**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

**Department of Health Care Finance**


# MEDICAID MANAGED CARE

# PERFORMANCE REPORT

**(January – December 2019)**

**October 14, 2020**

## Table of Contents

# I. EXECUTIVE SUMMARY

## A. BACKGROUND

The District of Columbia's (DC) Department of Health Care Finance's (DHCF) managed care program is the largest single expenditure in the agency's budget consisting of the Medicaid (including the Children's Health Insurance Program (CHIP)-funded Medicaid), Alliance and Immigrant Children's Program (ICP)[1] publicly funded health insurance programs.

As of December 2019, 196,844 Medicaid and ICP beneficiaries and 15,469 Alliance enrollees were assigned to one of the four following Managed Care Organizations (MCOs):

- Amerigroup DC, Inc. (Amerigroup)
- AmeriHealth Caritas DC (AmeriHealth)
- CareFirst BlueCross BlueShield Community Health Plan DC (CareFirst), formerly known as Trusted Health Plan[2]
- Health Services for Children with Special Needs (HSCSN)

All four MCOs have continued to offer comprehensive benefits during 2019. Three of these MCOs – Amerigroup, AmeriHealth, and CareFirst – operated under full risk-based contracts while HSCSN operated under a risk sharing arrangement with the District.

The District spent roughly $1 billion[3] on MCO services in 2019. Roughly 84% ($881 million) of this amount funded the full risk-based contracts signed by Amerigroup, AmeriHealth, and CareFirst, while approximately 16% ($174 million) funded the risk sharing contract with HSCSN. DHCF continually strives to improve the health and well-being of the residents of the District of Columbia, as described later in this report through the agency's vision, mission, values, and strategic priorities.

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

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

[2] CareFirst BlueCross BlueShield (CareFirst) purchased Trusted Health Plan (District of Columbia), Inc. (Trusted) earlier this year and recently announced the new plan name of CareFirst BlueCross BlueShield Community Health Plan DC (CareFirst CHPDC). This report references CareFirst in the following exhibits and analysis for the corresponding reporting periods.

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

## B. MEDICAID PROGRAM VISION, MISSION, AND VALUES

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

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

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

**Values**:

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

**Strategic Priorities:**

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

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

## C. GOALS AND OBJECTIVES

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

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

- Provide objective data on the performance of the MCOs across several domains to inform decision making about possible policy changes for the managed care program.

- Facilitate an assessment of each MCO to help guide oversight activities and prioritize areas for enhanced monitoring and corrective action.

This report illustrates the financial condition of the MCOs during 2019, which includes reporting on whether MCO revenues were sufficient to cover claims and operating costs while maintaining a benchmark (85%) Medical Loss Ratio (MLR) for medical service costs and quality improvement expenses. Administrative functions are closely monitored by DHCF - timely claims processing, robust member encounter systems, and appropriate use of claims denial procedures – which DHCF tracks on a regular basis and which are reflected in subsequent sections of this report. This report includes quantitative and qualitative analysis of key service level utilization – primary care visits for both adult and children as well as inpatient admission rates – in addition to MCO performance with member care coordination via progress against established quality measures during the period under review.

## D. KEY FINDINGS

### FINANCIAL RESULTS

Two of the three full risk-based MCOs reported healthy financials for the 2019 reporting period. Each of the full risk-based MCOs reported risk-based capital (RBC) positions that are well above the required minimum level of 200%. While two of the MCOs posted profits ranging from 6%-13% with ample reserves to meet incurred but not reported (IBNR) claims with liquid assets, these two MCOs continued to fall short of the threshold for premium spent on medical and quality improvement costs. Conversely, AmeriHealth, DHCF's largest MCO, was once again an exception – continuing to report disproportionately higher medical costs than the other full risk-based MCOs, resulting in notable operating losses in 2019.

Beginning with the FY 2018 contract year, the population previously enrolled in MedStar, whom was previously contracted with DHCF, primarily shifted to Amerigroup. Subsequent to this initial population shift, a disproportionate share of the high-acuity, high-cost MedStar population ultimately transitioned to AmeriHealth from the other two full risk-based MCOs, leading to unforeseeable operating and financial challenges for AmeriHealth in 2018 and which have continued throughout 2019. While trends in enrollment and medical cost growth have begun to subside compared to rates observed in 2018, the significant disparity in overall costs and enrollment when compared to the other full risk-based MCOs are indicative of continued adverse selection observed within the managed care program. This has culminated in both operating losses and the need for additional rate adjustment considerations as discussed later in this section.

Amerigroup and CareFirst continue to report high operating margins in 2019, though overall growth in profits have slowed compared to 2018 levels. The District risk adjusted the MCO District of Columbia Healthy Families Program (DCHFP) base capitation rates in May 2019 and again in October 2019, which is partially responsible for the reductions in revenue relative to expenses observed for both MCOs. Amerigroup's MLR has increased significantly from the 64% reported in 2018, to 80% in 2019. CareFirst has fallen short of this requirement for the past two years, due primarily to loss of a

contract with one of the District's major hospitals - George Washington Hospital, coupled with a noticeable decrease in high-cost utilizers of services from 2017 to 2018. It is also worth noting, CareFirst released a significant amount of prior period reserves relative to overall claims as an accounting adjustment which resulted in an understated reported MLR for 2019. Additional details of IBNR estimates and impact on reported MLR is discussed in Section IV of this report.

The financial results for the District's risk-sharing MCO – HSCSN - contracted to manage the CASSIP program, are consistent with results reported in 2018. HSCSN reported relatively flat trends in per member per month (PMPM) medical costs and a consistent MLR with 2018; however, the MCO reported growth in administrative costs resulting in a marginal net operating loss for 2019. Additional analysis of service categories and PMPM trends is discussed in Section IV of this report.

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

**MCO FINANCIAL CONDITION - JANUARY TO DECEMBER 2019**

| Financial Metric | Amerigroup | AmeriHealth | CareFirst | HSCSN |
|---|---|---|---|---|
| Reserves for Estimated IBNR Claims (Months Claims) | 1.4 | 1.6 | 2.1 | 2 |
| Risk-based Capital | 1822% | 324% | 554% | 386% |
| Defensive Interval Ratio (Days) | 26 | 84 | 15 | 52.1 |
| Operating Margin/Loss ($M) | $24.4 | $(49.2) | $8.2 | $(0.3) |
| Operating Margin/Loss Percentage | 13% | -9% | 6% | 0% |
| Medical Loss Ratio | 80% | 100% | 76% | 88% |

## ADMINISTRATIVE PERFORMANCE

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

- The MCOs have maintained comprehensive and diverse provider networks to ensure access to a full range of services as well as robust systems to report patient encounters. However, some of the MCOs have struggled to contract with all District hospitals, which DHCF will focus on remediating through future Medicaid reform initiatives.

- All the MCOs exceeded the District's timely payment requirement in 2019, ensuring the continuity of operations for their contracting providers.

- The overall claims denial rate for District MCOs in CY 2019 was 8.3%. The denial rate is calculated by dividing the count of claims with a final disposition of denied by the sum of all paid and denied claims. CareFirst had the highest rate of denied claims with a 13.1% denial rate, followed by

AmeriHealth at 8.0%, Amerigroup at 7.7%, and HSCSN at 4.1%. DHCF is currently working with the MCOs to improve the agency's data exchange and update its methods for analyzing denied claims later paid and the reasons for denials, which will be provided in a future report.

**MCO ADMINISTRATIVE PERFORMANCE - JANUARY TO DECEMBER 2019**

| Administrative Metric | Amerigroup | AmeriHealth | CareFirst | HSCSN |
|---|---|---|---|---|
| Accuracy rate for encounter submissions | 99% | 99% | 92% | 95% |
| Claims paid within 30 days | 99.9% | 99.9% | 99.3% | 96.8% |
| Claims denial rate | 7.7% | 8.0% | 13.1% | 4.1% |

Notes: Denial rate reflects claims with a final disposition of denied.
Source: DHCF analysis of MMIS and MCO-supplied data extracts.

## MEDICAL COSTS AND UTILIZATION TRENDS

### *MEDICAL EXPENSES*

Only one of the three full-risk MCOs spent at least the required 85% of MCO revenue on medical expenses while generally avoiding spikes in their PMPM costs in 2019. As reported in 2018, Amerigroup fell short of this requirement, due to lower than expected average monthly claims and release of prior period reserves. With the implementation of risk adjustment in 2019, Amerigroup's expenses are more closely aligned with reported revenues. Amerigroup's reported medical expenses are showing growth across most service categories, driven primarily by the adult populations in both the DCHFP and Alliance programs. CareFirst's PMPM expenses for DCHFP adult and children are showing some growth, driven by inpatient, outpatient, and behavioral health service costs. CareFirst's Alliance costs continue to decrease and remain the lowest among the three full risk-based MCOs. Overall, medical expenses for Amerigroup and CareFirst are showing modest growth in 2019, with total PMPM growth for DCHFP adults and children at 2% and 5% across all full risk-based MCOs from 2018 to 2019.

The growth in PMPM cost for the Alliance program was relatively modest at 3% in 2019, a sharp decrease from the 13% growth in 2018. Past Alliance spending growth was attributed primarily to the transition of pharmacy benefits into the managed care program in 2016. While enrollment growth is stable, the Alliance population is becoming slightly older with more complex medical problems. This has driven increased spending in pharmacy, outpatient, and inpatient hospital costs. Though the PMPM growth rate for the Alliance population in 2019 has appeared to slow compared to prior periods, the inherent short runout period for this report results in a high degree of uncertainty for reported claims reserve estimates and future financial results may vary.

AmeriHealth's total Alliance PMPM costs remain disproportionately higher than the other MCOs, driven primarily by the plan's disproportionate share of Alliance enrollees and their use of inpatient, outpatient, and pharmacy services. AmeriHealth attributes the increase in pharmacy spend due to both pharmacy cost and utilization increases for specialty drugs. Specifically, oncology drugs are a major source of disparity for Alliance enrollees, with AmeriHealth spending roughly four times as much on a PMPM basis compared to the other MCOs. For both the DCHFP and Alliance populations, AmeriHealth continues to experience significantly higher pharmacy, inpatient, outpatient and physician medical

service utilization driven primarily by enrollees with the following conditions: rheumatoid arthritis, diabetes and asthma. Beginning with the exit of MedStar in late 2017, the challenges experienced by the other two full-risk based MCOs in securing contracts with some of the key District hospitals, continue to drive enrollment of a disproportionate share of high-utilizers to AmeriHealth.

With the start of the FY 2020 contract year, DHCF implemented the following rate adjustments and contract amendments to address these financial pressures and help curtail the losses experienced by AmeriHealth, while better aligning cost and associated risk across the managed care program:

- Adopting a new risk-adjustment model (CDPS+Rx) which better aligns disease conditions and the use of pharmaceuticals with future healthcare costs,
- Increasing the frequency of risk score review with quarterly updates for eligibility changes,
- Performing a one-time DCHFP pharmacy adjustment and an Alliance experience adjustment, and
- Incorporating a one-time trend and base-cost adjustment to AmeriHealth's base rates.

DHCF included new requirements in the MCO Request for Proposal (RFP) for the FY 2021 contract year – e.g., universal contracting for key providers – that are designed to help mitigate the adverse selection experienced by AmeriHealth and other MCOs in future contract years.

As mentioned above, risk adjustment seeks to align each MCO's risk as reflected in the disease prevalence of the enrolled population, with the incurred health care costs and associated payment for services provided to enrolled members. The figure below illustrates the comparison of each MCOs ranking on enrollee risk scores and their total medical costs, illustrating the distribution of risk and associated costs across the DCHFP program and MCOs. While risk adjustment improves the alignment of payment to projected cost, it does not capture all observed variation between MCO populations and utilization and in particular does not currently apply to the Alliance program.

**RANKING OF ENROLLEE RISK SCORE & MEDICAL COSTS**

| Ranking on Medical Cost | Ranking on Enrollee Risk Scores: Low | Ranking on Enrollee Risk Scores: Medium | Ranking on Enrollee Risk Scores: High |
|---|---|---|---|
| **Low** | Amerigroup – Child<br>CareFirst – Adult | | |
| **Medium** | | Amerigroup – Adult<br>CareFirst – Child | |
| **High** | | | AmeriHealth – Adult<br>AmeriHealth – Child |

Notes: Enrollee risk scores based off risk-adjustment study period of April 2018 - March 2019 and enrollment snapshot as of December 2019. Expenses incurred from January 1, 2019 to December 31, 2019 and paid as of January 31, 2020. IBNR is estimated based on historical payment lags.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data and encounter data submitted directly to DHCF.

