this report includes quantitative and qualitative analysis of key service level utilization — primary care visits for both adults and children, as well as inpatient (IP) admission rates — in addition to MCP performance with enrollees' care coordination measured via progress against established quality measures during the period under 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 DC have the supports and services they need to be actively engaged in their health and to thrive.

Mission: DHCF works to improve health outcomes by providing access to comprehensive, cost--effective, and quality healthcare services for residents of DC.

Values:

1. Professionalism — Treat all recipients and community partners with respect and dignity.
2. Accountability — Ensure the efficiencies built into the Medicaid managed care program are effective.
3. Compassion — Extend access to those who are unable to afford comprehensive health insurance.

[2] Total Capitation Revenue and District Exchange/Premium tax revenue are based on the Medical Loss Ratio letters and calculations provided by the MCPs and summarized and reported by DHCFs' actuaries. For HSCSN, capitation revenue excludes District Exchange/Premium tax revenue and Risk Share amounts.

4. Teamwork — Partner 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.

C. Strategic Priorities:

- Build a health system that provides whole person care.

- Ensure value and accountability in our programs.

- Strengthen DHCF's internal operational infrastructure.

- Successfully unwind from the 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.

D. GOALS AND OBJECTIVES

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

- Evaluate the degree to which DHCF's risk--based MCPs and the single risk-sharing plan successfully ensure beneficiary access to an adequate network of providers while managing the appropriate utilization of healthcare services.
- 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.

E. KEY FINDINGS

FINANCIAL RESULTS

DCHFP and Alliance MCPs reported mixed financial performance for the CY 2022 review period. MedStar and CareFirst posted a profit ranging from 0% – 4%, but AmeriHealth reported a loss of 2.6%. Other financial metrics indicate a healthier performance for AmeriHealth, whose profitability metrics are influenced by their conservative reserve reporting. Each of the DCHFP and Alliance MCPs reported risk-based capital (RBC) positions well above the required minimum level of 200%. All three MCPs also reported 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.

The key financial metrics are discussed with more detailed discussion in Section II of this report.

Beginning with fiscal year (FY) 2018 contract year, a disproportionate share of the high--acuity, high--cost population transitioned from the other DCHFP and Alliance MCPs to AmeriHealth, leading to unforeseeable operating and financial challenges for the MCP throughout 2018 and 2019. With implementation of the new MCP contracts in FY 2021, DHCF included a new requirement, ***"universal contracting"*** for key providers. Universal contracting requires each of the MCPs administering the

DCHFP, Alliance, and ICP to contract with every hospital, FQHC, and hospital-related provider group in DC. Likewise, through provider agreements executed by DHCF with these same providers and facilities, each must contract with all MCPs administering the DCHFP, Alliance, and ICP. This was designed to help mitigate in future years the adverse selection experienced by AmeriHealth. Still, because of their higher risk population, AmeriHealth continues to have the highest per member per month (PMPM) costs for all covered populations. DHCF accounted for this problem, in part, by the implementation of risk-adjusted rates 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. This better aligned capitation payments to risk levels for both the DCHFP and Alliance programs.

Additionally, effective the first quarter of FY 2022, DHCF implemented a risk-sharing arrangement for the DCHFP and Alliance programs. This arrangement limits the financial gains and losses under the contract through application of risk corridors and provides additional financial stability for the MCPs.

AmeriHealth reported an operating loss of $21.0 million, which can be attributed to medical expenses increasing at a higher rate than revenue (noting medical claims are directly impacted by AmeriHealth's increase in reported reserves). MedStar reported an operating profit of $18.2 million in 2022. CareFirst's expenses have remained constant relative to revenue, resulting in a 92% MLR, which was a 1% decrease from 2021. MedStar reported healthy reserves and capital levels, resulting in a 92% MLR and notable underwriting gain. In FY 2022, DHCF received risk corridor payouts from each MCP due to low realized MLRs specific to the Alliance program. DHCF also received a small payout from Medstar for DCHFP.

HSCSN, the MCP contracted to administer the CASSIP, reported an MLR of 91% but an operating loss of –$3.6 million. Although the MCP reported decreases in overall PMPM medical costs, HSCSN reported an increase in medical management costs (which increased the MLR), and high administrative costs which resulted in the reported loss. HSCSN reported healthy capital and liquidity levels.

Additional analysis of service categories and PMPM trends are discussed in Section IV of this report.

ADMINISTRATIVE PERFORMANCE

There are five areas 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, 4) successful execution of an encounter system, and 5) value--based payments. Data from this analysis indicates the MCPs are on balance, properly managing these significant responsibilities:

- The MCPs 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. Though some of the MCPs have historically struggled to contract with all District hospitals, DHCF addressed this issue through universal contracting requirements for certain providers.

- All the MCPs exceeded the District's timely payment requirement to pay clean claims within 30 days of receipt during CY 2022, ensuring continuity of operations for their contracting.

MEDICAL COSTS AND UTILIZATION TRENDS

MEDICAL EXPENSES

Overall, PMPM expenses remained relatively flat across the managed care program, increasing by only 1%. The slight increase was driven by increases to the DCHFP Child (11%) and SSI Adult (3%) populations when compared to 2021 levels. However, the overall increase was dampened by the TANF Adult population, which experienced a small decrease to their PMPM (−2%). To support States and promote stability of coverage during the COVID-19 PHE, beneficiaries that would have historically been disenrolled from the DCHFP have received continuous coverage. This primarily impacts the TANF and Expansion Adult populations in the DCHFP and Alliance programs, increasing enrollment for these groups during CY 2022.

The Alliance program PMPM increased 5% in 2022, following a 3% decrease in CY 2021. This program was impacted significantly by the District's continuous enrollment policy - enrollments increased 65% from March 2020 to August 2022. However, due to a sharp drop in service utilization during the pandemic and immediately afterwards, Alliance PMPM costs decreased 44%. The District resumed beneficiary-redeterminations in September 2022, and a sharp decrease in enrollment and corresponding increase in PMPMs was observed in the last quarter of 2022. The Alliance program has historically observed escalating PMPM trends, as higher beneficiary churn and aging of the population with more complex medical problems spiked spending on outpatient hospital costs. This program will be monitored closely as the enrollment and program costs emerge following 2022.

For HSCSN, medical service costs decreased in 2022, resulting in an overall decrease in PMPMs of 3% from 2021 levels. Similar to CY 2021, HSCSN's total PMPMs remain near pre--COVID-19 levels.

RISK-ADJUSTED CAPITATION RATES

Risk-adjustment seeks to align each MCP's risk as reflected in the disease prevalence of the enrolled population, with the incurred healthcare costs and associated payment for services provided to enrolled beneficiaries. The DCHFP rates have been risk-adjusted since the start of the FY 2021 managed care contracts, or October 1, 2020. With the start of the FY 2022 contract year in October 2021, the Alliance rates are also risk-adjusted on a quarterly basis to account for varying levels of costs based on the enrollment and acuity of the underlying MCP's population. AmeriHealth continues to have the highest PMPM costs and corresponding risk scores across all populations.

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 (SUDs). These efforts include implementation of a Section 1115 waiver in 2020 that expanded the array of BH services and providers covered under the Medicaid program, as well as planning a future managed care carve--in of certain BH services currently paid through fee-for---service (FFS) Medicaid. DHCF is working with a variety of stakeholders on these issues, and 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 — enrollees' use of the emergency room (ER) for routine care, repeated occurrences of potentially avoidable hospital admissions, and the problem of hospital readmissions — have been well

documented and remain stubborn challenges, but with some improvement. With the approval of the Centers for Medicare & Medicaid Services (CMS), DHCF implemented the MCP pay--for--performance (P4P) program in Federal Fiscal Year (FFY) 2017. For the period reflecting 2022 reporting, the MCPs have spent approximately $83 million on patient care that may have been avoided using more aggressive care coordination strategies. These amounts are similar to FY 2021 reported results. The CY 2022 data period reflects new DCHFP populations, increased populations due to the MOE, and contractual requirements that greatly impact inpatient 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 in the future.

See Section V of this report for further details on the MCPs' performance on P4P metrics. DHCF postponed the P4P withhold in FY 2021 due to changes in the payment rates for the MCPs; however, DHCF plans to reinstitute the withhold incentive in FY 2025.

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 OM indicates a loss. DHCF's Actuary, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, established an OM benchmark of approximately 2 – 4% annually over a 3 – 5-year time horizon in order to sustain a strong financial position.
- RBC: Represents a measure of the financial solvency of MCPs and reflects the proportion of the required minimum capital maintained by a MCP 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 and continues each month.

Assuming adequacy in the base capitation payment rate, there are typically four 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 accounts for 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. Capitation rates paid in 2022 for DCHFP and Alliance were risk-adjusted. The DCHFP risk scores were updated on a quarterly basis. Alliance risk scores were updated quarterly from January 2022 – September 2022. With the end of the Alliance MOE, risk scores were updated monthly from October 2022 – December 2022 to capture enrollment changes due to beneficiary disenrollments during that period.

- Provider Contract Rates: MCPs that negotiate contract rates adequate to build a solid network but lower than their competitors can realize significantly higher surpluses.

- Risk of Provider Financial Viability: MCPs must verify providers are paid in a timely and correct manner to ensure the providers are in healthy financial condition.

- Patient utilization management: Relative differences across MCPs 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 illustrates the total revenue, medical and administrative costs, and OM for each of the MCPs as of December 2022. DHCF reports this data on an adjusted basis:

- Total capitation revenue is reported by excluding District Exchange/Premium tax revenue and risk-share amounts based on the MLR letters and calculations provided by the MCPs.

- Total incurred claims include IBNR (as of December 31, 2022) and cost containment expenses which are net of reinsurance recoveries.

MCP REVENUE AND EXPENSE DATA — CY 2022

MCP	Revenue	Claims	Administrative Cost	OM (Loss)
AmeriHealth	$802.6M	$775.1M	$48.4M	$(21.0)M
CareFirst	$403.6M	$371.5M	$31.3M	$0.8M
MedStar	$402.3M	$368.5M	$15.5M	$18.2M
HSCSN	$178.6M	$163.4M	$18.8M	$(3.6)M

Source: MCP Annual Statement as of December 31, 2022, filed by the MCPs with the DISB.

- 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 MLR report and calculations provided by the MCPs.

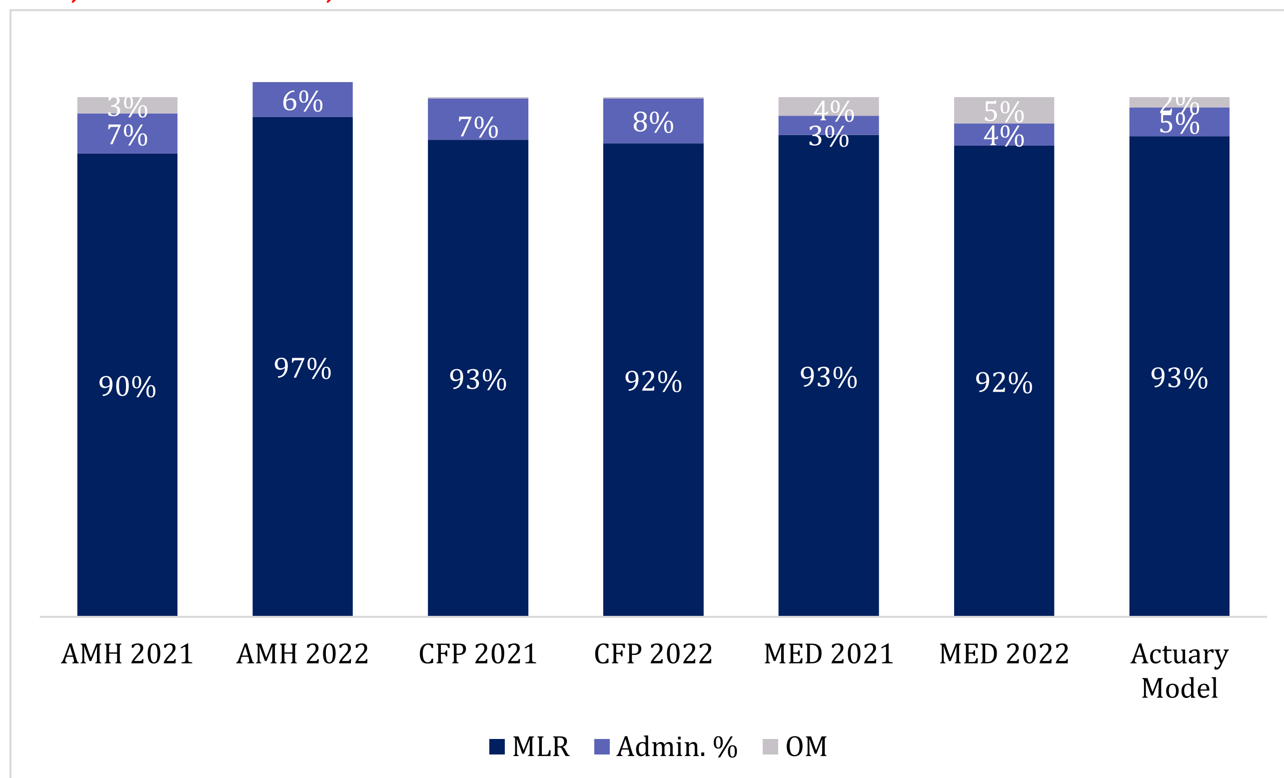
- OM is derived by subtracting adjusted claims and administrative costs from adjusted MCP revenue.