## *MENTAL HEALTH SERVICE UTILIZATION*

DHCF is currently undertaking a variety of transformation efforts related to behavioral health (BH) care services for both mental health and substance use disorders. These include the implementation of a Section 1115 waiver that expands the array of BH services and providers covered under the Medicaid program, as well as planning for a future managed care carve-in of certain BH services now paid under FFS. DHCF is working with a variety of stakeholders on these issues and in a future managed care report will provide data that aligns with related analyses currently under way.

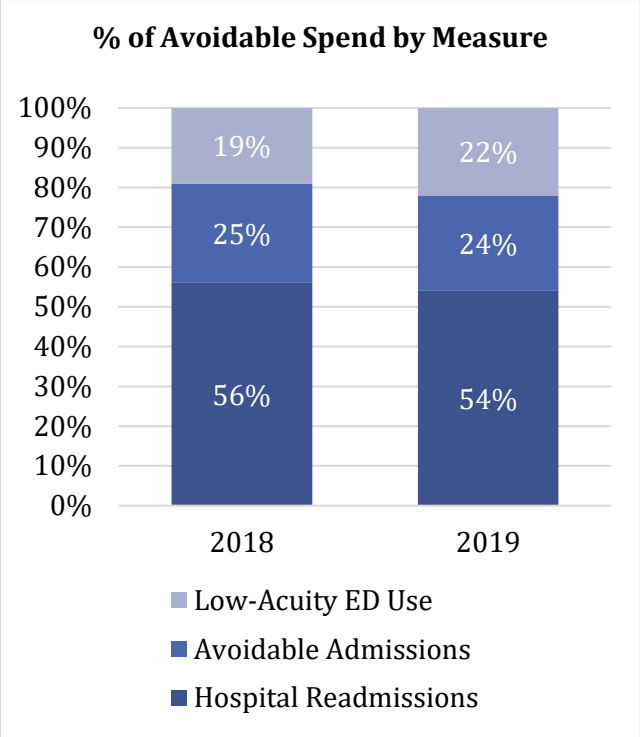
## *WELL-CHILD AND OTHER AMBULATORY CARE VISIT RATES*

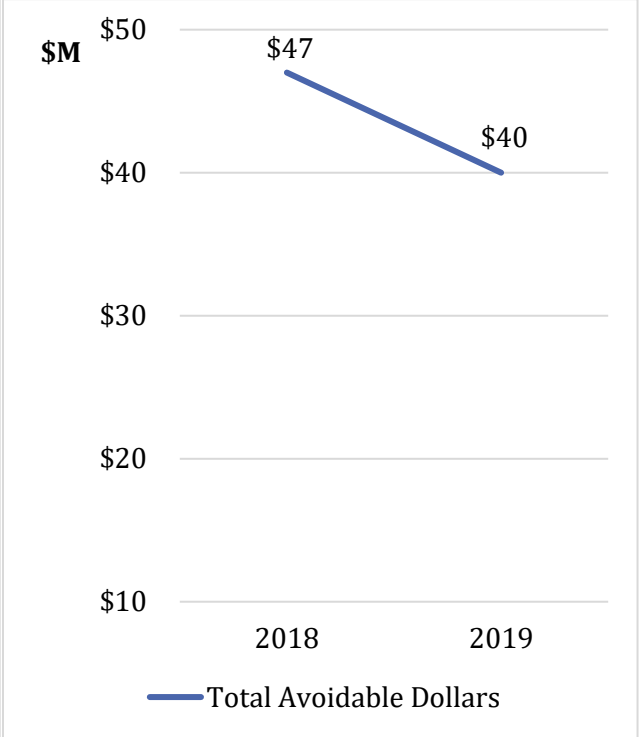
Well-child visit rates vary by plan and year. The overall MCO average was 71% in FY 2019, ranging from 63% for Amerigroup to 83% for HSCSN. WCV rates increased between FYs 2015 and 2017 for three of the four participating plans but have generally decreased since that time, with the exception of HSCSN in FY 2019. With regard to preventive and other ambulatory care for adults, visit rates also vary by plan and time period. For example, 63% of adult MCO enrollees had a visit in CY 2019, but rates ranged from 50% for CareFirst to 70% for AmeriHealth. Adult visit rates for MCOs overall decreased between 2015 and 2018, then remained steady in 2019. See Section IV of this report for detailed information of MCO utilization rates and DHCF's strategies to oversee utilization of these services.

## *CARE COORDINATION*

The care coordination challenges that plagued the District's three full risk-based MCOs from 2014 through 2016 have been well documented – members' use of the emergency room for routine care, the repeated occurrences of potentially avoidable hospital admissions, the problem of hospital readmissions – and remain stubborn challenges, but with some improvement. With CMS approval, DHCF implemented the MCO pay-for-performance (P4P) program in 2017. For FY 2019, the MCOs have spent approximately $40 million on patient care that may have been avoided using more aggressive care coordination strategies. These amounts are notably below FY 2018 reported results as seen in the figure below which illustrates both the percentage of avoidable spend by utilization metric and total avoidable spend in 2019 compared to 2018. DHCF will continue to work closely with MCOs on identifying opportunities for continued improvement in implementing effective care coordination interventions in the future.

**AVOIDABLE HOSPITALIZATION SPEND- 2018 TO 2019**




Notes: Current annual results reflect data incurred in October 2018 through September 2019 with payment runout through December 2019, compared to a similar time period in 2018. Total avoidable costs include Health Home enrollees
Source: Mercer analysis of MCO Encounter data for DCHFP reported by the MCOs to DHCF.

When comparing FY 2019 to the baseline period, AmeriHealth and CareFirst currently meet or surpass the minimum requirements on all three quality measures, with Amerigroup falling short on the non-emergent use of the emergency room efficiency measure. DHCF postponed the P4P withhold in FY 2019 due to changes in the payment rates for the MCOs; however, DHCF will continue to closely monitor this program.

# II. FINANCIAL PERFORMANCE

## A. INTRODUCTION

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

- Medical Loss Ratio (MLR) – represents the portion of total revenue used by the MCOs to fund medical expenses, including expenses for cost containment.

- Administrative Loss Ratio (ALR) – represents the portion of total revenue used by the MCOs to fund both claims processing and general administrative expenses.

- Operating Margin (OM) – also referred to as profit margin and is defined as the sum of MLR and ALR subtracted from 100%. A positive OM indicates a financial gain while a negative indicates a loss. DHCF's actuary, Mercer Government Human Services Consulting (Mercer), established a benchmark for the operating margin needed to sustain a strong financial position is approximately 2-4% annually over a 3-5-year time horizon.

- Risk-based Capital (RBC) – represents a measure of the financial solvency of managed care plans and reflects the proportion of the required minimum capital that is maintained by a managed care plan as of the annual filing.

Traditional concerns that patient care is being sacrificed are often expressed when MCOs report significant operating margins. Accordingly, DHCF routinely tracks the MCOs' performance against a target MLR of 85% for the full risk-based plans and an MLR target established during rate setting for the shared risk plan. MCOs that fall short of this standard face detailed scrutiny and possible financial penalties if warranted. MCOs can also artificially (and temporarily) inflate operating margins by repeatedly denying claims that should be paid. DHCF began monitoring denied claims in 2016 staring with CY 2015 denial rates. This report provides an analysis of CY 2019 denial rates only. Assuming adequacy in the base capitated payment rate, there are typically three important factors that impact whether an MCO will experience positive operating margins:

- Risk-adjusted payment rates: Risk adjustment ensures financial viability and operational sustainability for MCOs whose membership represent a disproportionate share of high-acuity, high-cost beneficiaries. With DHCF's payment model, MCOs whose enrollees evince greater medical risk in the form of disease prevalence, receive higher risk scores and greater payments. MCOs with lower risk enrollees receive reduced rates. Thus, plans that properly align membership risk based on enrollee disease prevalence with utilization of appropriate services based on the acute needs of their population, can gain a considerable advantage over others that do not. Both in May 2019 and again in October 2019, risk adjustment was applied to the actuarially sound capitation rates established during rate setting.

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

- Patient utilization management: Relative differences across plans in the degree to which their enrollees unnecessarily access high-end care as an alternative to less expensive treatment will drive variations in operating margins. In addition, differences in the application of medical

necessity requirements may directly impact utilization and incurred costs observed between MCOs.

The table below reflects enrollment growth for both the DCHFP and Alliance population serviced by the full risk-based MCOs, as well as the CASSIP population served by HSCSN, since the inception of the FY 2019 contracts. As illustrated in the table below, enrollment trends were relatively flat with decreases observed for HSCSN and moderate growth in AmeriHealth membership.

**ENROLLMENT GROWTH OCTOBER 2018 TO DECEMBER 2019**

| MCO | Enrollment October 2018 | Enrollment December 2019 | Net Change |
|---|---|---|---|
| Amerigroup | 46,868 | 46,954 | 0.2% |
| AmeriHealth | 120,704 | 125,343 | 3.8% |
| CareFirst | 34,480 | 35,003 | 1.5% |
| HSCSN | 5,255 | 5,013 | -4.6% |

Notes: Full risk-based MCOs enrollment results reflects both DCHFP and Alliance populations. HSCSN's results reflect enrollment for the CASSIP population for the referenced reporting period.
Source: Enrollment data extracted from DHCF's Medicaid Management Information System (MMIS) on June 22, 2020.

The table below illustrates the total revenue, medical and administrative costs, and operating margin for each of the MCOs as of December 2019. DHCF reports total capitation revenue by excluding Health Insurance Providers Fee (HIPF) payments and DC Exchange/Premium tax revenue based on the MLR letters and calculations provided by the MCOs. For HSCSN, capitation revenue excludes DC Exchange/Premium tax revenue and risk share amounts. Total incurred claims (including IBNR) and cost containment expenses as of December 31, 2019, net of reinsurance recoveries, are included in the calculation of MLR. Administrative expenses include all claims adjustment expenses as reported in quarterly filings to the Department of Insurance, Securities and Banking (DISB), excluding cost containment expenses and DC Exchange/Premium taxes as reported in MLR report and calculations provided by the MCOs. For HSCSN, administrative expenses are reported based on MCO submitted balance sheet and income statement. Finally, operating margin is derived by subtracting net claims and administrative costs from MCO revenue.

AmeriHealth increased their IBNR reserves due to observed increases in enrollment and lower than average claims observed in prior quarters, resulting in increased MLR and operating losses for the period. DHCF has put in place remediation efforts through implementation of new risk adjustment models and cost-experience adjustments in FY 2020 to help mitigate future operational losses for the MCO.

**MCO REVENUE AND EXPENSE DATA FOR JANUARY TO DECEMBER 2019**

| MCO | Revenue | Claims | Administrative Cost | Operating Margin (Loss) |
|---|---|---|---|---|
| Amerigroup | $183.1M | $147M | $11.7M | $24.4M |
| AmeriHealth | $561.4M | $561.2M | $49.4M | $(49.2)M |
| CareFirst | $136.5M | $103.2M | $25.1M | $8.2M |
| HSCSN | $173.6M | $152.7M | $21.2M | $(0.3)M |

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

## B. RISK-BASED CAPITAL

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

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

1. No action - Total Adjusted Capital of 200% or more of Authorized Control Level.

2. Company Action Level - Total Adjusted Capital of 150%-200% of Authorized Control Level. Insurer must prepare a report to the regulator outlining a comprehensive financial plan that identifies the conditions that contributed to the company's financial condition and a corrective action plan.

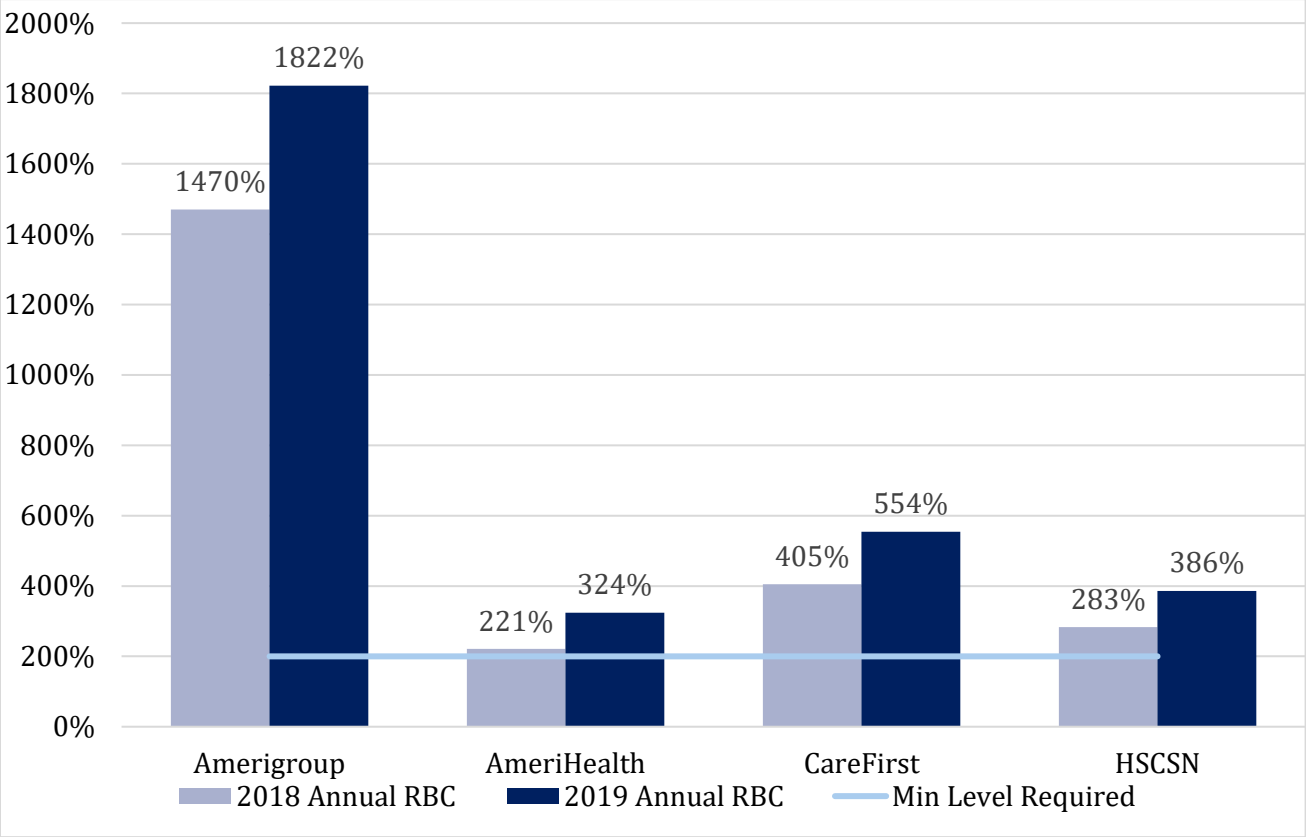
3. Regulatory Action Level - Total Adjusted Capital of 100%-150% of Authorized Control Level. Company is required to file an action plan and the Insurance Commissioner issues appropriate corrective orders to address the company's financial problems.

4. Authorized Control Level - Total Adjusted Capital 70%-100% of the Authorized Control Level triggers an action in which the regulator takes control of the insurer even though the insurer may technically be solvent.

5. Mandatory Control Level - Total Adjusted Capital of less than 70% triggers a Mandatory Control Level that requires the regulator to take steps to place the insurer under control. Most companies that trigger this action level are technically insolvent (liabilities exceed assets).

The figure below illustrates the results of the annual RBC measures reported by the MCOs in their official 2019 financial statements compared to their 2018 filings with DISB. Positive trends are indicated by results at or above the stated 200% threshold. As illustrated below, all MCOs maintained risk-based capital levels that exceeded recommended standards for 2019.

**RISK-BASED CAPITAL 2019 COMPARED TO 2018 ANNUAL LEVEL**




Notes: HSCSN is not subject to DISB Risk-Based Capital reporting requirements. The reported numbers are calculated and included in this report for monitoring and informational purposes.
Source: Reported figures are from the full risk-based MCO's annual 2018 and 2019 financial statements reported to DISB and self-reported financials for the shared risk MCO.

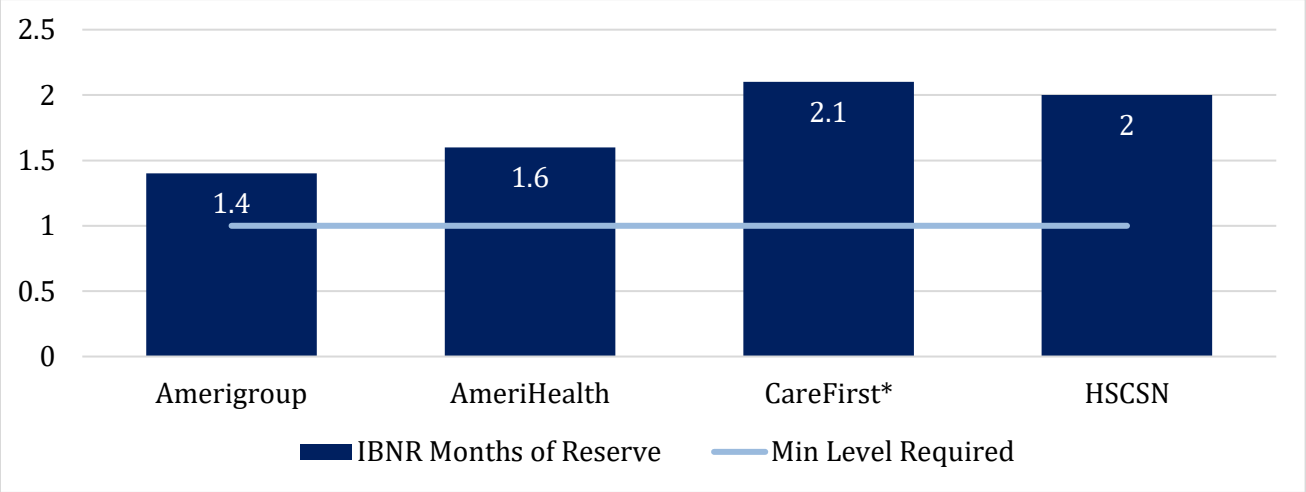
Based on MCO reported results for 2019, all MCOs maintained risk-based capital levels that exceeded recommended standards for the 2019 annual review period. Amerigroup's results for RBC continue to be high due to the MCO's retained profits in 2019. AmeriHealth received an additional $30 million from their parent company in Q4, with a total $70 million in capital contribution from their parent company in 2019. This capital infusion resulted in healthy RBC levels for the MCO, despite their operating losses in 2019.

## C. RESERVE AND LIQUIDITY METRICS

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

The figure below illustrates the level of reserves MCO's have available to satisfy incurred but not reported claims (IBNR) for the annual 2019 reporting period.

**IBNR MONTHS CLAIMS - JANUARY TO DECEMBER 2019**

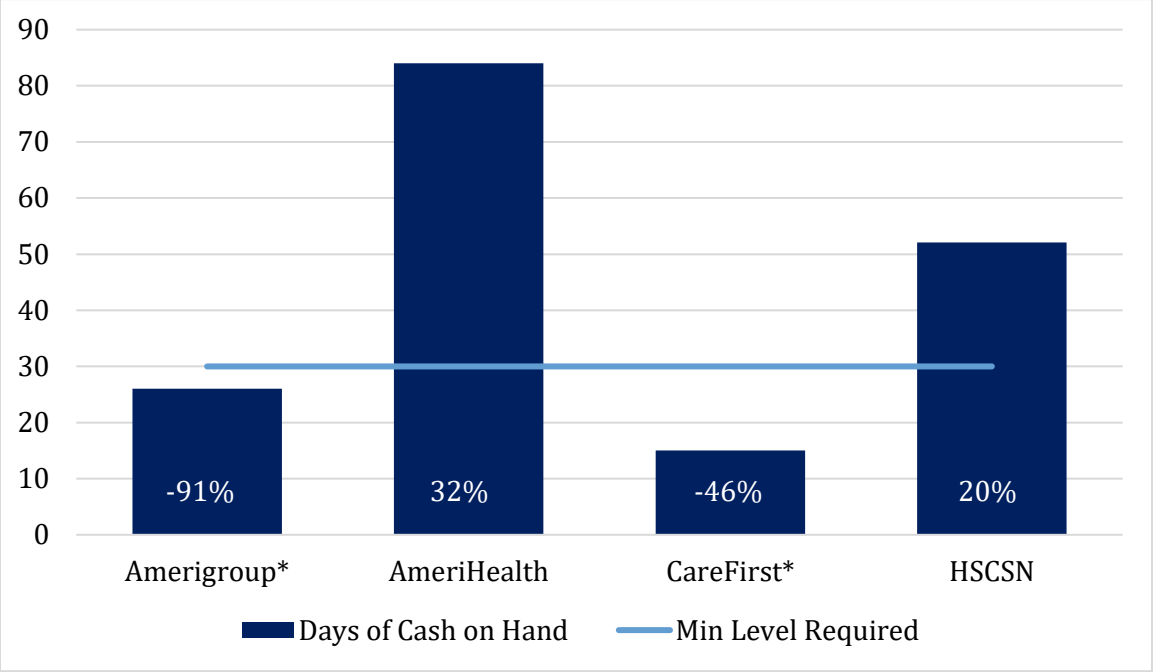



Notes: Estimated number of months of reserves compared to average monthly incurred claims. *CareFirst has historically had a longer claims runout period than the other MCOs, which impacts derived IBNR amounts.
Source: IBNR is based on amounts reported on the MCO's annual filings for the three full risk-based plans and self-reported financials for the shared risk plan.

Based on the results illustrated in the figure above, all four MCOs have a sufficient number of months in reserve for estimated incurred but not reported claims. AmeriHealth increased their IBNR assumption for Q4 when compared to prior quarters in 2019, driven by increased enrollment and lower than average claims observed in Q2 and Q3 of 2019. These IBNR estimates may impact other financial results reported in the following sections of this report.

The figure below illustrates the level of liquidity for each MCO, by reporting on the number of days the MCOs can operate without accessing long-term assets observed during 2019, along with trends when comparing to 2018 levels. This is described as a Defensive Interval Ratio (DIR) which is, in essence, a liquidity measure - the degree to which the MCOs can survive on liquid assets without having to access long-term assets. DHCF derives the liquidity metric by taking the cash, cash equivalents and short-term investments as reported in the MCOs DISB submissions, or income statement for HSCSN, divided by total daily operating expenses. DHCF uses the NAIC's definition of cash, cash equivalents and short-term investments which aligns with the reported line items included in the statutory filings based on statutory accounting principles.

**DEFENSIVE INTERVAL RATIO AND TRENDS**




Source: Mercer calculated the Defensive Interval Ratio as cash and cash equivalents divided by daily operating expenses for the period from January to December 2019.

Two of the four MCOs met the standard liquidity benchmark for 2019 based on the formula used for this report to calculate the cash, cash equivalents, and short-term investments component of the Defensive Interval Ratio. DHCF will work closely with the other two MCOs to ensure sufficient liquid assets are available as reported in the statutory filings.

# III. ADMINISTRATIVE PERFORMANCE

## A. INTRODUCTION

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

1. Build an adequate network of providers and pay health care claims to service providers on time and through an electronic claims process with documentation to facilitate reconciliation of payments.

2. Create an accurate electronic record of all patient health care encounters and transmit the files containing this information to DHCF with a minimal error rate.

3. Establish a system of care management and care coordination to identify MCO enrollees with special or chronic health care issues and ensure that these enrollees each receives access to appropriate care, while managing the delivery of health care services for all enrollees.

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

## B. ENCOUNTER DATA

DHCF monitors encounter submissions from MCOs to the agency's Medicaid Management Information System (MMIS), and tracks number of recorded encounters and the accuracy of encounter submissions to the agency's MMIS. As seen in the table below, all MCOs except CareFirst met or exceeded the DHCF established target of 95% compliance, thus continuing to maintain accurate encounter data file submissions for the current January through December 2019 reporting period. DHCF is working closely with CareFirst to enhance their encounter oversight processes, including oversight of MCO vendors contracted to report encounters, as well as more comprehensive tracking of encounter submissions for accuracy and completeness.

**NUMBER OF RECORDED ENCOUNTERS AND ACCURACY RATE - JANUARY TO DECEMBER 2019**

| MCO | Total Submitted Encounters* | Accuracy Rate of Encounter Submissions |
|---|---|---|
| Amerigroup | 412,252 | 99% |
| AmeriHealth | 1,788,506 | 99% |
| CareFirst | 349,703 | 92% |
| HSCSN | 358,050 | 95% |

Notes: *Gross count can include originals, voids and resubmissions. Reported numbers are currently abnormally high due to correction and resubmission of historical encounters to support the FQHC Wrap process. The District expects this number to remain higher than normal for one to two more reporting periods.
Source: Department of Health Care Finance MMIS each month January through December 2019.