Of the three MCPs serving DCHFP and Alliance, AmeriHealth is the largest health plan in terms of revenue and expenses, and it shows a calculated loss for 2022. CareFirst and MedStar have similar levels of revenue and claim expenses, but MedStar reports lower administration costs, which results in a larger OM. HSCSN, the single health plan managing the CASSIP, reported a loss for 2022. Please see below for commentary on these results.

DCHFP AND ALLIANCE MCPS

The figure below illustrates the portion of the DCHFP and Alliance MCP revenue spent on medical service costs (MLR), the portion spent on administrative costs, and the portion of MCP revenue remaining as OM. These are compared to the MLR, administrative, and OM relationship based on the capitation rate components.

MLR, ADMINISTRATIVE, AND OM FOR DCHFP AND ALLIANCE — CY 2021 TO CY 2022



Note: For the purposes of this graph, AmeriHealth, CareFirst, and MedStar are represented by AMH, CFP, and MED, respectively.
Source: MCP Annual Statements as of December 31, 2022, filed by the MCPs with the DISB.

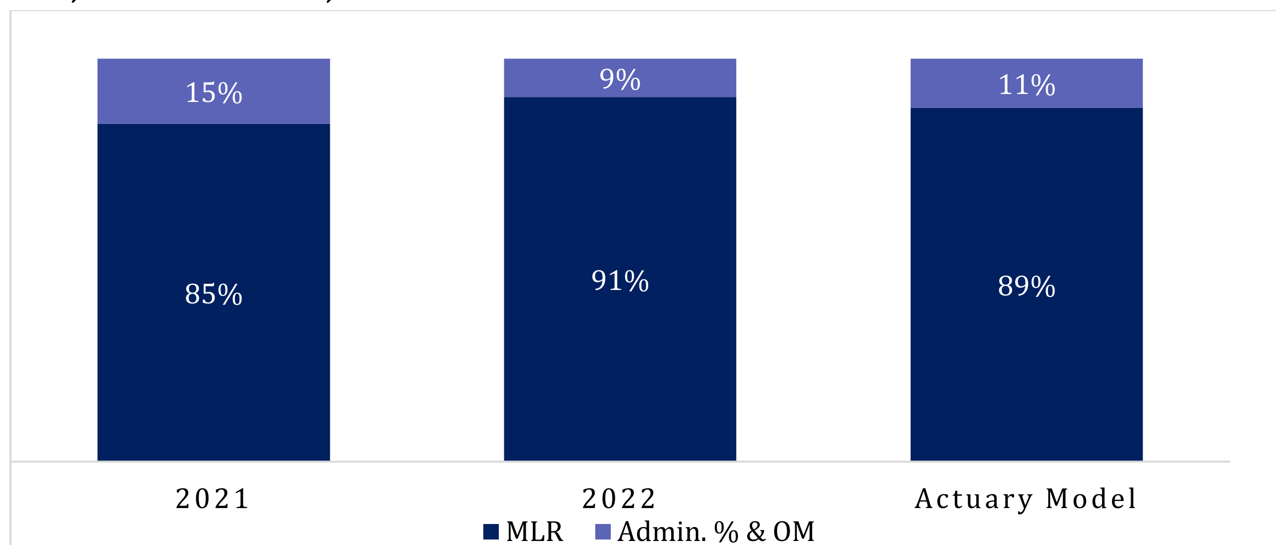
All DCHFP and Alliance MCPs spent at or above the minimum level of premium revenue on medical and quality improvement costs, as reflected in each MCP's reported MLR. As noted earlier, DHCF risk adjusted the DCHFP base capitation rates quarterly, which helped to align revenue and claims expenses. Listed below are comments for each MCP:

- AmeriHealth reported a loss of 3% of capitation revenue for CY 2022, compared to a large positive OM in CY 2021 ($20.2 million); their MLR has risen to 97% for 2022 from 93% at year-end 2021. These changes from the prior year are driven by claim expenses rising at a higher rate than revenue. AmeriHealth continues to hold a relatively high level of IBNR reserves, which directly impacts expense levels and reported profits. Their reserves, which increased to $34 million as of December 2022, are reflected as claims expenses in the MLR calculation.
- CareFirst's OM and MLR are consistent with CY 2021 results. Their revenue and expenses have also risen, but at similar rates.
- MedStar's administration costs for DCHFP and Alliance are shared with their State of Maryland lines of business. The amounts allocated to the District programs are relatively small as a percentage of premium, which drives a larger OM compared to other MCPs with a similar MLR.

CASSIP

This report also provides a financial overview and medical service cost analysis for DHCF's CASSIP MCP, HSCSN. The figure below shows the percentage of MCP revenue spent on medical service costs and administrative costs. HSCSN's MLR has risen from 85% in CY 2021 to 91% in CY 2022. This is as a result of total revenue remaining flat year -over -year, while medical claims expense has grown by 8%.

MLR, ADMINISTRATIVE, AND OM FOR CASSIP — CY 2021 TO CY 2022



Source: Annual statements as of December 31, 2022, submitted to DHCF by HSCSN.

The underlying trends in medical service costs for all DCHFP, Alliance, and CASSIP MCPs are discussed in additional detail below in Section IV.B of this report.

RISK-SHARING

DHCF included risk-sharing arrangements for DCHFP, Alliance, and CASSIP in order to limit the financial gains and losses under the contract through the application of risk corridors. The arrangements set risk corridors around an annual target MLR established during rate setting. For the FFY 2022 rate setting period, the target MLR for DCHFP and Alliance is approximately 93%, and the target MLR for CASSIP is approximately 89%. All risk corridors apply to gains and losses of more than 2%. Therefore, if the MCP experiences cost below 91% in DCHFP or Alliance (87% in CASSIP), the District shares in the financial gain. Conversely, if the MCPs incur costs above 95% (91% in CASSIP), the District absorbs a portion of the cost, as shown in the table below.

DCHFP AND ALLIANCE FFY 2022 RISK CORRIDOR — SHARE OF DHCF AND MCP GAINS/LOSSES

MLR Corridor	MLR Corridor — Target of 93.3%	DHCF Share of Gains/Losses	MCP Share of Gains/Losses
Greater than or equal to Target MLR +5%	MLR greater than or equal to 98.3%	80%	20%
Target MLR +5% to Target MLR +2%	MLR of 95.3% to 98.3%	50%	50%
Target MLR +/− 2%	MLR of 91.3% to 95.3%	0%	100%

MLR Corridor	MLR Corridor — Target of 93.3%	DHCF Share of Gains/Losses	MCP Share of Gains/Losses
Target MLR −2% to Target MLR −5%	MLR of 88.3% to 91.3%	50%	50%
Less than or equal to Target MLR −5%	MLR less than or equal to 88.3%	80%	20%

CASSIP FFY 2022 RISK CORRIDOR — SHARE OF DHCF AND MCP GAINS/LOSSES

MLR Corridor	MLR Corridor — Target of 88.7887%	DHCF Share of Gains/Losses	MCP Share of Gains/Losses
Greater than or equal to Target MLR +11%	MLR greater than or equal to 99.7887%	100%	0%
Target MLR +11% to Target MLR +2%	MLR of 90.7887% to 99.7887%	50%	50%
Target MLR +/− 2%	MLR of 86.7887% to 90.7887%	0%	100%
Target MLR −2% to Target MLR −11%	MLR of 77.7887% to 86.7887%	50%	50%
Less than or equal to Target MLR −11%	MLR less than or equal to 77.7887%	100%	0%

ILLUSTRATIVE RISK-SHARE BASED ON TARGET MLR — CY 2022

Risk Share Based on Target MLR	AmeriHealth	CareFirst	MedStar	HSCSN
Total (At Risk) or Underspend[1]	$(26.3)M	$5.0M	$6.8M	$(4.4)M
Amount Due to MCP[2]	$(5.1)M	$0	$0	$(0.4)M
Amount Due to District[3]	$0	$0	$0	$0

Footnotes:
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 each program, the actual risk corridor evaluations are performed in alignment with the MCP contract years (FFY from October 2022–September 2023 basis). Below is commentary on the CY 2022 MLRs, and what this would look like if modeled as the risk corridor results.

HSCSN

HSCSN's CY 2022 MLR falls just above the 2% corridor bound and would result in a small amount due from the District. HSCSN's calculated OM (shown in the revenue and expense table above) shows a loss of roughly $3.6 million, primarily driven by medical and administration costs rising relative to revenue.

AMERIHEALTH

AmeriHealth's CY 2022 MLR for the combined DCHFP and Alliance programs is 97%, which would trigger payment from DHCF to the MCP if these were actual results for DCHFP and Alliance combined. As discussed above, AmeriHealth's reported reserves increase claims costs used to calculate the MLR.

The risk corridor evaluation is calculated with longer payment runout and includes a review of reported IBNR for reasonability, which helps to control for the higher reserves reported in the DISB filing.

CAREFIRST

CareFirst's CY 2022 MLR for the combined DCHFP and Alliance programs is 92%, which would not trigger payment from DHCF to the MCP if these were actual results for DCHFP and Alliance combined.

MEDSTAR

MedStar's CY 2022 MLR for the combined DCHFP and Alliance programs is 92%, which would not trigger payment from DHCF to the MCP if these were actual results for DCHFP and Alliance combined.

B. RBC

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 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. The 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.

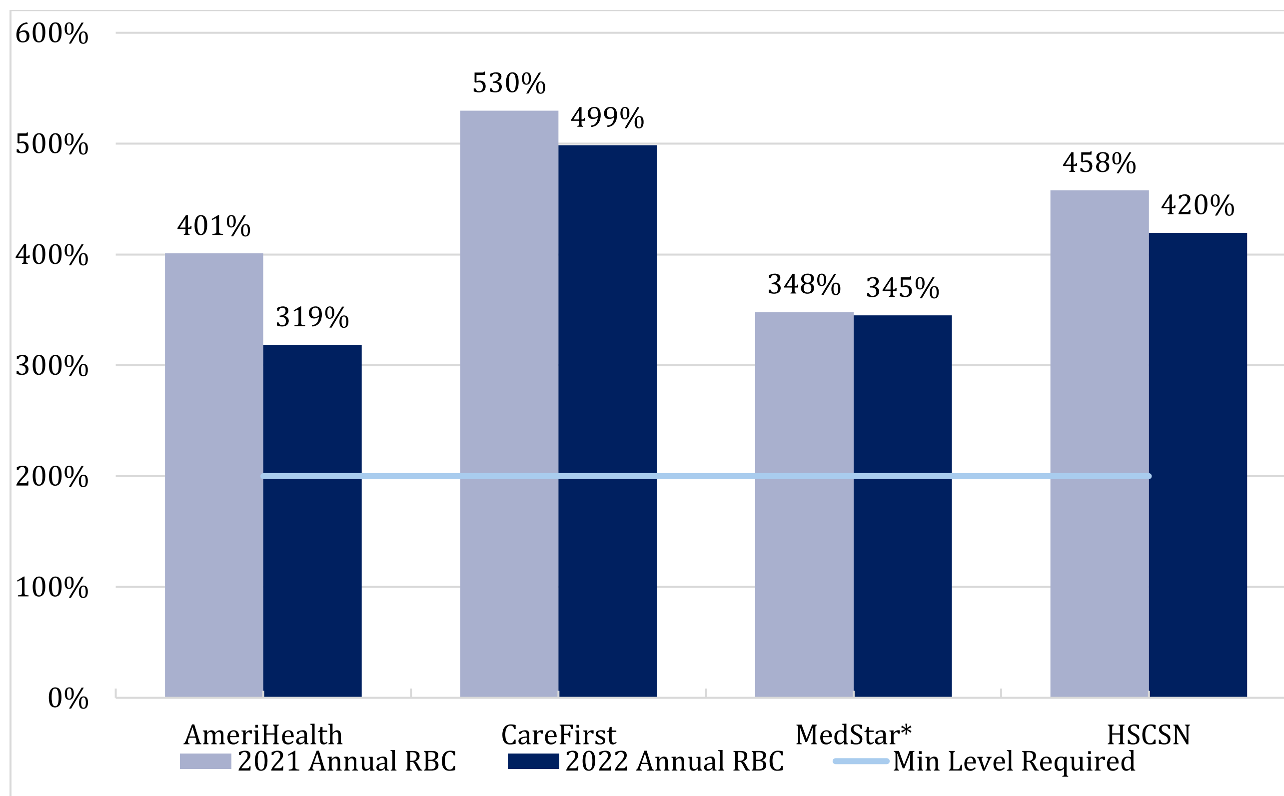
3. Regulatory Action Level: Total Adjusted Capital of 100%–150% of Authorized Control Level. The company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems.

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 2022 RBC for each MCP compared to the 2021 filings with DISB. Positive trends are indicated by results at or above the stated 200% threshold. As illustrated below, all MCPs maintained RBC levels that exceeded recommended standards for the annual 2022 period.

RBC Ratio — CY 2022 COMPARED TO CY 2021



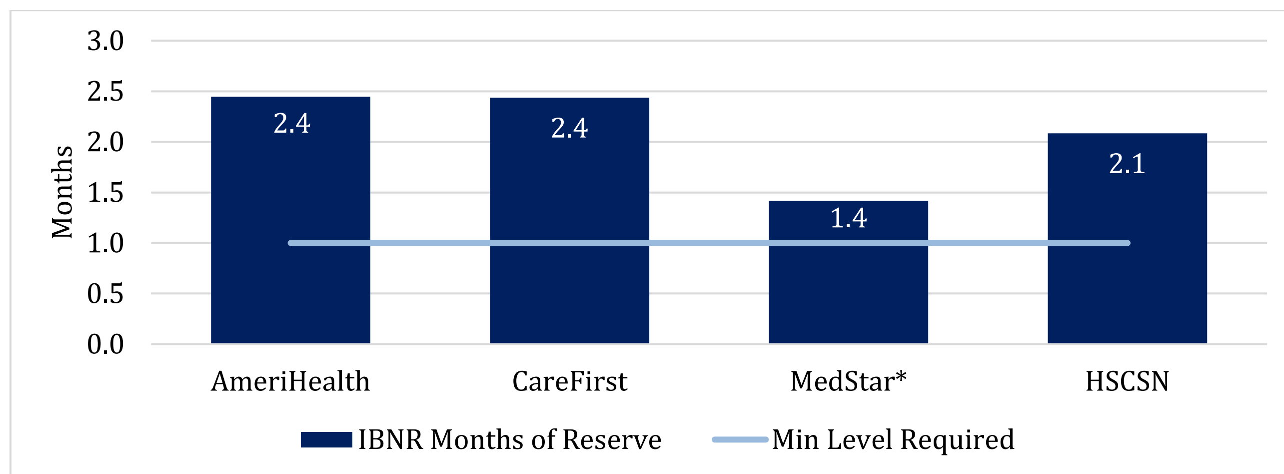
*MedStar's IBNR, RBC, and Defensive Interval results are based on the MCP's reported DISBs, which include both MedStar's District and State of Maryland lines of business.
Source: Reported figures are from the MCP's annual 2021 and 2022 financial statements reported to DISB.

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 MCPs have available to satisfy IBNR claims for the CY 2022 reporting period.

IBNR MONTHS CLAIMS — CY 2022

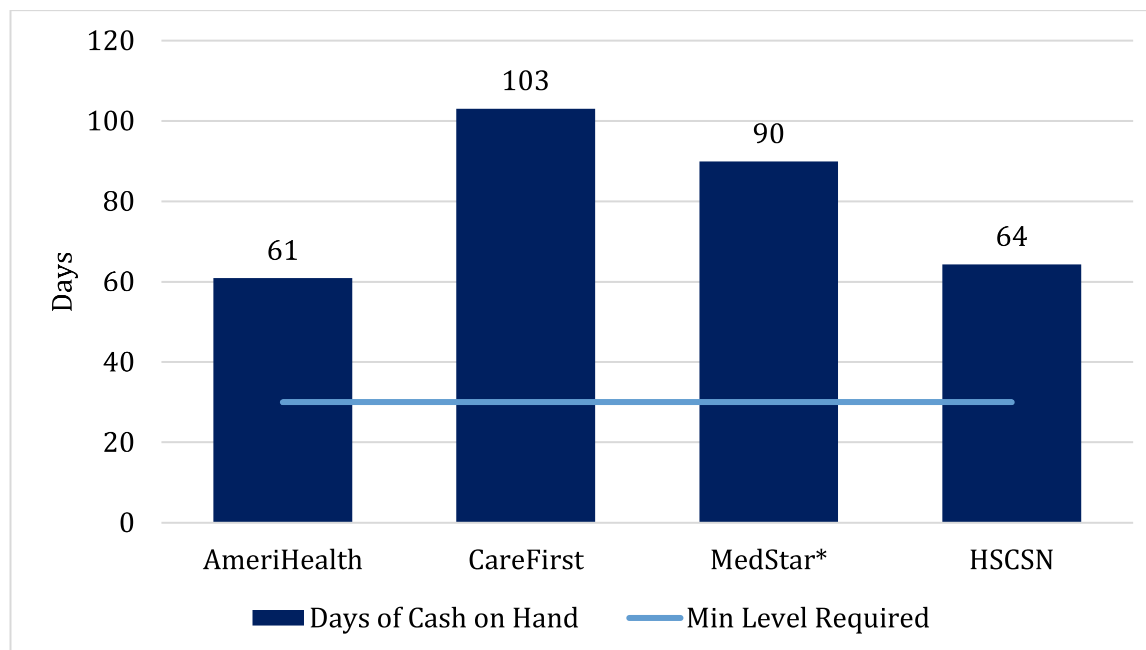


*MedStar's IBNR, RBC, and Defensive Interval results are based on the MCP's reported DISBs, which include both MedStar's District and State of Maryland lines of business.
Note: Estimated number of months of reserves compared to average monthly incurred claims.
Source: IBNR is based on amounts reported 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.

The following figure 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 2022 period, along with trends (percentages included in the table below) when comparing to 2021 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 2022 AND TRENDS



*MedStar's IBNR, RBC, and Defensive Interval results are based on the MCP's reported DISBs, which include both MedStar's District and State of Maryland lines 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 2022 to December 2022.

All MCPs met the standard liquidity benchmark for the annual 2022 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 healthcare 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 healthcare 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 healthcare issues and ensure each of these enrollees receives access to appropriate care, while managing the delivery of healthcare services for all enrollees.

Certain contractual requirements exist to ensure adequate healthcare provider networks exist, which DHCF continually monitors for compliance by each MCP. The 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, 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 except for MedStar met or exceeded the DHCF established target of 95% acceptance rate, therefore continuing to maintain accurate encounter data file submissions for the CY 2022 reporting period. DHCF continues to work closely with the MCPs 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 2022

MCP	Total Submitted Encounters*	Acceptance Rate of Encounter Submissions
AmeriHealth	1,792,115	99.78%
CareFirst	694,092	97.59%
MedStar	857,096	87.20%
HSCSN	303,800	98.34%

*Gross count can include originals, voids, and resubmissions. All MCPs' Acceptance Rates are calculated based on submissions through the end of the CY 2022.
Source: DHCF MMIS each month January 2022 through December 2022.

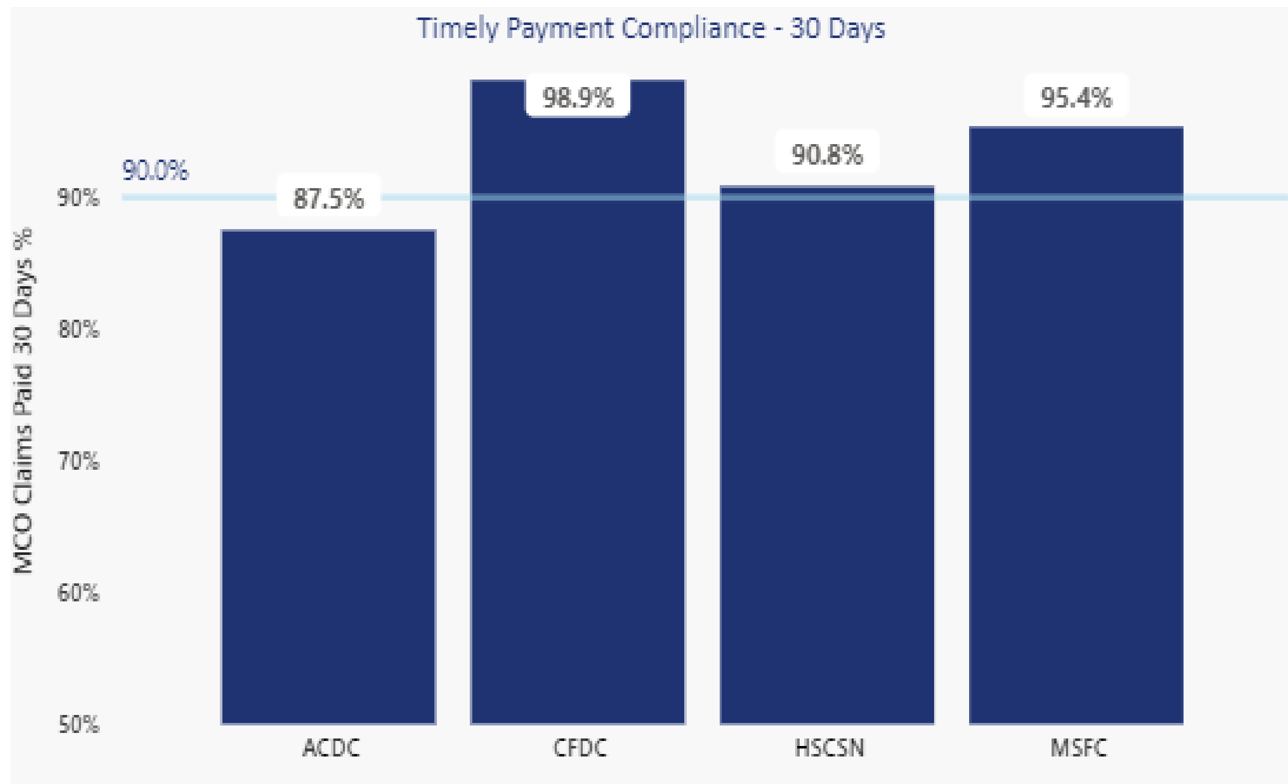
C. TIMELY PAYMENT OF CLAIMS

Timely payment of healthcare claims is a core requirement for the District's managed care plans. 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 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, and
- Payments for services delivered to non-eligible patients.

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 on page 17, each MCP exceeded DHCF's timely payment requirement for the CY 2022 reporting period.

TIMELY PAYMENT COMPLIANCE — CY 2022



Note: 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 -calculated by measuring the lag between the MCPs Claims Received Date and the MCPs Claims Paid Date on the encounters. Only claims/encounters received by DHCF for CY22 are included in the calculation.

The 30-Day Timely Payment Compliance percentages for the MCPs for CY22 are shown above. All MCPs, with the exception of AmeriHealth (ACDC) 87.5%, met or exceeded the 90% benchmark for Claims Paid within 30 days.

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 MCPs' networks, and potentially cause access to care issues. As a result, DHCF has analyzed data on MCP denied claims for the past several years to monitor plan performance in this area.