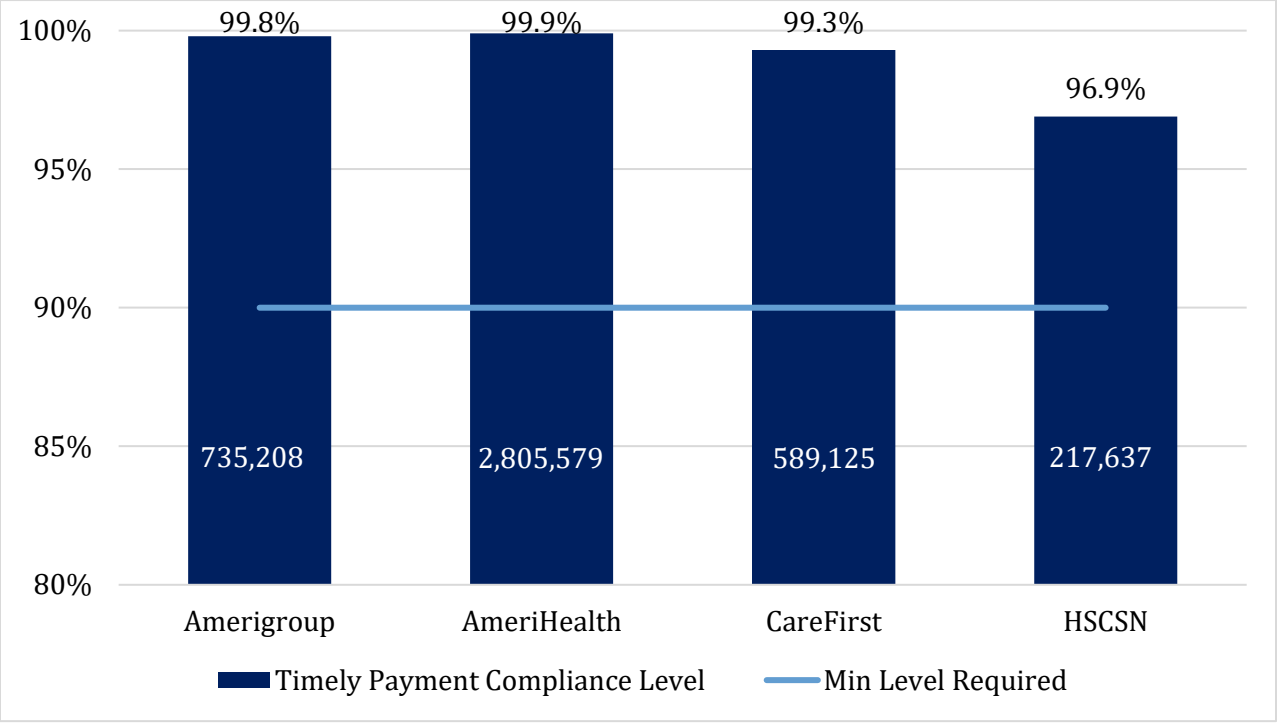
## C. TIMELY PAYMENT OF CLAIMS

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

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

DHCF monitors compliance with timeliness requirements by comparing MCOs' submissions to a target goal of 90% compliance of payment of all clean claims, as part of regular oversight reporting from each contracted MCO. Compliance with the timeliness requirement is measured by calculating the lag between the date the MCO receives a clean provider claim, and the date of payment for that claim. As seen in the figure below, each MCO exceeded DHCF's timely payment requirement for the January through June 2019 reporting period.

**TIMELY PAYMENT COMPLIANCE - JANUARY TO DECEMBER 2019**




Notes: The 30-day timely payment requirement only applies to "clean claims" that meet the requirement for payment. Total adjudicated claims are included in the figure for each MCO.
Source: Data self-reported by MCOs on the Department of Health Care Finance's Claims Monthly Payment Report.

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

## D. DENIED CLAIMS

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

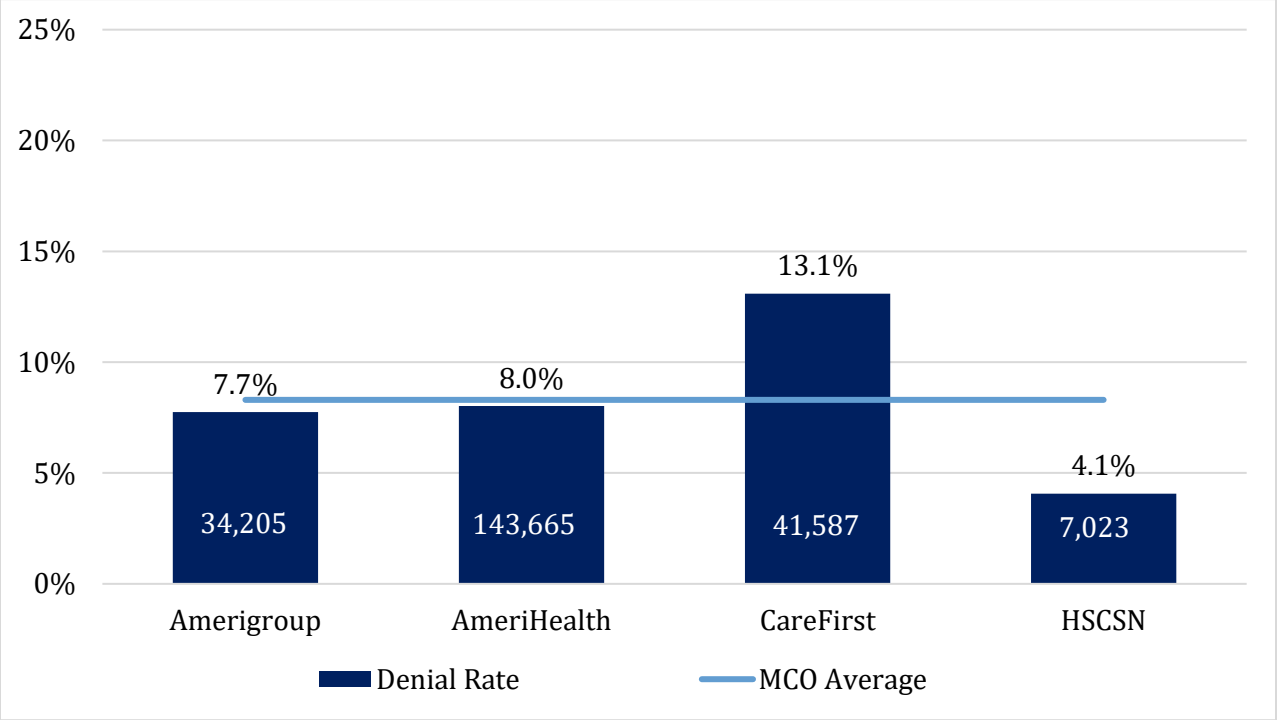
This report provides information on the incidence of CY 2019 managed care claims with a final disposition of denied. DHCF is currently working with the health plans to improve the agency's data exchange and update its methods for analyzing denied claims later paid and the reasons for denials, which will be provided in a future report.

### METHODOLOGY

The key steps executed to obtain CY 2019 denial rates as reported in the figure below, were as follows:

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

**MCO CLAIMS DENIAL RATES - JANUARY TO DECEMBER 2019**




Note: Due to discrepancies in adjudication practices among the MCO's pharmacy benefit managers (PBMs), findings exclude denied pharmacy claims. Total number of denied claims are included in the figure for each MCO.
Source: Patient encounters with January 1-December 31, 2019 dates of service from DHCF MMIS system were merged with MCO files containing denied claims for the same period.

The overall claims denial rate for District MCOs in CY 2019 was 8.3%. CareFirst had the highest rate of denied claims with a 13.1% denial rate, followed by AmeriHealth at 8.0%, Amerigroup at 7.7%, and HSCSN at 4.1%. DHCF is currently working with the health plans to improve the agency's data exchange and update its methods for analyzing denied claims later paid and the reasons for denials, to augment future reporting including observed trends and underlying operational drivers for denials.

# IV. MEDICAL SPENDING AND UTILIZATION TRENDS

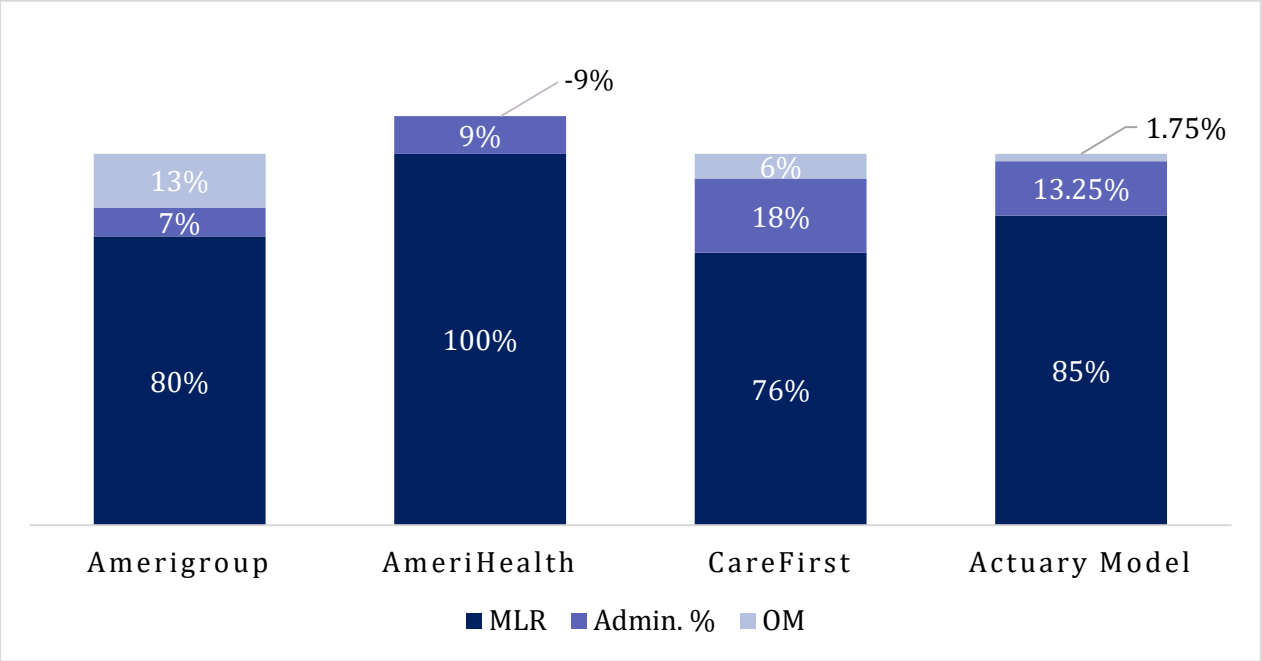
## A. INTRODUCTION

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

### FULL RISK MCOS

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

**MLR, ADMINISTRATIVE AND OPERATING MARGIN - JANUARY TO DECEMBER 2019**




Source: MCO Annual Statements filed by the MCOs with the Department of Insurance, Securities, and Banking for the three full risk-based MCOs.

As illustrated in the above figure, DHCF's largest MCO, AmeriHealth, continues to report medical costs exceeding the target MLR for rate setting, as expenses continue to rise with revenue. Note, AmeriHealth increased their reserve for IBNR claims liability in Q4 of 2019, which may have resulted in higher than expected MLR for the reporting period. Conversely, CareFirst's 2019 expenses reflect a large release of IBNR for prior period reserves, resulting in a roughly 10% reduction in 2019 MLR. Amerigroup's reported MLR of 80%, though below the target 85%, is up significantly from the 64% at the end of the 2018 reporting period – reflecting a rise in expenses along with revenues due to risk adjustment in Q4 2019. Note, the level of reserves for incurred but not reported (IBNR) claims expense held by an MCO directly impacts the overall expenses and operating margins reported by the health plan.

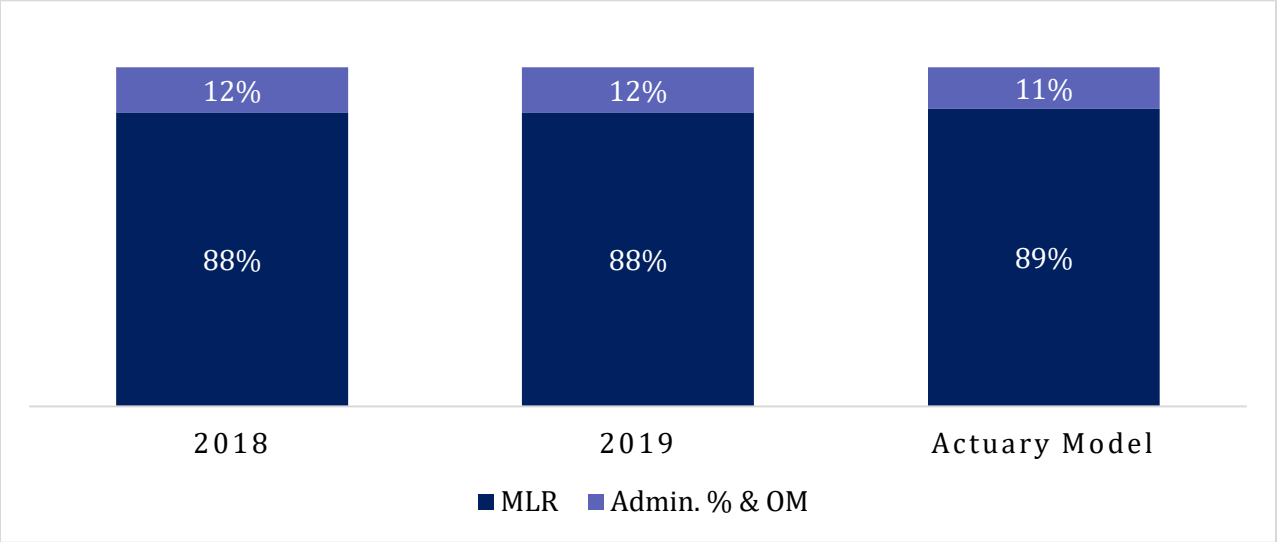
The underlying trends in medical service costs are discussed below in Section B of this report.