This report provides information on the incidence of CY 2022 managed care claims with a final disposition of denied claims. 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 the CY 2022 denial rates were as follows:

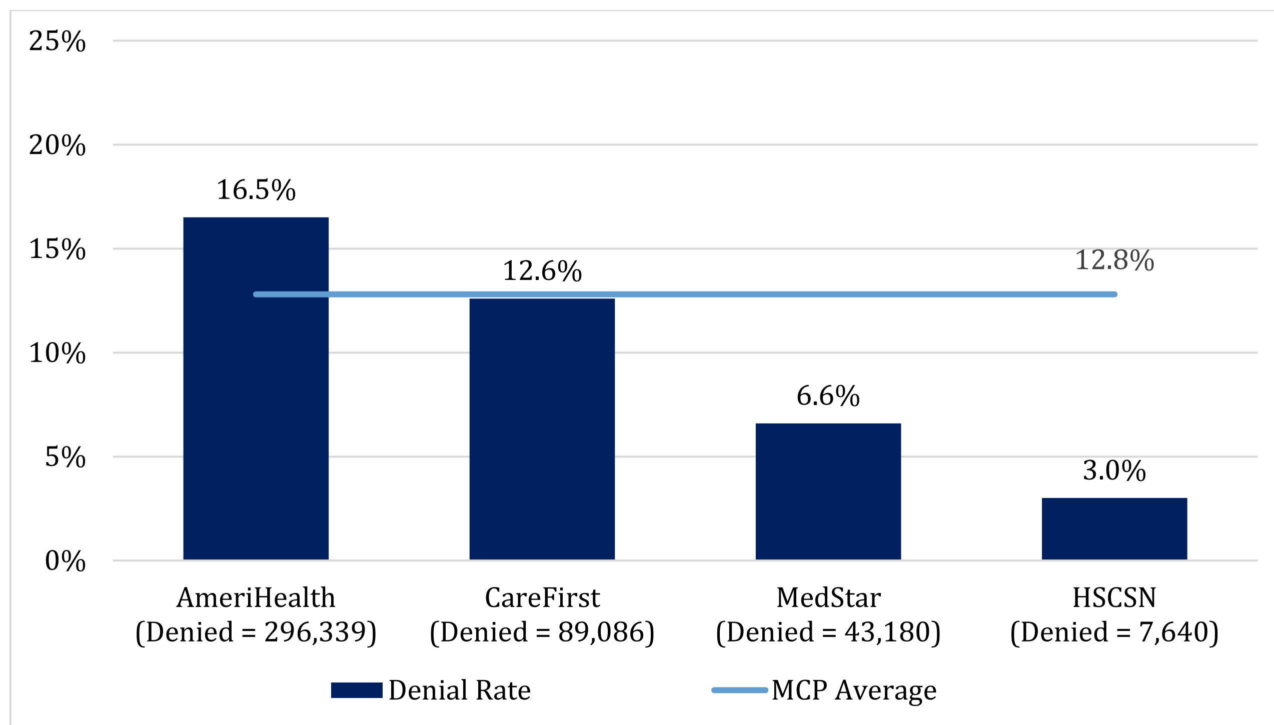
- Using DHCF's MMIS, all paid claims with dates of service during the report CY were extracted for each MCP.
- All MCP claims with a final disposition as "denied" and a date of service during the report CY were obtained directly from the District's MCPs.
- Due to discrepancies in adjudication practices among MCP 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).

The results are reported below. The overall claims denial rate for District MCPs in CY 2022 was 12.8%. AmeriHealth had the highest rate of denied claims with a 16.5% denial rate, followed by CareFirst at 12.6%, MedStar at 6.6%, and HSCSN at 3.0%. Across all plans, the top five reasons for denials were:

- Submitter Billing Error (20%)
- Prior Authorization (16%)
- Duplicate Claim (11%)
- Third Party Liability (9%)
- Service Not Payable (8%)

However, the top denial reasons vary by plan. For example, "Submitter Billing Error" was the most common reason for AmeriHealth (21%), MedStar (24%), and HSCSN (35%). It was the third most common reason for CareFirst (14%) behind "Prior Authorization" (23%) and "Provider Out of Network" (18%). DHCF is continuing to work with the health plans to improve the agency's data exchange and augment future reporting with additional analyses of observed trends and underlying operational drivers for denials.

MCP CLAIMS DENIAL RATES — CY 2022



Note: Due to discrepancies in adjudication practices among MCP PBMs, findings exclude denied pharmacy claims. Total number of denied claims are included in the figure for each MCP.
Source: Patient encounters with January 1, 2022 – December 31, 2022, dates of service from DHCF's MMIS system were merged with MCP files containing denied claims for the same period.

IV. MEDICAL SPENDING AND UTILIZATION TRENDS

A. INTRODUCTION

This report provides an overview of the underlying enrollment, medical service cost trends, and utilization driving the financial results for the four MCPs.

To support states and promote stability of coverage during the COVID-19 PHE, members that would have historically been disenrolled from the DCHFP or Alliance programs have received continuous coverage. The enrollment changes include both individuals newly enrolled and those who historically would have been disenrolled but who had extended enrollment due to MOE requirements. For Alliance, the disenrollment process began in September 2022. For DCHFP, the disenrollment process began in June 2023. The MOE led to growth for TANF and Alliance enrollment and lower PMPM costs. The population growth and any associated PMPM changes were limited for SSI Adults enrolled in DCHFP and the CASSIP population.

ENROLLMENT

The table below and continued on page 20, reflects enrollment growth for both the DCHFP and Alliance populations, as well as the CASSIP population enrolled in HSCSN, from December 2021 to December 2022. As illustrated, enrollment increases continued for the DCHFP and Alliance MCPs due to the COVID-19--related MOE, and there was a moderate increase observed for HSCSN.

Recertification began in late 2022 for the Alliance program, and membership declined sharply for this program. This was offset by continued increases in enrollment for DCHFP. With the end of the PHE that occurred in 2023, enrollment is expected to decrease for DCHFP as well.

ENROLLMENT GROWTH — DECEMBER 2021 TO DECEMBER 2022

MCP	Enrollment December 2021	Enrollment December 2022	Net Change
AmeriHealth	121,623	125,935	3.55%
TANF Child	42,992	44,781	4.16%
TANF Adult	63,417	69,280	9.25%
SSI Adult	5,362	5,510	2.76%
Alliance	9,852	6,364	-35.40%
CareFirst	68,976	69,821	1.23%
TANF Child	21,515	21,672	0.73%
TANF Adult	37,219	40,161	7.90%
SSI Adult	3,734	3,835	2.70%
Alliance	6,508	4,153	-36.19%
MedStar	67,583	68,625	1.54%
TANF Child	21,344	21,572	1.07%
TANF Adult	36,203	39,519	9.16%
SSI Adult	3,752	3,843	2.43%
Alliance	6,284	3,691	-41.26%
DCHFP Subtotal	235,538	250,173	6.21%
Alliance Subtotal	22,644	14,208	-37.25%
CASSIP Subtotal	4,998	5,070	1.44%
Total DCHFP and Alliance MCPs	258,182	264,381	2.40%
Total MCPs	263,180	269,451	2.38%

Note: 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 2022 Financial monitoring report.

B. PMPM MEDICAL COSTS

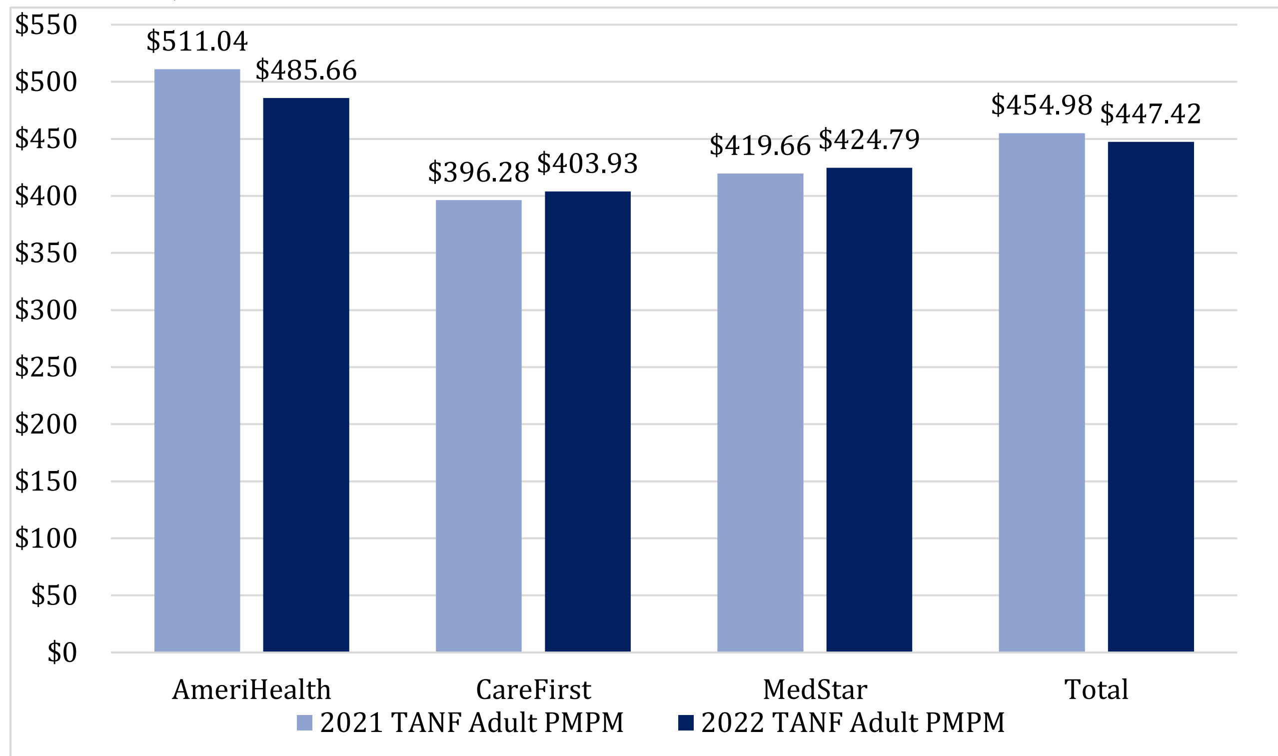
This report presents an analysis of the PMPM medical service costs for the DCHFP, Alliance, and CASSIP — both the Well Child population and the children who have special healthcare needs and receive SSI benefits — programs and populations. DHCF and its contracted actuaries review quarterly financial data submitted by the MCPs for expenses incurred from January 1, 2022 to December 31, 2022 and paid as of January 31, 2023.

The figures below also provide an analysis of changes in average PMPM expenses — January 1, 2022, to December 31, 2022, compared to January 1, 2021 to December 31, 2021 — 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 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. These estimates may change, potentially rapidly and to a significant degree, as more experience and information emerges.

The figures on pages 21 through 22 illustrate 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 2021 levels.

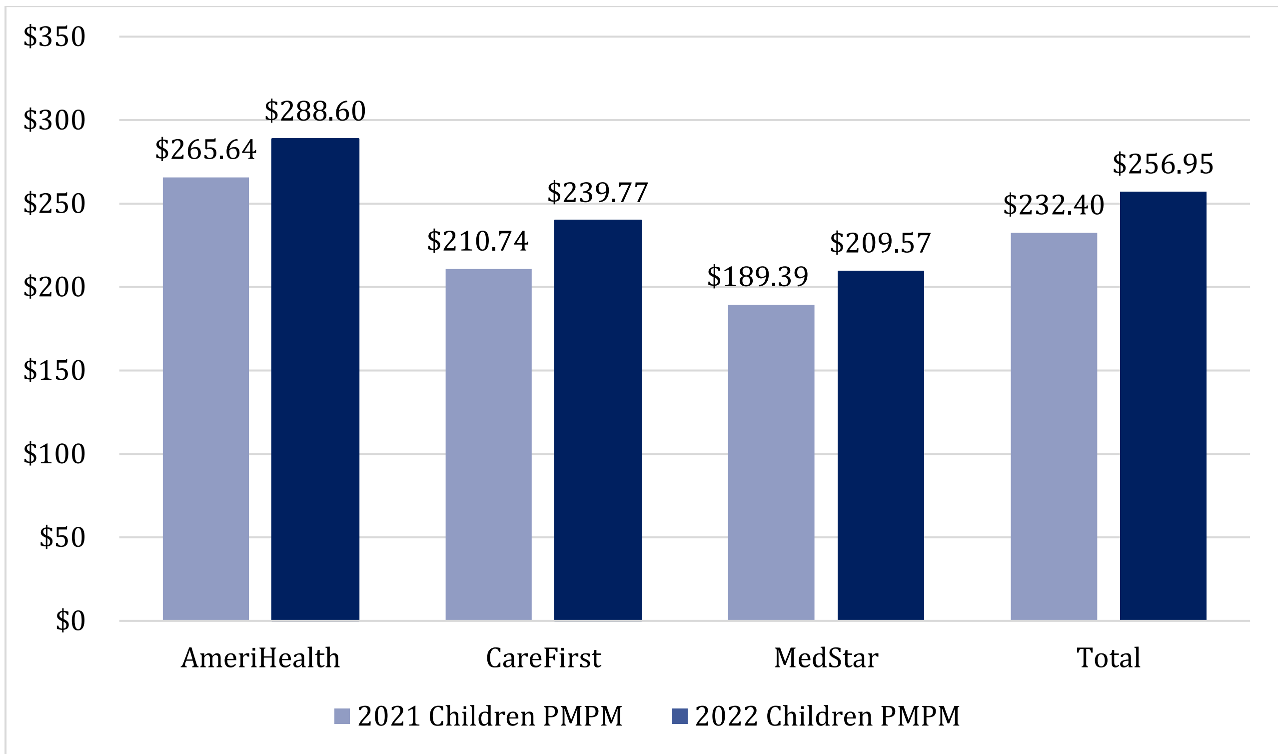
In general, CY 2021 experience still reflects impacts of depressed utilization for certain populations and services as a result of the COVID-19 PHE. Comparing CY 2021 to CY 2022, a return to historic utilization for most services resulted in PMPM increases. Additionally, MCPs are required to pay a minimum of the District's Inpatient/Outpatient and FQHC fee schedules. Increases in these fee schedules between 2021 and 2022 drove increases to these services. This is offset by the changes in population acuity due to the MOE for TANF Adults – a decrease in PMPM from CY 2021 to CY 2022.