## SHARED RISK MCO

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

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

**MLR, ADMINISTRATIVE AND OPERATING MARGIN FOR CASSIP - JANUARY TO DECEMBER 2019**




Source: Self-reported annual statements submitted to DHCF by HSCSN.

**RISK SHARE BASED ON TARGET MLR - JANUARY TO DECEMEBER 2019**

| Risk Share Based on 89% MLR | 2018 | 2019 |
|---|---|---|
| Total (At Risk) or Underspend[1] | $1.07M | $1.8M |
| Amount Due to MCO[2] | $0 | $0 |
| Amount Due to District[3] | $0 | $0 |

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

In 2019, HSCSN's medical expenses as a percent of its revenue (88%) was slightly below the threshold for the target Medical Loss Ratio (89%) set during annual rate development; however, the marginal amount falls within the acceptable ranges and does not trigger the risk-sharing provision for the 2019

annual reporting period. HSCSN reported a marginal loss of roughly $300K primarily due to a roughly 10% increase in administrative costs in 2019.

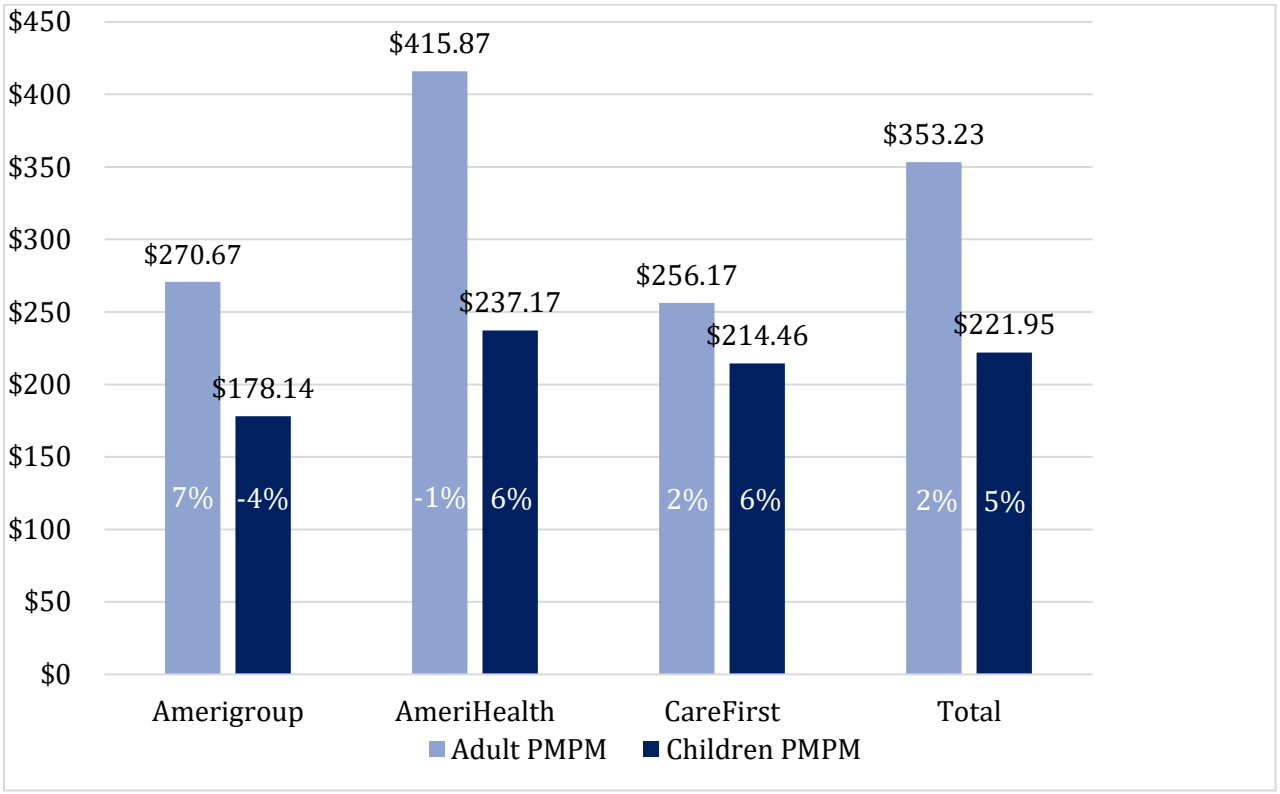
The underlying trends in medical service costs are discussed below in Section B of this report.

## B. PER MEMBER PER MONTH MEDICAL COSTS

This report presents an analysis of the per member per month (PMPM) medical service costs for the DCHFP, Alliance, and CASSIP - both the Well and children who have special health care needs and receive Supplemental Security Income (SSI) benefits – programs and populations. DHCF and its contracted actuaries review quarterly financial data submitted by the MCOs for expenses incurred from January 1, 2019 to December 31, 2019, and paid as of January 31, 2020 for Amerigroup, AmeriHealth, CareFirst, and HSCSN. The figures below also provide an analysis of changes in average PMPM expenses, January 1, 2019 to December 31, 2019 compared to January 1, 2018 to December 31, 2018, for high-cost medical service categories for the four MCOs. Note, IBNR is estimated based on historical payment lags and the relatively short runout period for this report results in a high degree of uncertainty for IBNR estimates, and final results will differ from those reported in the below figures.

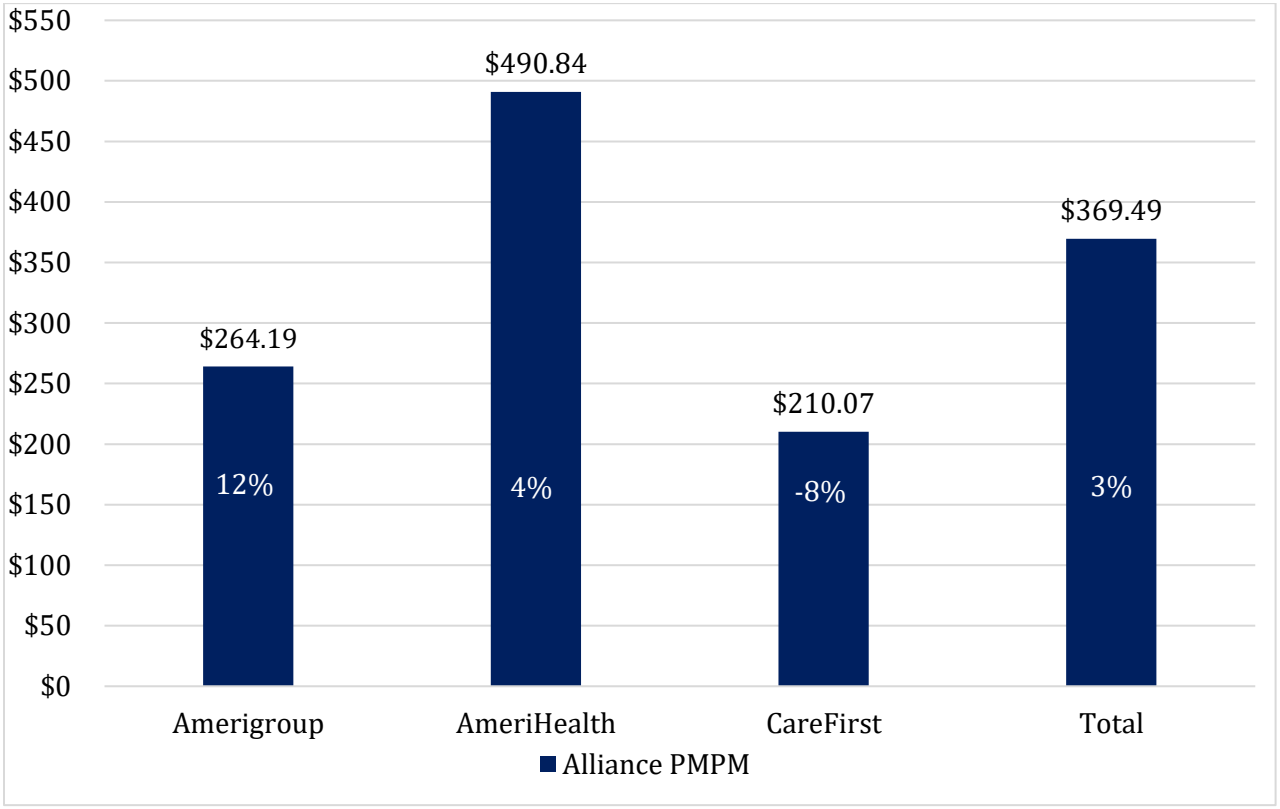
The figure below illustrates the total PMPM costs associated with the DCHFP Adult and Child populations, along with trends in PMPM costs when comparing to the prior year. A similar exhibit is provided below for the Alliance total PMPM costs and cost trends when comparing to 2018 levels.

**DCHFP ADULT AND CHILD TOTAL PMPM AND TRENDS**




Notes: Children defined as person up to age 21 in this analysis for the three full risk-based MCOs.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

**ALLIANCE TOTAL PMPM AND TRENDS**




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

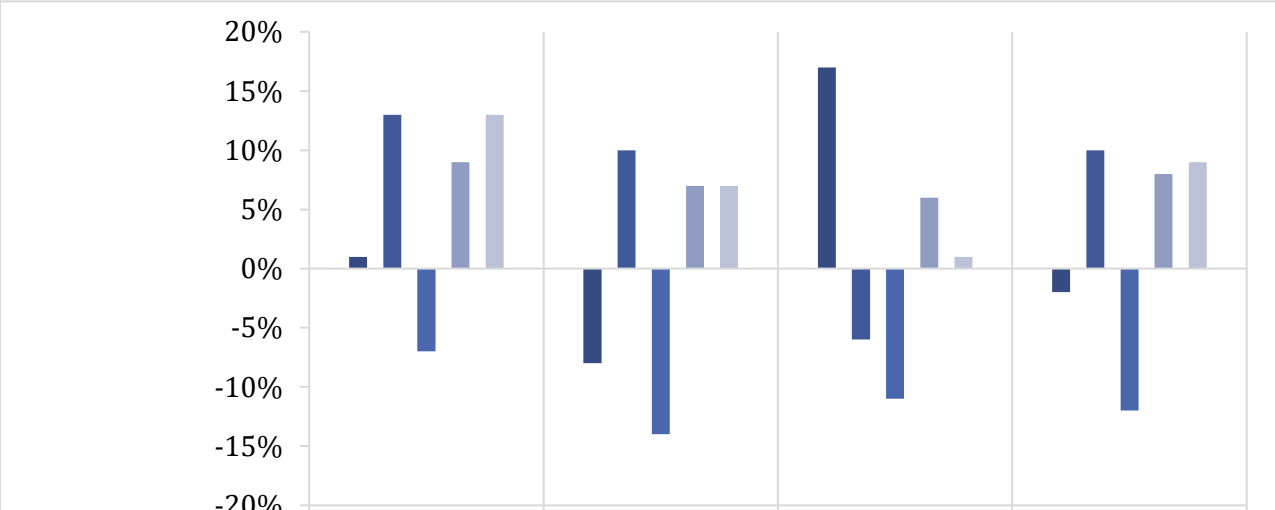
Overall, moderate growth in PMPM expenses were experienced for both the DCHFP Adult and Child, and Alliance populations over the past year. The DCHFP Adult population showed relatively consistent PMPMs from 2018 to 2019, while the DCHFP Child PMPMs showed emerging growth, driven by inpatient, outpatient, and behavioral health services. Although cost and utilization growth for most services has leveled off for the Alliance program, higher trends in both unit cost and utilization continue to be observed for prescription drugs, primarily specialty drugs. DHCF and its actuaries review pipeline drugs to anticipate future cost trends as part of annual rate setting. This analysis has identified future growth in traditional drug classes such as diabetes, asthma, substance abuse and dependence, and specialty drugs such as rheumatoid arthritis and other inflammatory conditions, oncology, HIV PrEP as well as other new and emerging therapeutic drugs and categories. A few recent examples of emerging drugs that have impacted expected pharmacy costs are treatments for hemophilia, enzyme deficiency, oncology, cystic fibrosis and hepatitis C.