DCHFP TANF ADULT PMPM — CY 2021 TO CY 2022 – THE DISPARITY AMONG MCPs DECREASED, OVERALL PMPM DECREASED



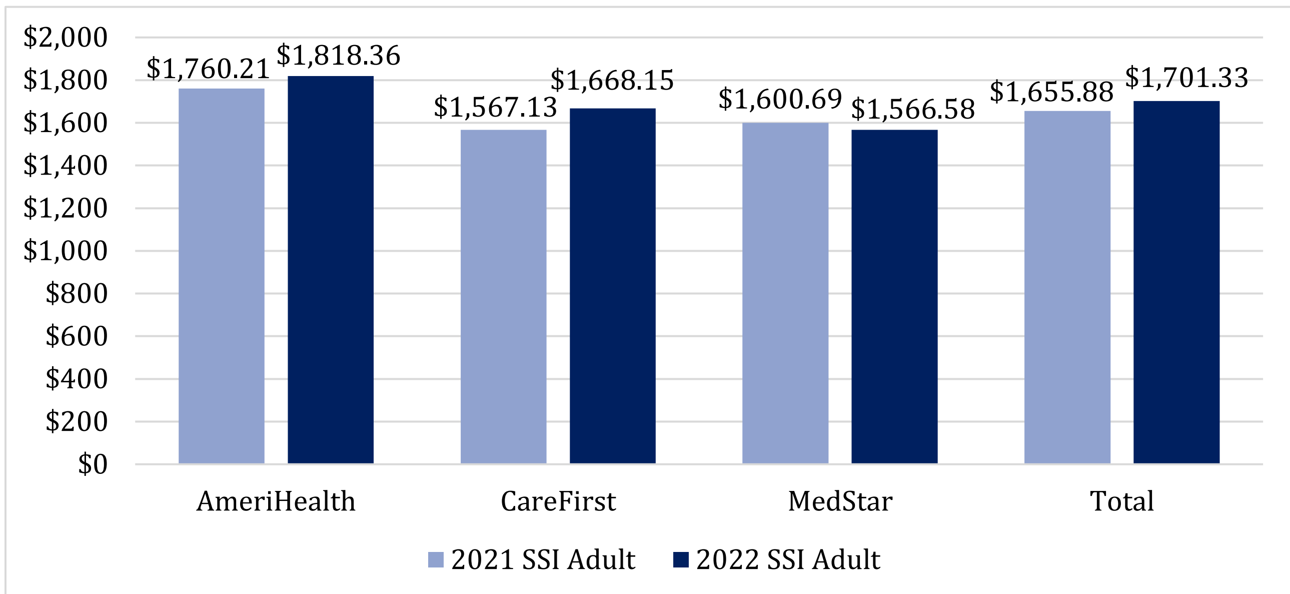
Source: Enrollment and expense data are based on self--reported MCP Quarterly Financial Data submitted directly to DHCF.

DCHFP CHILDREN PMPM — CY 2021 TO CY 2022 – PMPM INCREASE FOR ALL MCPs



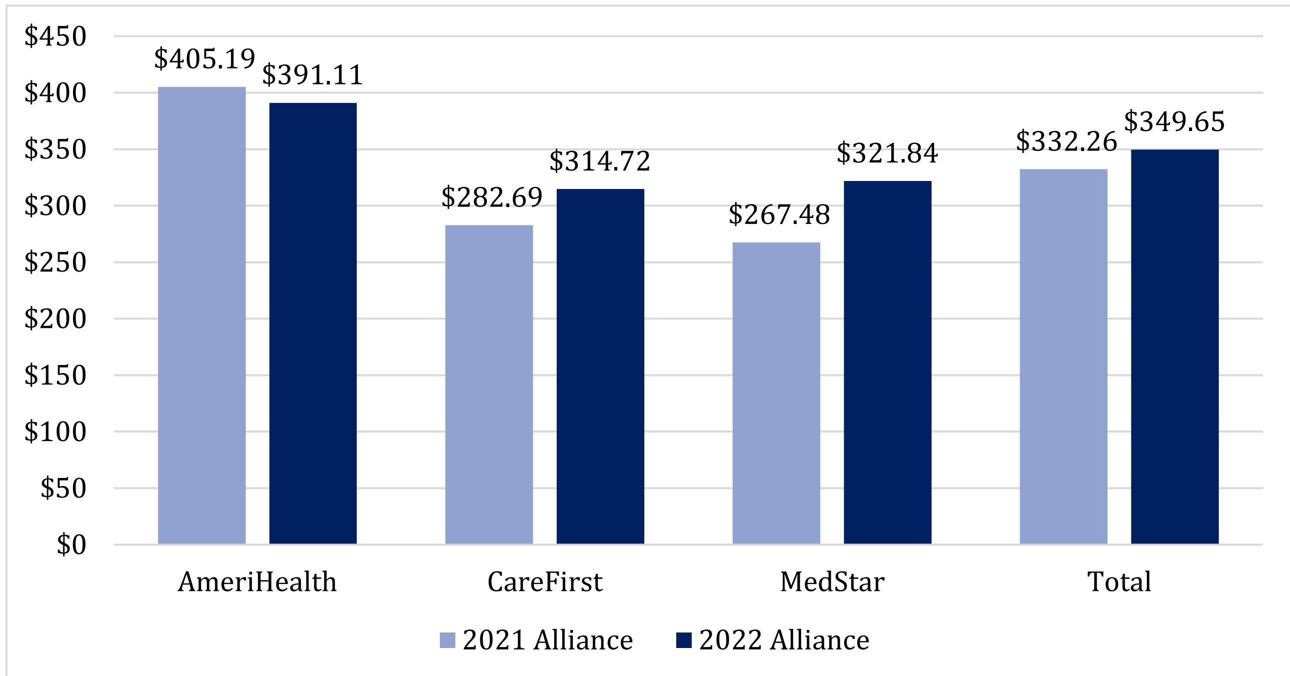
Note: Children are defined as persons up to age 21 years in this analysis for the MCPs.
Source: Enrollment and expense data are based on self--reported MCP Quarterly Financial Data submitted directly to DHCF.

DCHFP SSI ADULT PMPM — CY 2021 TO CY 2022 – LIMITED PMPM INCREASE FOR AMERIHEALTH AND CAREFIRST, DECREASE FOR MEDSTAR



Note: All results represent 12 months of operation, from January 1, 2022 to December 31, 2022 compared to January 1, 2021 through December 31, 2021.
Source: Enrollment and expense data are based on self--reported MCP Quarterly Financial Data submitted directly to DHCF.

ALLIANCE PMPM — CY 2021 TO CY 2022 – THE DISPARITY AMONG MCPs DECREASED, OVERALL PMPM INCREASED

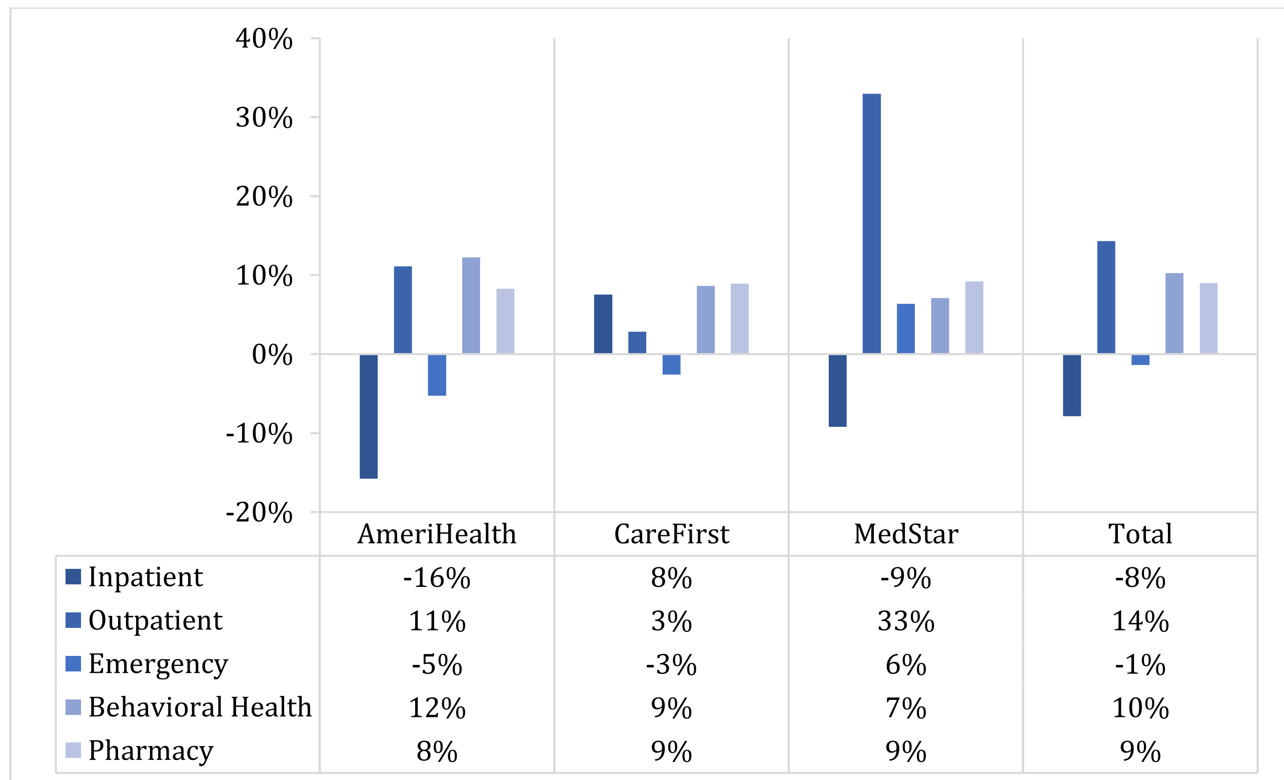


Source: Enrollment and expense data are based on self--reported MCP Quarterly Financial Data submitted directly to DHCF.

As the graphs illustrate, notable disparities in total PMPMs remain for AmeriHealth when compared to the other MCPs, with higher PMPM costs for both Alliance and the DCHFP populations. AmeriHealth also has the highest risk score for all populations. CareFirst and MedStar reported similar PMPM costs for all populations, but CareFirst DCHFP PMPM costs showed stronger growth and slightly higher costs. MedStar showed stronger growth and a higher PMPM for Alliance . 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 2021 levels, decreasing by 3% in total. Decreases in IP and outpatient hospital costs, in addition to decrease in pharmacy costs, were offset by moderate increases in physician, ER, and home health services. The HSCSN "Well" population has limited enrollment, which results in more volatility in PMPM costs. See the figures below for overall trends in CASSIP cost growth and high--cost medical service categories.