Notable disparities in medical service costs remain for AmeriHealth, both for Alliance and DCHFP, compared to the other full risk-based MCOs; however, AmeriHealth's growth in PMPM costs have begun to subside in 2019. AmeriHealth's historically high costs are driven by a disproportionate share of high-utilizers with the following illnesses: rheumatoid arthritis, diabetes, and asthma. For Alliance, AmeriHealth's high costs are driven by pharmaceutical spending for oncology and related inpatient, outpatient, and physician medical service spending. Amerigroup's reported expenses are showing PMPM growth across most services, primarily driven by outpatient, physician and pharmacy services, for both their DCHFP Adult and Alliance populations. CareFirst's DCHFP Adult and Children PMPM expenses are showing marginal growth, driven by inpatient, outpatient and behavioral health costs.

CareFirst's Alliance PMPMs continue to decrease in 2019 and remain the lowest among the three full risk-based MCOs. See the figures below for PMPM trends by high-cost medical service categories for DCHFP Adult and Children, and CASSIP.

For DHCF's risk-sharing MCO – HSCSN, overall growth in PMPM expenses are relatively flat in 2019, with notable increases in Durable Medical Equipment (DME) and Home Health costs, offset by decreases in physician services. As part of the FY 2021 rate-setting process, DHCF's actuaries reviewed the contracted rates of HSCSN's related-party providing Home Health services – HSC Home Care, and identified significantly higher unit cost compared to the average of other providers for in-home Licensed Practical Nurse (LPN) services and Personal Care services. HSCSN provided documentation of new Home Health contracts for HSC Home Care and Linac Services, Inc. (the other highest utilized Home Health provider) which partially resolved the cost disparity. DHCF's actuaries made an overall downward adjustment to Home Health services for the FY 2021 rate period. Overall, HSCSN's costs are historically volatile among individual rate cell and service category, due to their small population with acute health care needs. See the figures below for overall trends in CASSIP cost growth and high-cost medical service categories.

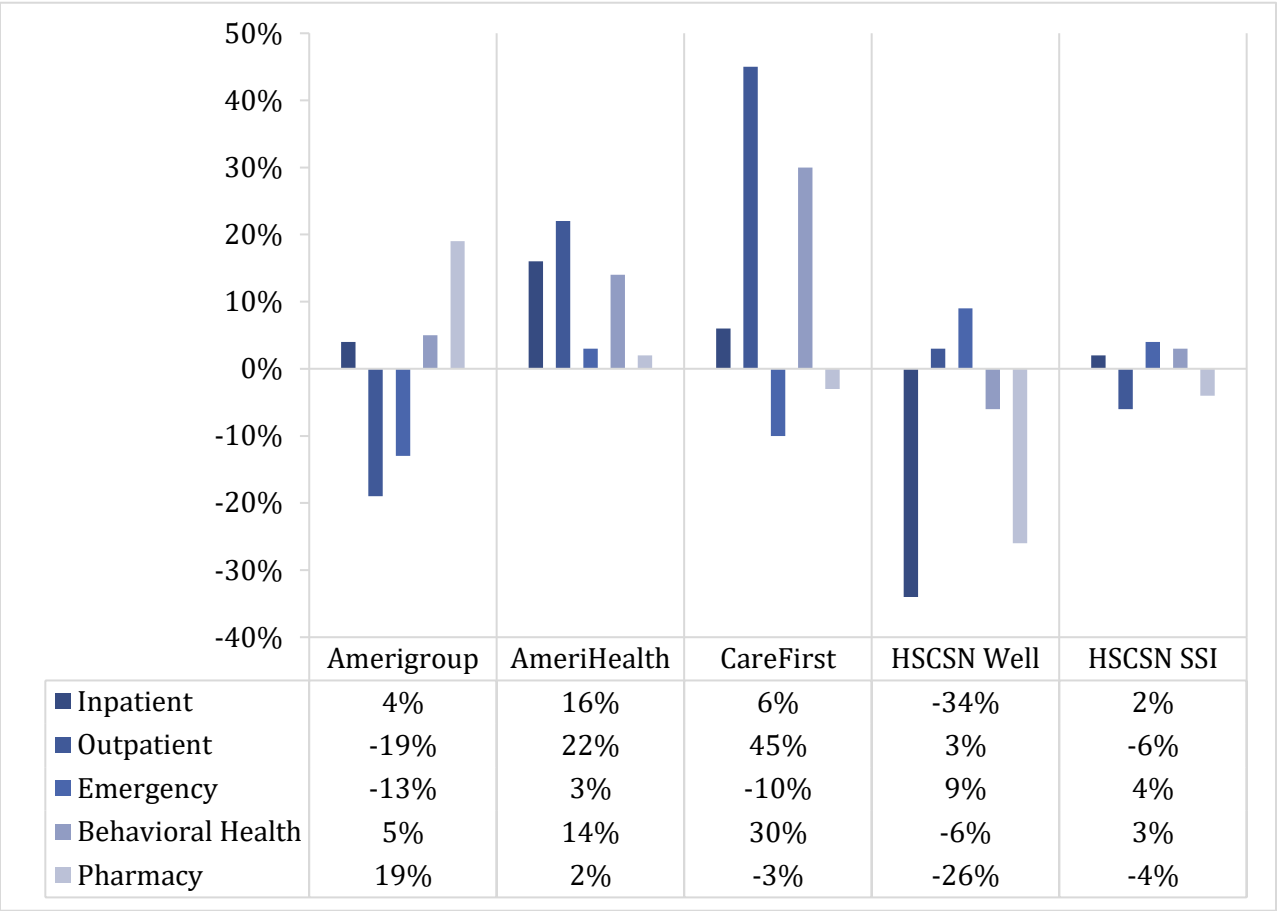
**DCHFP ADULT PMPM TRENDS – 2018 TO 2019**




| | Amerigroup | AmeriHealth | CareFirst | Total |
|---|---|---|---|---|
| Inpatient | 1% | -8% | 17% | -2% |
| Outpatient | 13% | 10% | -6% | 10% |
| Emergency | -7% | -14% | -11% | -12% |
| Behavioral Health | 9% | 7% | 6% | 8% |
| Pharmacy | 13% | 7% | 1% | 9% |

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

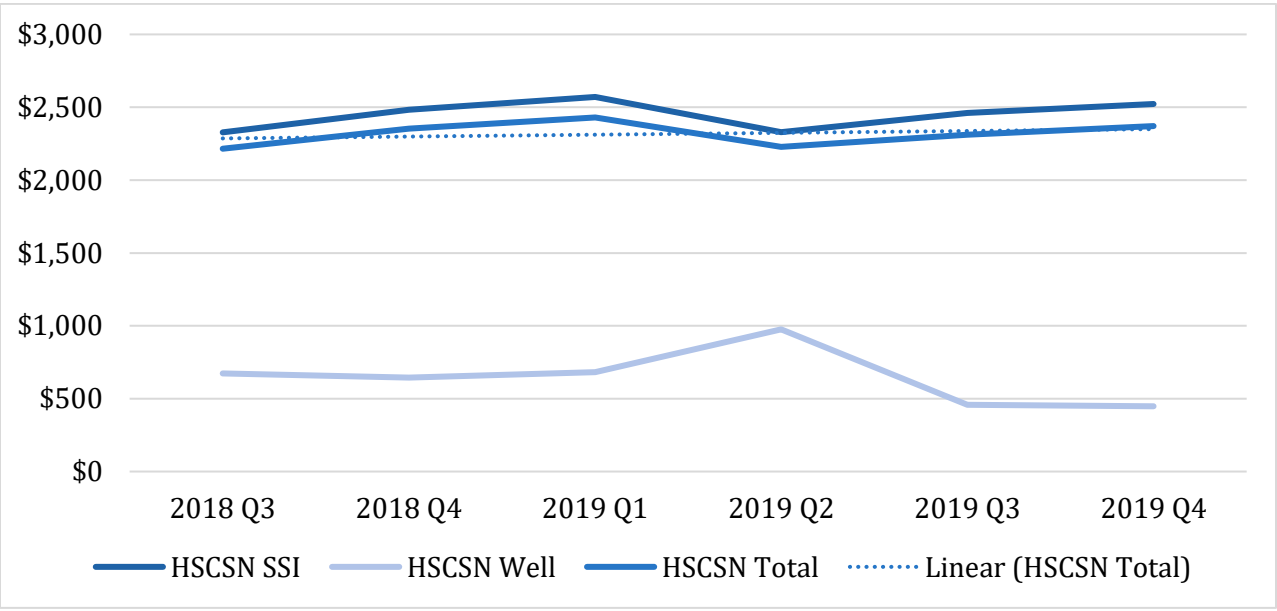
**DCHFP & CASSIP CHILDREN PMPM TRENDS – 2018 TO 2019**




| | Amerigroup | AmeriHealth | CareFirst | HSCSN Well | HSCSN SSI |
|---|---|---|---|---|---|
| Inpatient | 4% | 16% | 6% | -34% | 2% |
| Outpatient | -19% | 22% | 45% | 3% | -6% |
| Emergency | -13% | 3% | -10% | 9% | 4% |
| Behavioral Health | 5% | 14% | 30% | -6% | 3% |
| Pharmacy | 19% | 2% | -3% | -26% | -4% |

Notes: Children defined as person up to age 21 in this analysis for the three full risk-based MCOs and age 26 for HSCSN. HSCSN's financial results are reported for both the Well and children who have special health care needs and receive Supplemental Security Income (SSI) benefits.
Source: Enrollment and expense data are based on self-reported MCO Quarterly Financial Data submitted directly to DHCF.

**CASSIP PMPM TRENDS – 2018 TO 2019**




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

## C. UTILIZATION TRENDS

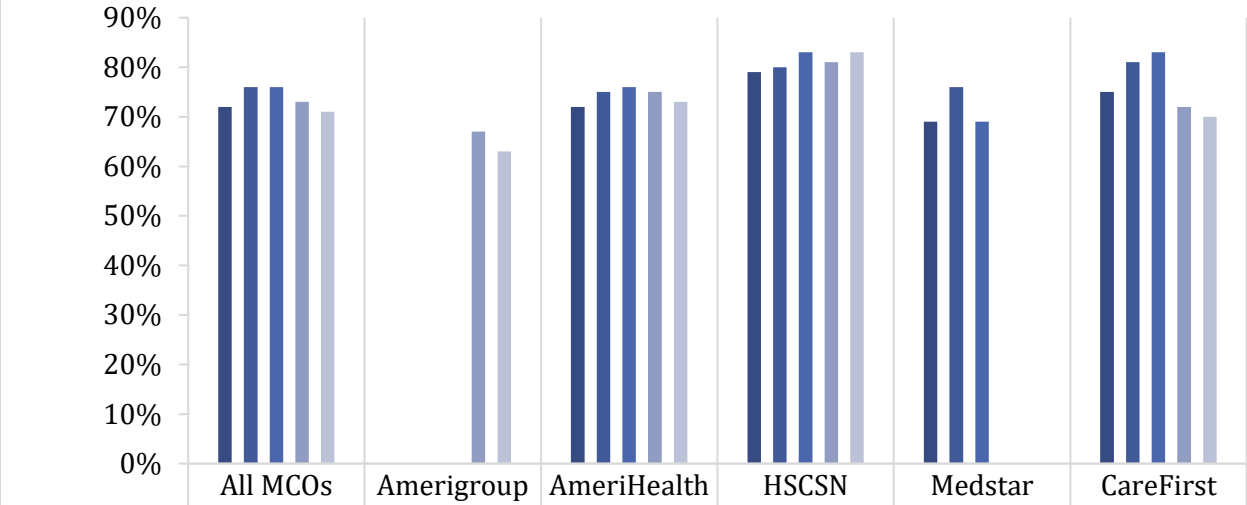
### WELL-CHILD AND OTHER AMBULATORY CARE VISIT RATES

Well-child visit (WCV) rates vary by plan and year. The overall MCO average was 71% in FY 2019, ranging from 63% for Amerigroup to 83% for HSCSN. WCV rates increased between FYs 2015 and 2017 for three of the four participating plans but have generally decreased since that time, with the exception of HSCSN in FY 2019. This data reflects information reported by each MCO in accordance with Centers for Medicare & Medicaid Services (CMS) Form CMS-416 specifications for WCV and other child utilization measures. In previous DHCF MCO reports, well-child visits were reported at lower rates because calculations used encounter data submitted by the plans and a methodology that differed from the CMS-416. However, the trends observed in previous DHCF reports are consistent with current findings that show WCV rates generally rising through 2017 and falling in 2018 and 2019.