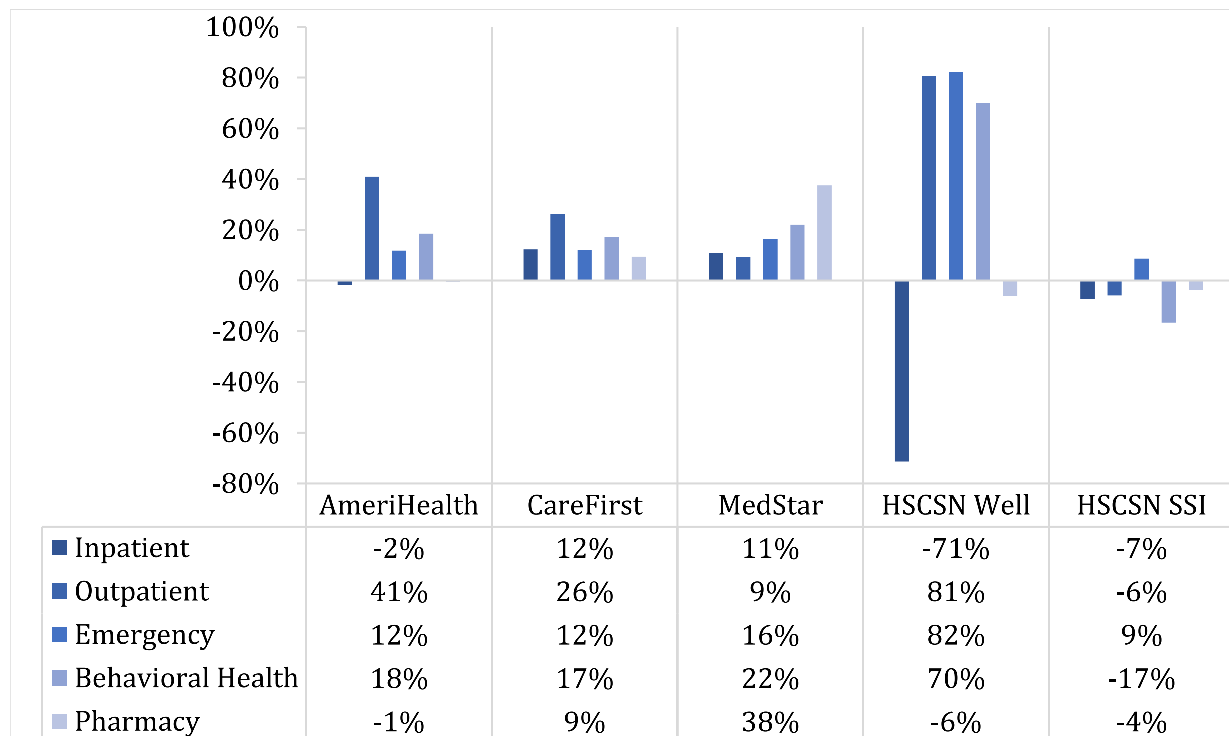
DCHFP TANF ADULT PMPM TRENDS — CY 2021 TO CY 2022 - INPATIENT AND ER NEGATIVE WHILE OTHER SERVICES INCREASED



	AmeriHealth	CareFirst	MedStar	Total
Inpatient	-16%	8%	-9%	-8%
Outpatient	11%	3%	33%	14%
Emergency	-5%	-3%	6%	-1%
Behavioral Health	12%	9%	7%	10%
Pharmacy	8%	9%	9%	9%

Note: All results represent 12 months of operation, from January 1, 2022 to December 31, 2022 compared to January 1, 2021 through December 31, 2021.
Source: Enrollment and expense data are based on self--reported MCP Quarterly Financial Data submitted directly to DHCF.

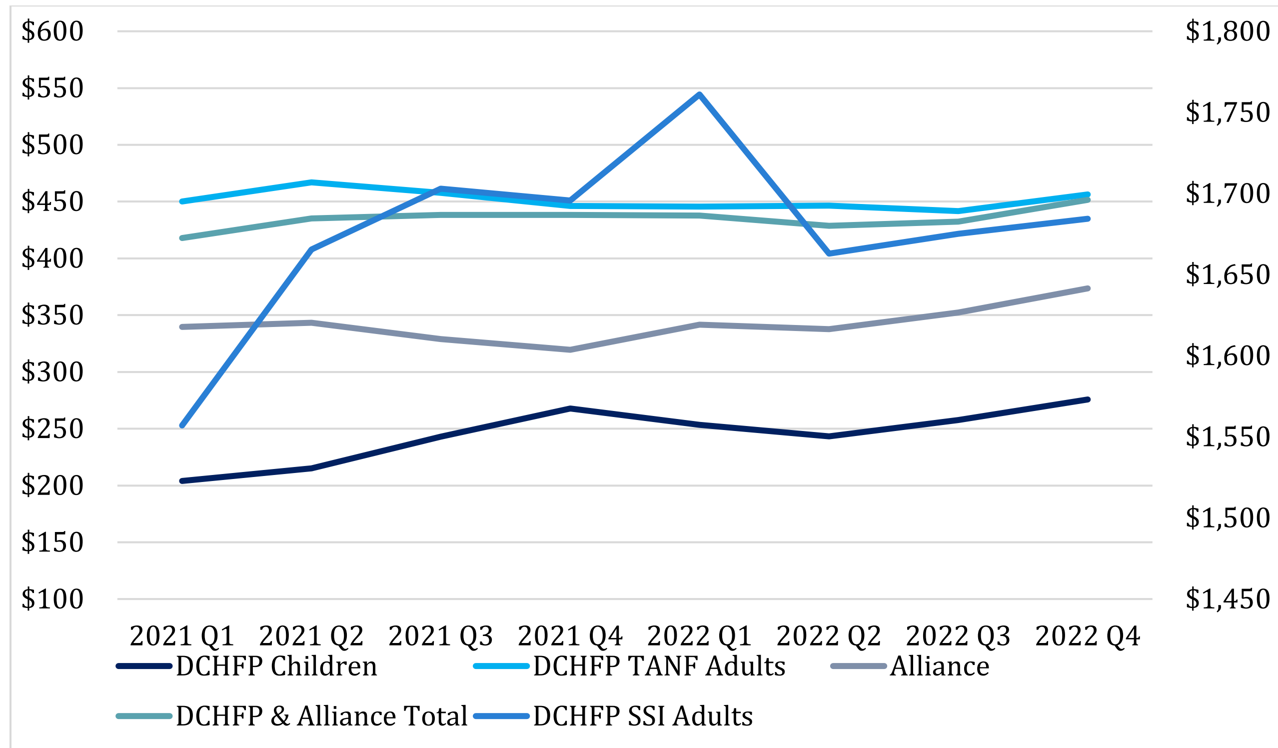
DCHFP AND CASSIP CHILDREN PMPM TRENDS — CY 2021 TO CY 2022 – DCHFP SHOWED POSITIVE TRENDS WHILE CASSIP TRENDS NEGATIVE



	AmeriHealth	CareFirst	MedStar	HSCSN Well	HSCSN SSI
Inpatient	-2%	12%	11%	-71%	-7%
Outpatient	41%	26%	9%	81%	-6%
Emergency	12%	12%	16%	82%	9%
Behavioral Health	18%	17%	22%	70%	-17%
Pharmacy	-1%	9%	38%	-6%	-4%

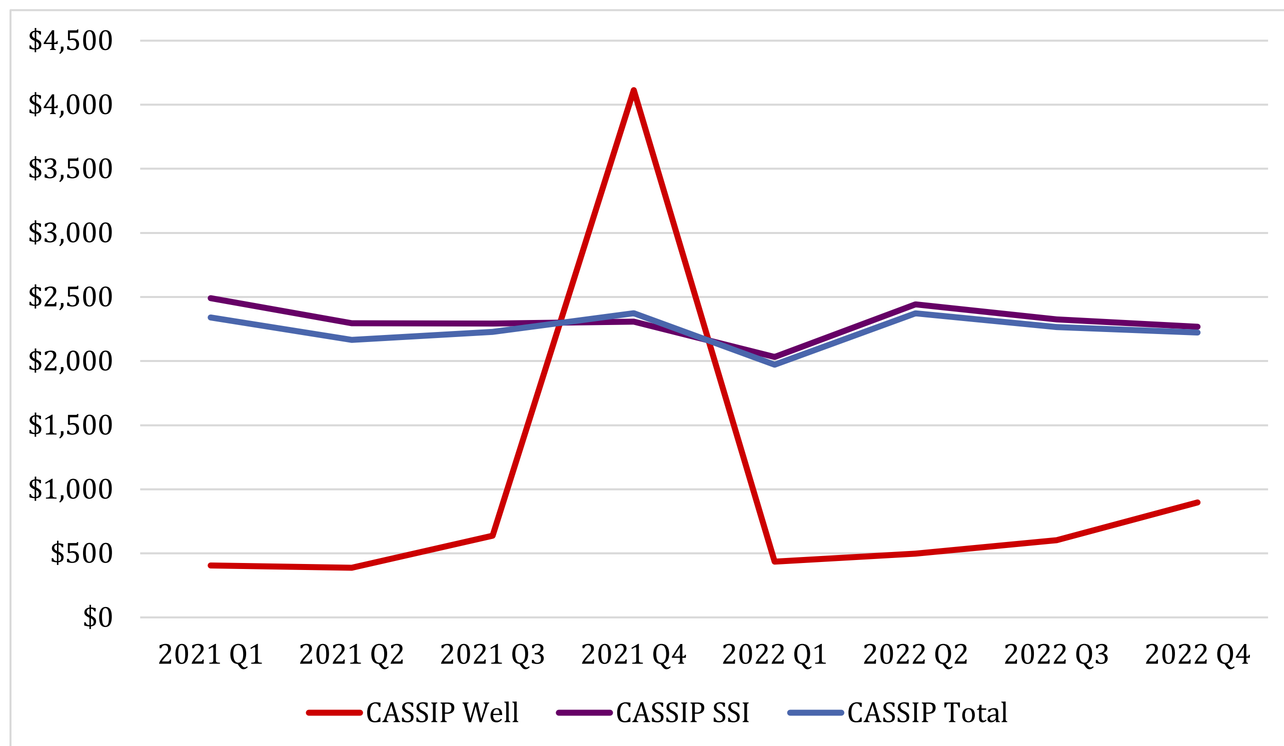
Note: HSCSN's financial results are reported for both the Well Child population and the children who have special healthcare needs and receive SSI benefits. All results represent 12 months of operation, from January 1, 2022 to December 31, 2022 compared to January 1, 2021 through December 31, 2021.
Source: Enrollment and expense data are based on self--reported MCP Quarterly Financial Data submitted directly to DHCF.

DCHFP AND ALLIANCE PMPM TRENDS — CY 2021 TO CY 2022 – INCREASING FOR CHILDREN AND ALLIANCE WHILE FLAT FOR DCHFP



Note: DCHFP Children, DCHFP TANF Adults, Alliance, and DCHFP and Alliance Total trend lines scale to the left-side Y-axis. The DCHFP SSI Adults trend line scales to the right side Y--axis-.

CASSIP PMPM TRENDS — CY 2021 TO CY 2022 – GENERALLY FLAT OVER LAST TWO YEARS



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

C. UTILIZATION TRENDS

WELL-CHILD AND OTHER AMBULATORY CARE VISIT RATES

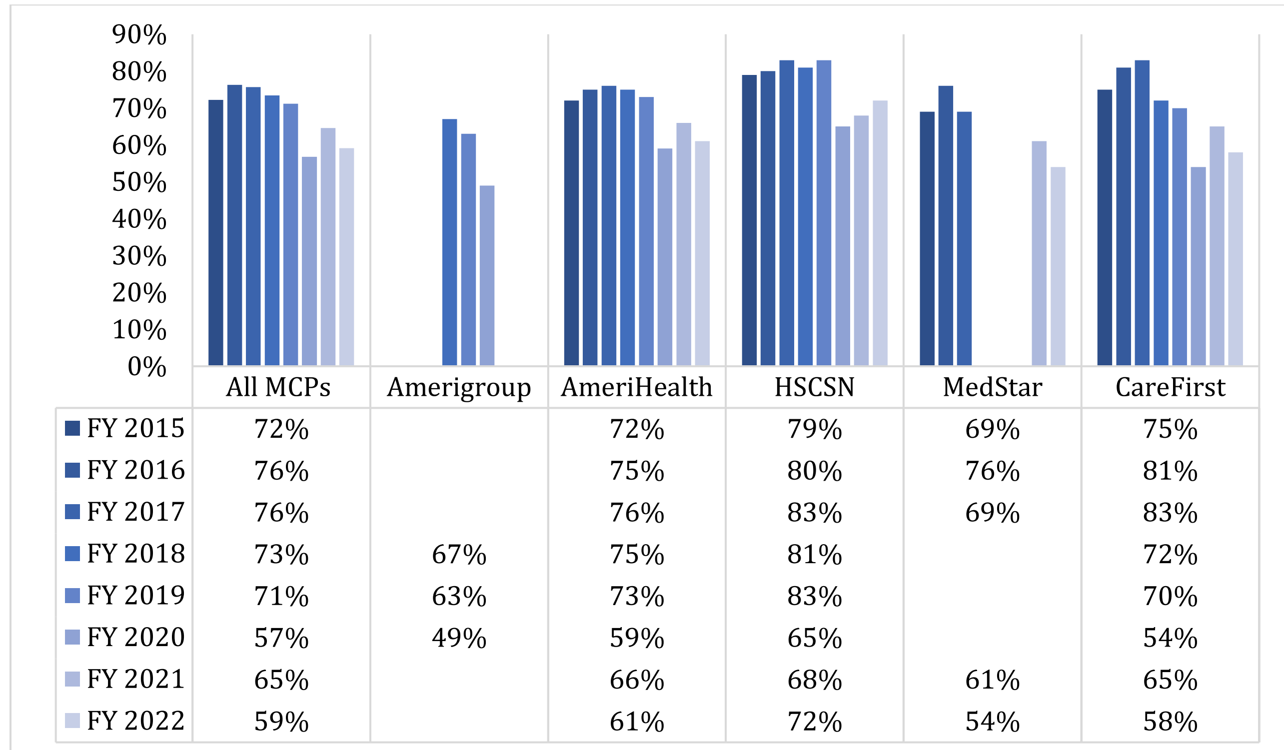
Well-c-hild visit (WCV) rates vary by MCP and year, based on data reflecting information reported by each MCP in accordance with CMS Form CMS--416 specifications for WCV and other child utilization measures. After holding relatively steady or increasing in recent years, the District experienced a large drop in WCVs in FY 2020, with the MCP average falling from 71% in FY 2019 to 57% in FY 2020 due to the COVID-19 PHE. WCV rates have risen from FY 2020, but remain below historic levels, with rates ranging from 54% for CareFirst to 72% for HSCSN in FY 2022.

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

With regard to preventive and other ambulatory care for adults, visit rates also vary by MCP and time period. For example, 56% of adult MCP enrollees had a visit in CY 2022, but rates ranged from 50% for CareFirst to 63% for AmeriHealth. Adult visit rates for MCPs overall decreased between 2015 and 2022. The overall rates for 2020 and after are not directly comparable to earlier years due to the entry of MedStar, exit of Amerigroup, and MCP member reassignments that occurred October 1, 2020. This data excludes emergency department care and reflects a visit definition based on Healthcare Effectiveness Data and Information Set (HEDIS) measure specifications for Adults' Access to

Preventive/Ambulatory Health Services (AAP). In DHCF MCP 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 MCP performance and will work with plans to address observed trends with adult visit rates.

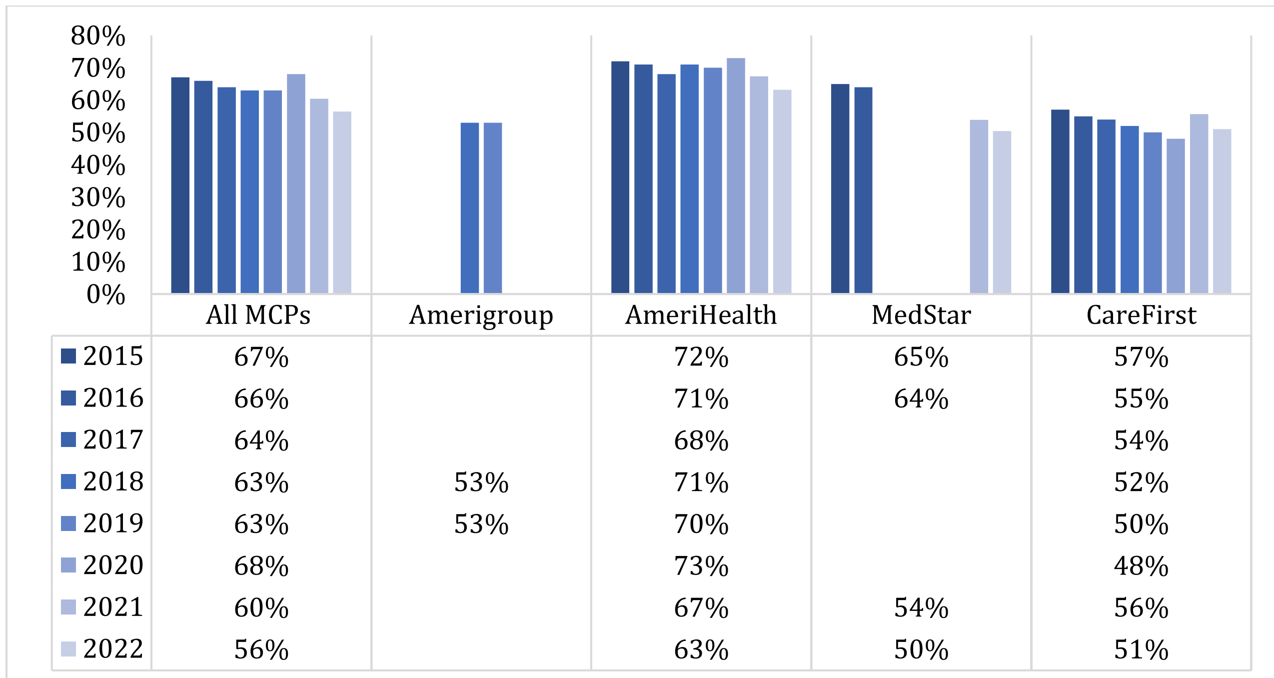
PERCENTAGE OF CHILDREN WITH A WCV — FY 2015 TO FY 2022



	All MCPs	Amerigroup	AmeriHealth	HSCSN	MedStar	CareFirst
FY 2015	72%		72%	79%	69%	75%
FY 2016	76%		75%	80%	76%	81%
FY 2017	76%		76%	83%	69%	83%
FY 2018	73%	67%	75%	81%		72%
FY 2019	71%	63%	73%	83%		70%
FY 2020	57%	49%	59%	65%		54%
FY 2021	65%		66%	68%	61%	65%
FY 2022	59%		61%	72%	54%	58%

Note: Reflects Medicaid beneficiaries under age 21 years with at least 90 days of continuous enrollment. Average for all MCPs is weighted by the number of children in each plan.
Source: Line 10 Participant Ratio from Form CMS--416 reports submitted by MCPs.

PERCENTAGE OF ADULTS WITH A PREVENTIVE OR OTHER AMBULATORY CARE VISIT — CY 2015 TO CY 2022



	All MCPs	Amerigroup	AmeriHealth	MedStar	CareFirst
2015	67%		72%	65%	57%
2016	66%		71%	64%	55%
2017	64%		68%		54%
2018	63%	53%	71%		52%
2019	63%	53%	70%		50%
2020	68%		73%		48%
2021	60%		67%	54%	56%
2022	56%		63%	50%	51%

Note: Reflects Medicaid beneficiaries ages 21 years or older with at least 11 months of coverage during the CY with a given MCP. The average for all MCPs is weighted by the number of adults in each plan. Includes both MCP encounters from DHCF's MMIS system and any FFS use by MCP beneficiaries. Visit definition reflects HEDIS measure specifications for AAP.
Source: DHCF MMIS data as of June 28, 2023.

IP ADMISSIONS RATES

In addition to providing an analysis of primary and preventive care utilization, this report also includes an analysis of IP admission rates, expressed as utilization per 1,000 member months (util/1000), which reflect more costly healthcare utilization. The figure below illustrates the current indexed IP admission rates for the CY 2022 period, based on MCP encounter claims from DHCF's MMIS data and trends when comparing to those for CY 2021.

IP ADMISSION RATES AND TRENDS — CY 2021 TO CY 2022

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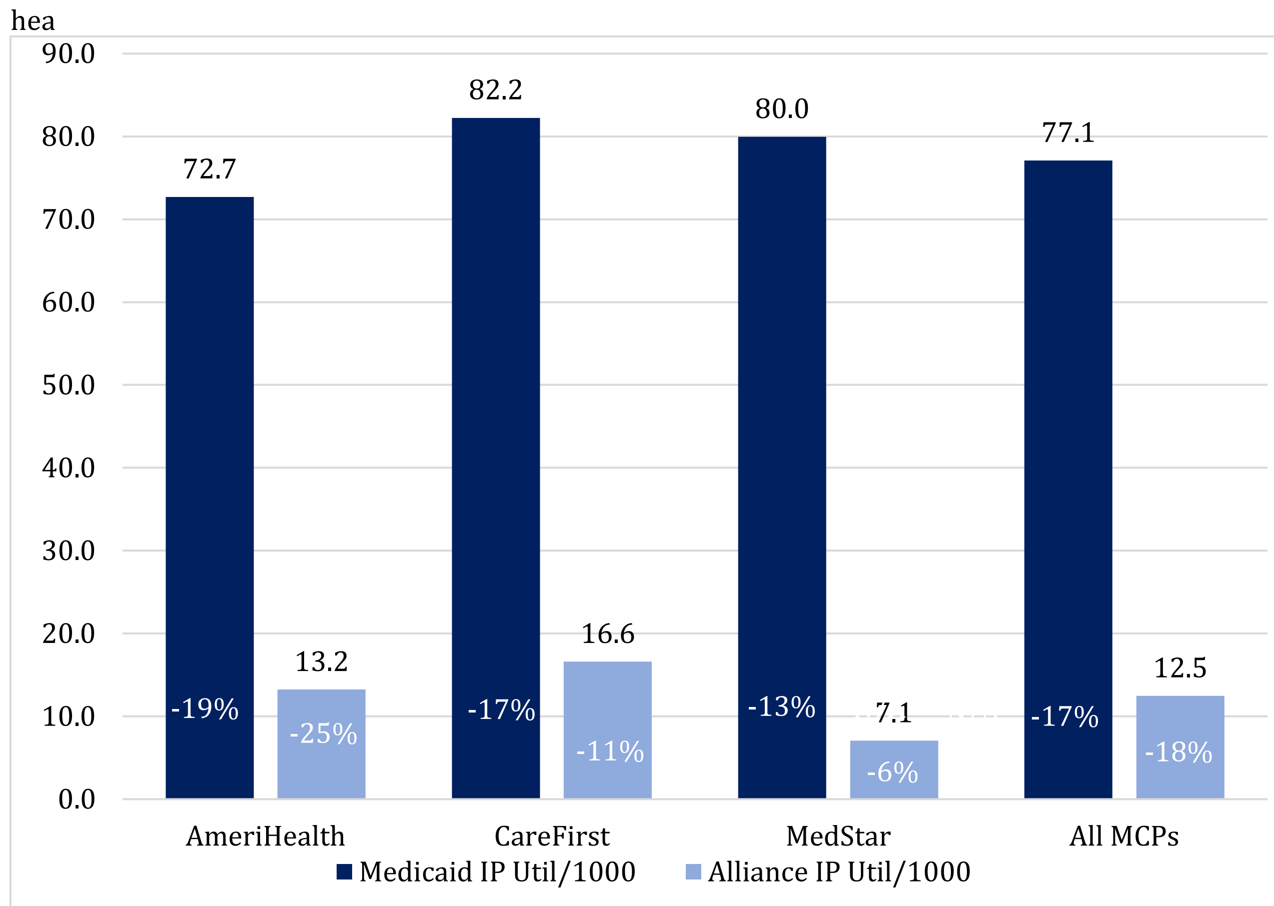


Note: All results represent 12 months of operation, from January 1, 2022, to December 31, 2022, compared to January 1, 2021, through December 31, 2021.
Source: Data based on MCP encounter data submitted to MMIS.

For the current performance period, IP utilization for the DCHFP program decreased by 17% from 2021 levels. Further analysis of the numerators (IP stays) and the denominators (enrollment sizes) shows that for the AmeriHealth population, decreases in IP stays (−12.3%) and increases to their enrollment (8.3%) resulted in a 19% decrease in IP rates from CY 2021 levels for the Medicaid population. Similarly, the CareFirst population saw decreases in IP stays (−13.3%) and increases to their enrollment (4.2%), which resulted in a 17% decrease in IP rates from CY 2021 levels for the Medicaid population. Finally, the MedStar population experienced similar trends, but to a lesser degree. MedStar saw decreases in IP stays (−8.9%) and increases in their enrollment (4.6%) that resulted in a 13% decrease in IP rates from CY 2021 levels for the Medicaid population. These trends are driven by the TANF population, which account for a majority of inpatient admissions, but similar downward trends were also observed for the SSI adults.

Alliance enrollment decreased from 2021 to 2022 due to the ending of the MOE, which drives the overall decrease in IP admissions relative to member months. The figure on page 30 is limited to IP admissions within managed care, and therefore 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 percentage changes from year to year.

D. RISK ADJUSTMENT

Risk adjustment seeks to align each MCP's risk as reflected in the disease prevalence of the enrolled population, with the incurred healthcare costs and associated payment for services provided to enrolled members. The DCHFP rates have been risk adjusted since the start of the FY 2021 managed care contracts in October 2020. The risk adjustment in CY 2022 has been updated quarterly. With the start of the FY 2022 contract year in October 2021, the Alliance rates are also risk adjusted on a quarterly basis to account for varying levels of costs based on enrollment and acuity of the underlying MCP's population. The Alliance risk scores moved to a monthly update starting in October 2022 to account for beneficiary changes as a result of the end of continuous enrollment.

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. Although risk adjustment improves the alignment of payment to projected cost, it does not capture all observed variation between MCP populations, utilization, provider contracting, care management, and other variables that contribute to overall MCP cost.

RANKING OF ENROLLEE RISK SCORE AND MEDICAL COSTS

		Ranking on Enrollee Risk Scores		
		Low	**Medium**	**High**
Ranking on Medical Cost	**Low**	MED — Child		
		CFP — TANF Adults	MED — SSI Adult	
		CFP — Alliance	MED — SSI Adult	
	Medium		CFP — Child	
			MED — TANF Adult	
		CFP — SSI Adult	MED — Alliance	
	High			AMH — Child
				AMH — TANF Adult
				AMH — SSI Adult
				AMH — Alliance

Note: Enrollee risk scores based off risk adjustment study period of October 2020–September 2021 and enrollment snapshot as of October 2022. Expenses were incurred from January 1, 2022, to December 31, 2022, and paid as of January 31, 2023. 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.