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

With regard to preventive and other ambulatory care for adults, visit rates also vary by plan and time period. For example, 63% of adult MCO enrollees had a visit in CY 2019, but rates ranged from 50% for CareFirst to 70% for AmeriHealth. Adult visit rates for MCOs overall decreased between 2015 and 2018, then remained steady in 2019. This data excludes emergency department care and reflects a visit definition based on HEDIS measure specifications for Adults' Access to Preventive/Ambulatory Health Services (AAP). In previous DHCF MCO reports, adult visits were reported at somewhat lower rates based on specifications that differ from HEDIS, but both approaches produce rates with similar trajectories over time. As with WCV rates, DHCF will continue to monitor MCO performance and will work with plans to address observed issues with adult visit rates.

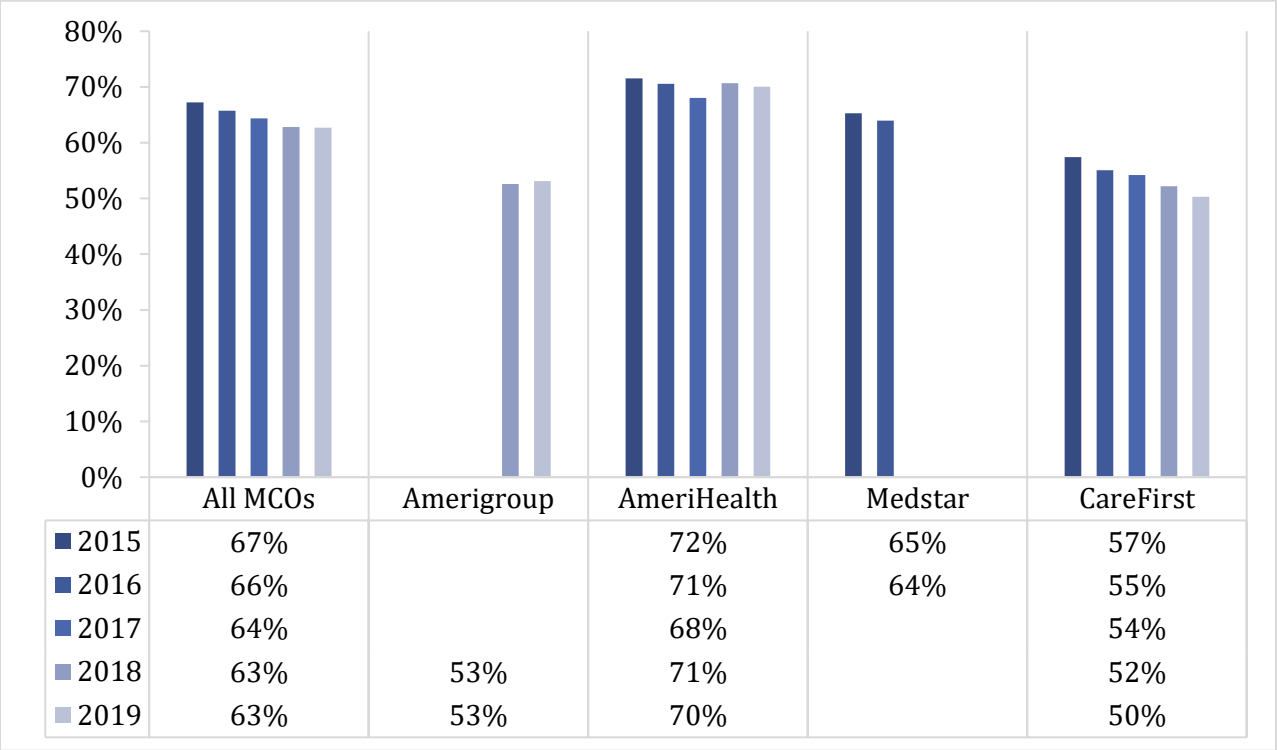
**PERCENTAGE OF CHILDREN WITH A WELL-CHILD VISIT, FY 2015-FY 2019**




| | All MCOs | 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% |

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

**PERCENTAGE OF ADULTS WITH A PREVENTIVE OR OTHER AMBULATORY CARE VISIT, 2015-2019**



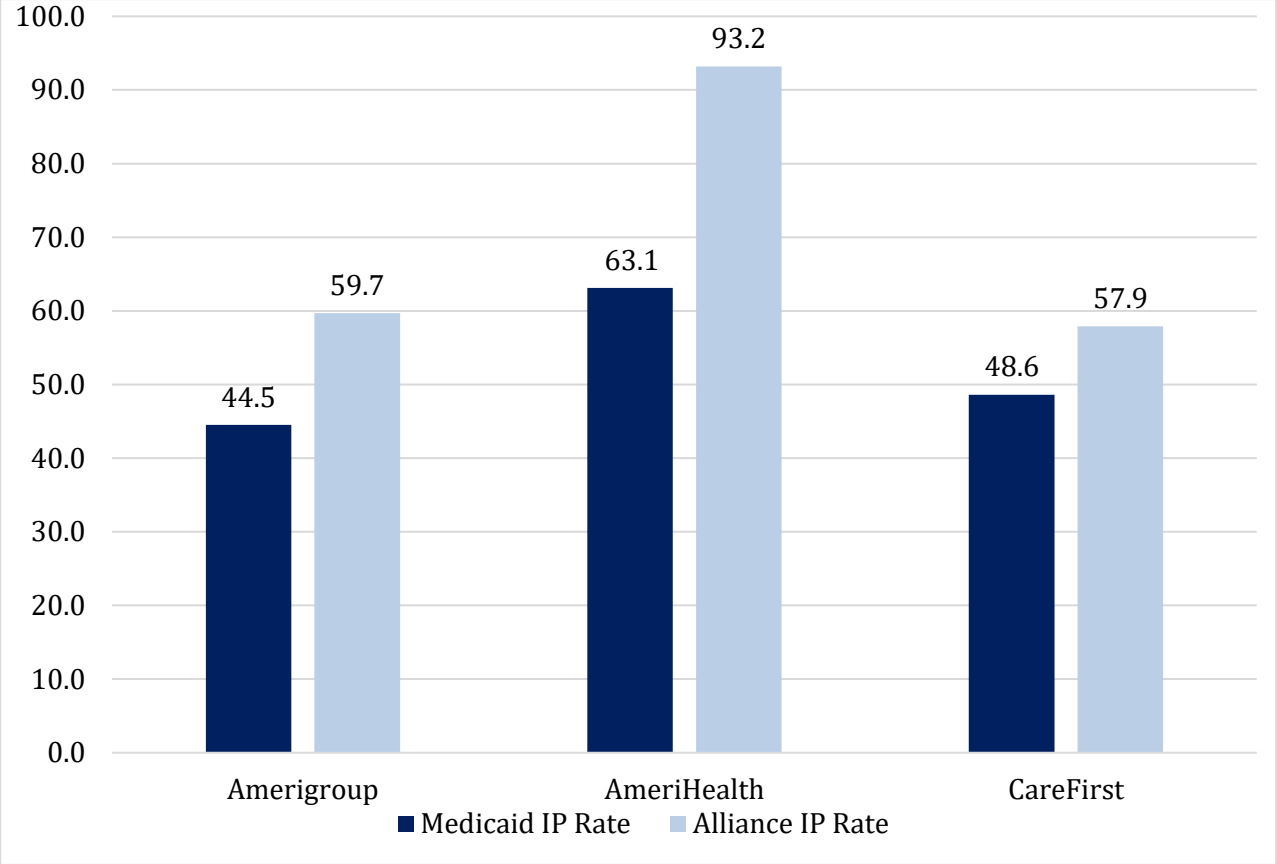

| | All MCOs | Amerigroup | AmeriHealth | Medstar | CareFirst |
|---|---|---|---|---|---|
| 2015 | 67% | | 72% | 65% | 57% |
| 2016 | 66% | | 71% | 64% | 55% |
| 2017 | 64% | | 68% | | 54% |
| 2018 | 63% | 53% | 71% | | 52% |
| 2019 | 63% | 53% | 70% | | 50% |

Notes: Reflects Medicaid beneficiaries age 21 or older with at least 11 months of coverage during the calendar year with a given MCO. Average for all MCOs is weighted by the number of adults in each plan. Includes both MCO encounters from DHCF's MMIS system and any fee-for-service use by MCO beneficiaries. Visit definition reflects HEDIS measure specifications for Adults' Access to Preventive/Ambulatory Health Services (AAP).
Source: DHCF Medicaid Management Information System data as of July 13, 2020.

## INPATIENT ADMISSIONS RATES

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

**TOTAL NUMBER OF INPATIENT ADMISSIONS IN CY2019 PER 1000 MEMBERS**




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

As illustrated in the figure above, AmeriHealth's inpatient admissions rates are significantly higher than the other two MCOs. This is undoubtedly related to the higher risk members that have transferred into the MCO, as discussed previously in this report.

# V. PAY FOR PERFORMANCE AND CARE COORDINATION

## A. INTRODUCTION

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

- Low acuity non-emergent (LANE) visits - emergency room utilization for non-emergency conditions[4];
- Potentially preventable admissions (PPA) – admissions to the hospital which could have been avoided with access to quality primary and preventative care[5]; and
- 30-Day All-Cause Readmissions - Hospital readmissions for problems related to the diagnosis which prompted a previous and recent – within 30 days – hospitalization[6].

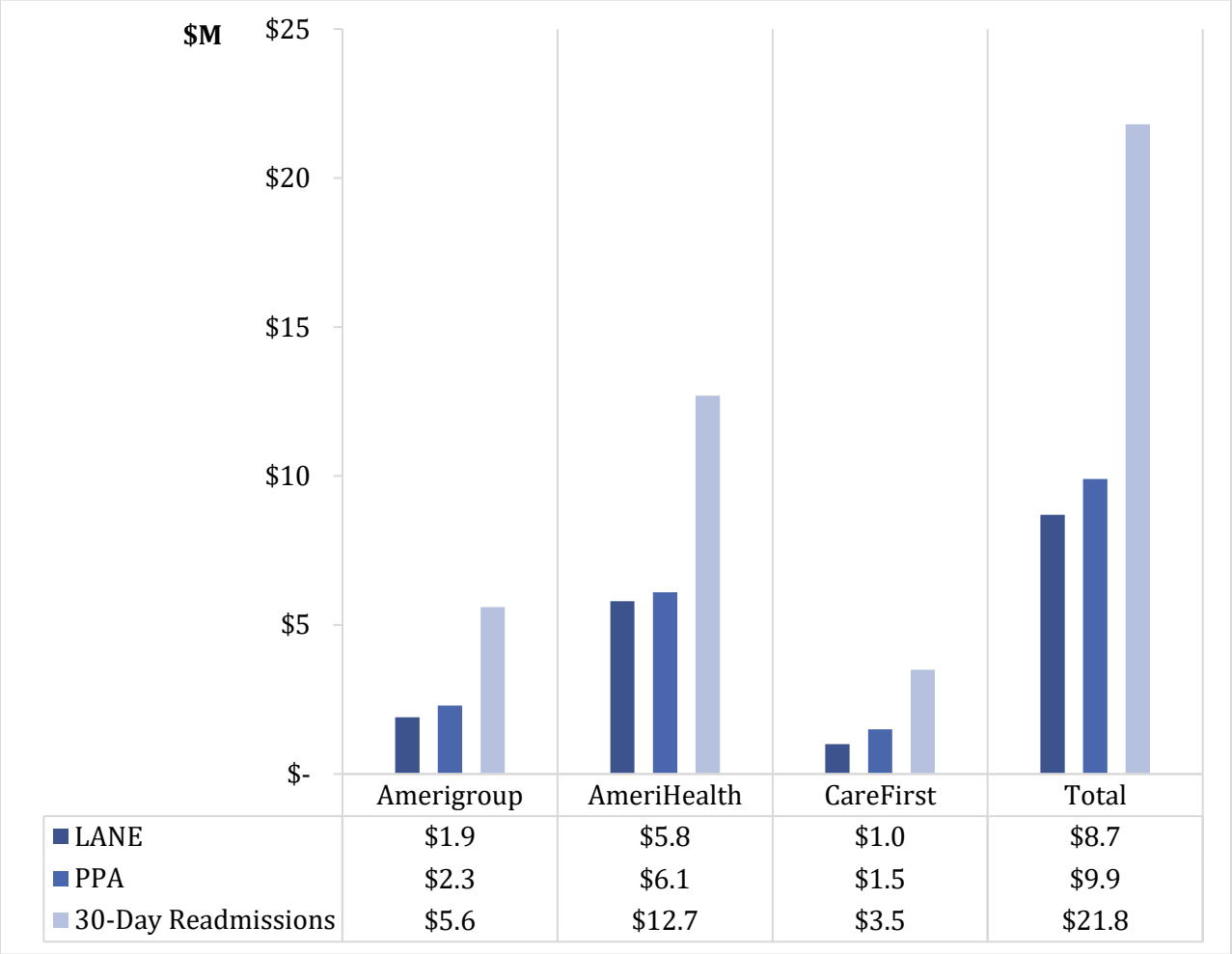
The MCOs could potentially save millions by reducing their enrollees use of the ER for non-emergent reasons, reducing potentially avoidable hospitalizations, and slowing the rate of hospital readmissions. The figure below illustrates the aggregate avoidable costs incurred by the MCOs for potentially avoidable emergency room visits and hospitalizations. Note, the amounts listed as potentially avoidable would likely be offset by other costs if the MCOs improved their care management, such as increased outpatient costs due to increased use of ambulatory care.

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

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

[6] Readmissions represent inpatient visits that are within 30 days of a qualifying initial inpatient admission.

**AVOIDABLE SPEND ON MANAGED CARE SERIVCES – FY 2019**



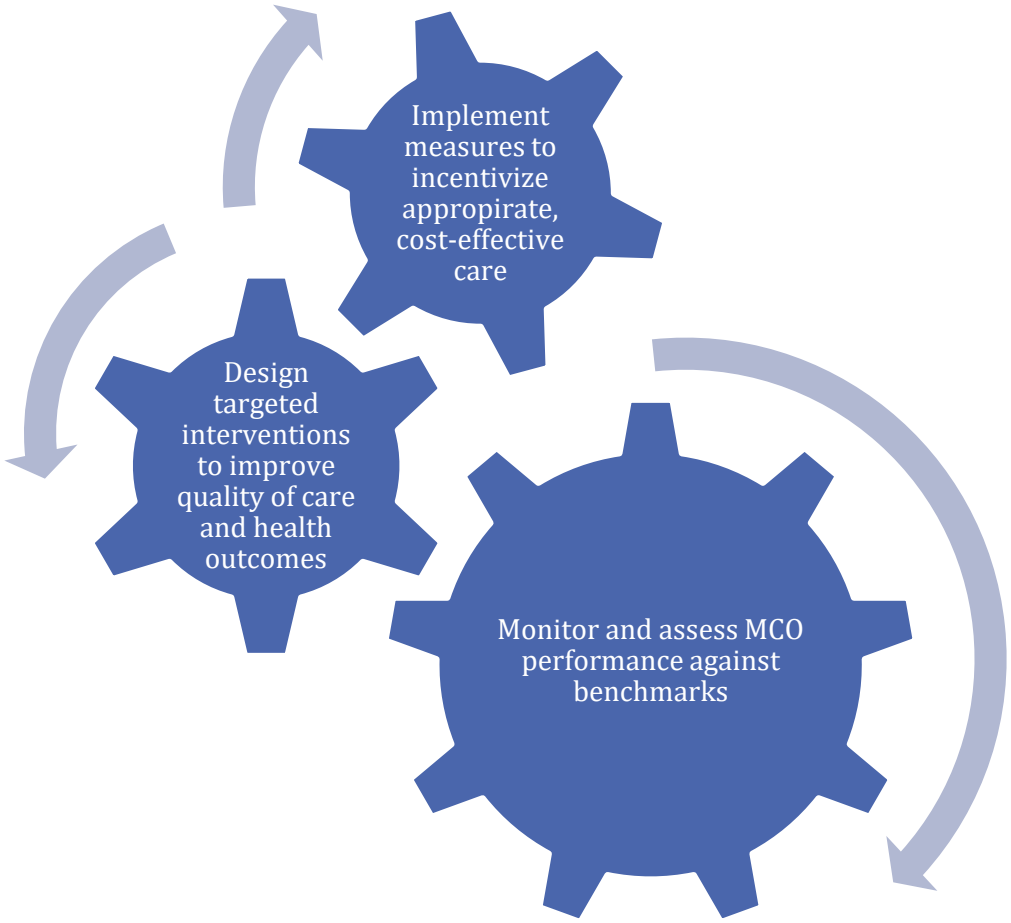

| | Amerigroup | AmeriHealth | CareFirst | Total |
|---|---|---|---|---|
| LANE | $1.9 | $5.8 | $1.0 | $8.7 |
| PPA | $2.3 | $6.1 | $1.5 | $9.9 |
| 30-Day Readmissions | $5.6 | $12.7 | $3.5 | $21.8 |

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

## B. METHODOLOGY

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

The capitation withhold was not in effect for the current FY 2019 measurement year, though DHCF plans to reinstitute quality incentive requirements in future years.




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

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

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

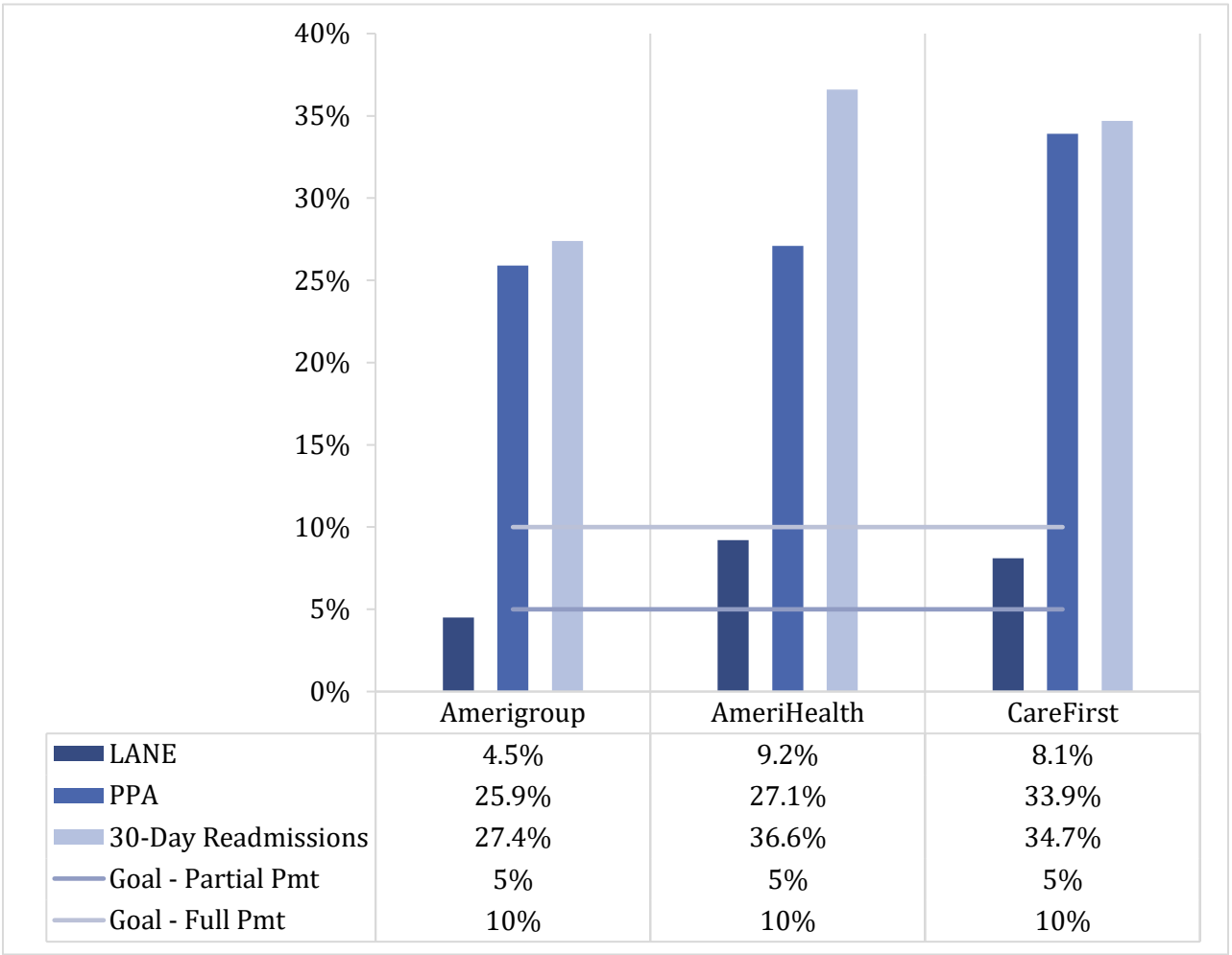
will likely occur 4 to 7 months after the measurement period closes in years when the withhold is in effect.

DHCF is reassessing the P4P program for FY 2021, and may modify requirements (e.g., performance measures, targets, incentive structure, etc.) for the FY 2021 contract year and future contract years. DHCF would like to move MCOs towards a greater focus on interventions and will require each MCO to develop and report on targeted interventions and impacts on attributed populations, which should result in improved performance on the established P4P metrics. DHCF will work with the MCOs through routine meetings, reporting templates, and data sharing and analysis, to better understand the underlying conditions and population behaviors driving performance on these metrics.

## C. P4P RESULTS

The figure below illustrates the improvement on the three P4P quality measures from the baseline to the current reporting period – FY 2019, for the three full risk-based MCOs providing services to the DCHFP population.

**PERCENTAGE IMPROVEMENT ON P4P FY 2019 COMPARED TO BASELINE**




| | Amerigroup | AmeriHealth | CareFirst |
|---|---|---|---|
| LANE | 4.5% | 9.2% | 8.1% |
| PPA | 25.9% | 27.1% | 33.9% |
| 30-Day Readmissions | 27.4% | 36.6% | 34.7% |
| Goal - Partial Pmt | 5% | 5% | 5% |
| Goal - Full Pmt | 10% | 10% | 10% |

Notes: Current annual results reflect data incurred from October 2018 through September 2019, with payment runout through December 2019. Final metrics are net of Health Home enrollees.
Source: Mercer analysis of MCO Encounter data for DCHFP reported by the MCOs to DHCF.

Both AmeriHealth and CareFirst met at least minimal improvement thresholds – 5% reduction in avoidable visits compared to the baseline – for the FY 2019 P4P measurement year. All three full risk-based MCOs met the 10% target for improvement for PPA and 30-Day All-Cause Readmissions; however, Amerigroup fell short of the minimum level of improvement for LANE to receive any portion of their capitation withhold. The capitation withhold is not in effect for the current FY 2019 measurement year, though DHCF plans to reinstitute quality incentive requirements in future years.

# VI. CONCLUSION

Each MCO's financial, operational, and utilization management results were assessed as part of this annual report. This current annual review highlighted a number of key observations in the District's managed care program, predominately AmeriHealth's continued operating pressures and disproportionate share of the high-cost DCHFP and Alliance enrollees. While AmeriHealth's total PMPM medical costs remain the highest of the full risk-based MCOs, their growth in medical service costs have begun to subside in 2019. The District has observed modest growth in overall DCHFP and Alliance PMPM medical costs and enrollment in 2019, though continues to observe high costs in inpatient and pharmacy services. With the implementation of new risk adjustment methodologies in FY 2020 including increased frequency of enrollment review, the District has observed better alignment of cost and associated payment across the DCHFP program.

The District continues to monitor avoidable hospitalization utilization and expenditures tied to avoidable admissions, readmissions and ED utilization as part of the managed care P4P program and has observed largely positive trends in reducing these unnecessary services and health care costs in 2019. However, due to the disproportionate distribution of high-acuity enrollees across the managed care plans, overall trend for inpatient admissions rates are not equal amongst the full risk-based MCOs.

For preventative care, DHCF updated its methodology from previous reports for both well-child and adult preventative care rates to be more aligned with CMS regulatory and other authoritative measure reporting standards. Well-child visit rates increased between FYs 2015 and 2017 for three of the four participating plans but have generally decreased since that time, with the exception of HSCSN in FY 2019. With regard to preventive and other ambulatory care for adults, visit rates vary by plan and time period. As described earlier in this report, DHCF has mechanisms in place to monitor utilization of critical primary and preventative care and will continue working with MCOs to develop strategies to encourage utilization of these services.

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

- More value over volume: Increase expectations for value-based purchasing through managed care, including a greater focus on aligning payment with improved outcomes and reduction in avoidable health care spending.
- Increased access to care: Require universal contracting for key providers to mitigate adverse selection in managed care and prevent MCOs from falling short of medical spending requirements.
- Better alignment of payment with underlying health conditions: Continue application of new diagnostic and pharmacy combined risk-adjustment model to better assess beneficiary risk and curtail growing costs for MCOs with high-acuity, high-cost enrollees.
- More coordinated care: Transition FFS Medicaid population to managed care and expand care management requirements for highly vulnerable populations.

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