V. P4P AND CARE COORDINATION

A. INTRODUCTION

Achieving high value in healthcare for Medicaid beneficiaries is a preeminent goal of DHCF's managed care program. The District's MCPs are expected to increase their members' healthcare and improve outcomes per dollar spent through aggressive care coordination and healthcare management. From October 2016 to September 2018, DHCF's three MCPs serving the DCHFP 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 — ER 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 preventive 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 ER for non-emergent reasons, reducing potentially avoidable hospitalizations, and slowing the rate of hospital readmissions. The figure on page 34 illustrates the aggregate avoidable costs incurred by the MCPs for potentially avoidable ER 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.

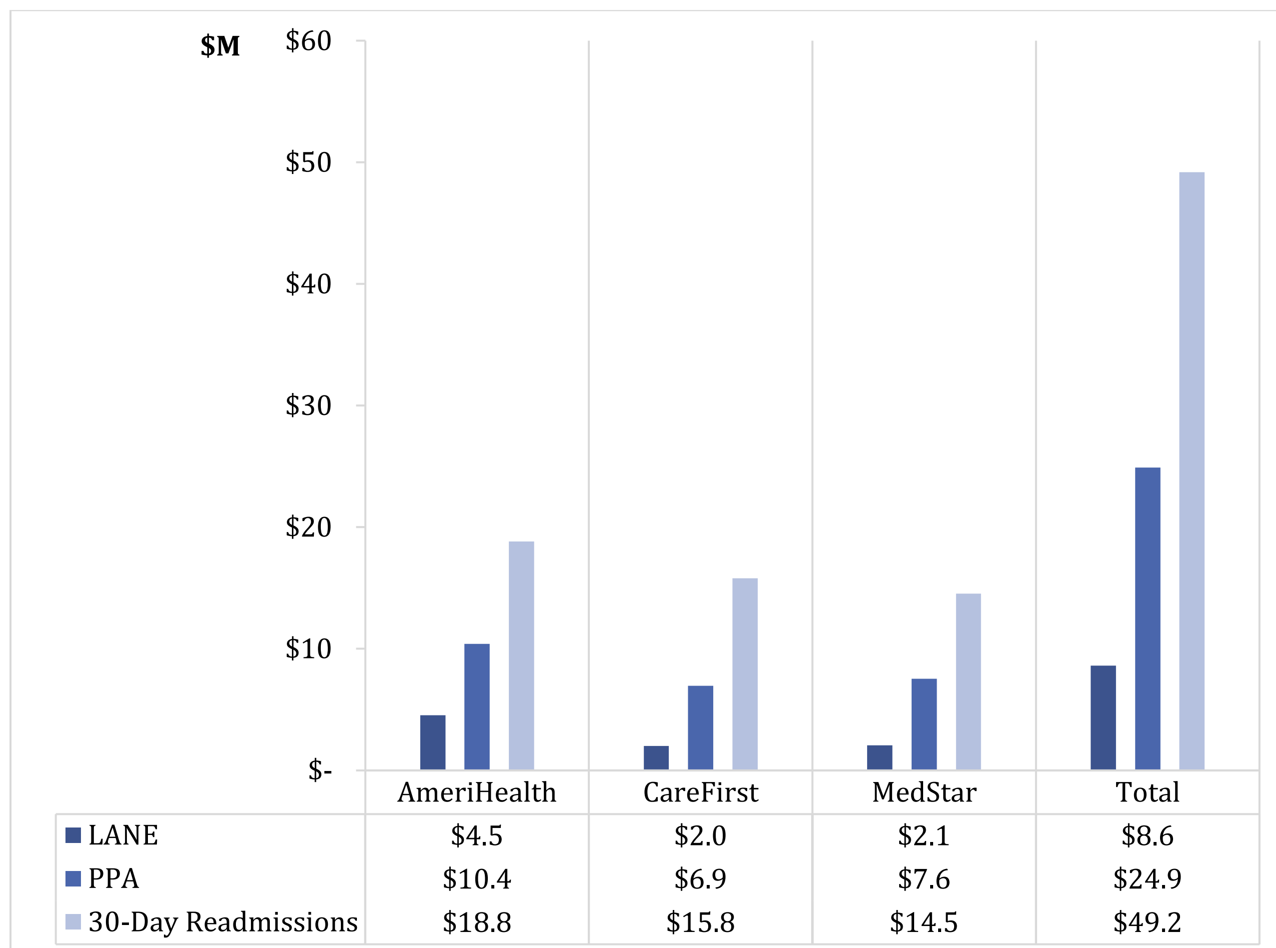
B. METHODOLOGY

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. MCPs were required to meet the minimum thresholds for improvement for all three performance measures in order to earn any portion of the withhold. Improvement was determined by comparing actual P4P results on MCP experience during a performance year compared to a historical baseline.

The capitation withhold was not in effect for the FY 2021 measurement year or thereafter, though DHCF plans to reinstitute quality incentive requirements in future years.

[3] LANE visits are ER 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.

POTENTIALLY AVOIDABLE SPEND ON MANAGED CARE SERIVCES — CY 2022



	AmeriHealth	CareFirst	MedStar	Total
LANE	$4.5	$2.0	$2.1	$8.6
PPA	$10.4	$6.9	$7.6	$24.9
30-Day Readmissions	$18.8	$15.8	$14.5	$49.2

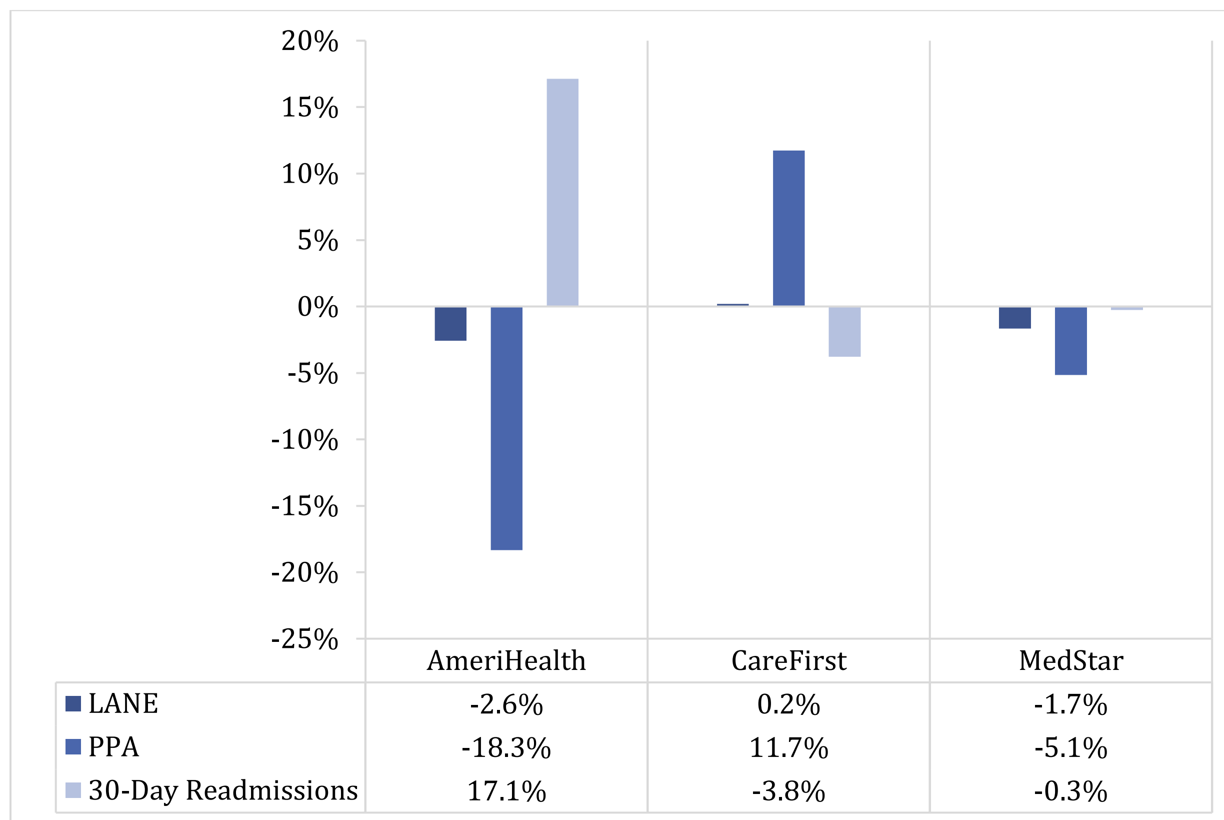
Note: Current annual results for 2022 reflect data incurred during the 12--month period (October 2021 through September 2022), with payment runout through December 31, 2022. Total avoidable costs include Health Home enrollees.
Source: Mercer analysis of MCP Encounter data for DCHFP reported by the MCPs to DHCF.

DHCF is reassessing the P4P program, and may modify requirements (e.g., performance measures, targets, incentive structure) for future contract years. DHCF would like 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 improvement on the three P4P quality measures over the last year for the three MCPs providing services to the DCHFP population. A negative change shows improvement, as the percentage of ER or IP claims that could have been avoided has decreased.

PERCENTAGE IMPROVEMENT ON P4P — FY 2022 COMPARED TO FY 2021



	AmeriHealth	CareFirst	MedStar
LANE	-2.6%	0.2%	-1.7%
PPA	-18.3%	11.7%	-5.1%
30-Day Readmissions	17.1%	-3.8%	-0.3%

Note: Current annual results for 2021 reflect data incurred during the 12-month period (October 2021 through September 2022), with payment runout through December 31, 2022. Final metrics are net of Health Home enrollees.
Source: Mercer analysis of MCP Encounter data for DCHFP reported by the MCPs to DHCF.

Historically, when the P4P program was active, each MCP's annual results would be compared to a benchmark established by the District, with improvement targets required to be met on all three metrics in order to earn back the 2% withhold. Since the suspension of the program, the contracted MCPs have changed through procurement and additional populations, such as SSI adults, have entered the program. The year -over -year change shows how the MCPs have performed under the new contract but does not reflect performance against any District requirements. Overall, MCPs reported improvements for the three P4P metrics in 2022 compared to 2021. AmeriHealth and MedStar saw reductions in LANE visits of 2.6% and 1.7%, respectively, while CareFirst saw a marginal increase in LANE visits of 0.2%. PPA experienced a similar dynamic with both AmeriHealth and MedStar reporting decreases in PPA of 18.3% and 5.1%, respectively, whereas CareFirst saw an increase in PPAs of 11.7% when compared to 2021. Finally, for 30--day readmissions both CareFirst and MedStar had reductions of 3.8% and 0.3%, respectively, while AmeriHealth saw a notable increase of 17.1% from 2021.

DHCF plans to reinstitute quality incentive requirements in future years and will re-establish appropriate baselines and performance goals that reflect the current MCPs and populations.

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 continued effects of the COVID19 PHE on medical service utilization and costs for the District's contracted MCPs. The DCHFP and Alliance programs observed substantial enrollment increases in CY 2022 as a result of the MOE. This resulted in lower PMPM costs for affected populations (TANF Adult and Alliance adults). With the Alliance redeterminations resuming September 2022, a decrease in enrollments and a corresponding increase in PMPMs were observed in late 2022.

The District has observed better alignment of cost and associated payment across the DCHFP and Alliance programs due to the continued application of risk adjustment. Moreover, DHCF implemented risk-sharing arrangements for DCHFP and Alliance programs in October 2021 and has continued the long-standing CASSIP risk corridor arrangement. These risk-sharing arrangements provide additional financial stability to both the MCPs and the District.

AmeriHealth's total PMPM medical costs remain the highest of the MCPs, and their reported medical service costs have increased relative to revenue in 2022, resulting in negative reported margins for the MCP. This measure is influenced by AmeriHealth's reported reserves and is subject to change; this continues to be monitored by Mercer and DHCF.

The District continues to monitor avoidable hospitalization utilization and expenditures tied to avoidable admissions, readmissions, and emergency department utilization as part of the managed care P4P program. We have observed mostly positive trends in reducing these unnecessary services and healthcare costs during the current reporting period, but the gains are small. However, the impact of COVID-19 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 healthcare landscape continues to evolve, DHCF is focused on strategic initiatives targeted towards improving the health outcomes of Medicaid beneficiaries by imagining perfect 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;
- Where program design and implementation support increase beneficiaries' access to the services they need to manage and improve their health and to address inequities in health;
- Where quality of care is a focus that improves beneficiary health and addresses health inequities; 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.