MARYLAND
DEPARTMENT OF HEALTH

Consolidated Significant Matters HealthChoice Financial Monitoring Report (Includes Kaiser)

For the Calendar Year Ending December 31, 2022
Experience through September 30, 2023

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

October 21, 2024

Maryland Department of Health
Office of Finance, Medical Care Programs
201 West Preston Street
Baltimore, MD 21201

The purpose of this letter is to provide you with a summary of significant matters related to our agreed-upon procedures (AUP) engagement. Our AUP engagement included analyzing certain financial information of the managed care organizations (MCOs) participating in the Maryland HealthChoice Program (Program) for the year ended December 31, 2022.

We have prepared separate AUP reports for the following nine MCOs participating in the Program for the year ended December 31, 2022:

- *Aetna Better Health of Maryland, Inc.*
- *CareFirst Community Health Plan Maryland*
- *Jai Medical Systems Managed Care Organization, Inc.*
- *Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.*
- *Maryland Care, Inc. D/B/A Maryland Physicians Care Managed Care Organization*
- *Medstar Family Choice, Inc.*
- *Priority Partners Managed Care Organization, Inc.*
- *UnitedHealthcare of the Mid-Atlantic, Inc.*
- *WellPoint Maryland, Inc. (Formerly AMERIGROUP Maryland, Inc.)*

This engagement to apply agreed-upon procedures was performed in accordance with standards established by the American Institute of Certified Public Accountants. The sufficiency of the procedures was solely the responsibility of the Maryland Department of Health (MDH). Consequently, we made no representations regarding the sufficiency of the procedures described in each report either for the purpose for which the reports had been requested or for any other purpose.

Scope of Work

The MCOs manage the medical care of Program enrollees for a capitated per member per month premium. The MCOs enter into service contracts with various health care providers to provide the required health care services to the Program enrollees. In return, the MCO pays the participating providers through fee-for-service or managed care arrangements. Monthly capitation payments to health care providers are expensed as incurred. Medical services expense includes amounts for known services rendered and an estimate for incurred but not reported services (IBNR) rendered by hospitals, physicians, and other health care providers during the year. The estimated IBNR medical services liability is actuarially determined based on relevant industry data and historical trends.

Activity for the program is reported on the HealthChoice Financial Monitoring Report (HFMR). This report is a supplemental schedule to the quarterly and annual filings made to the Maryland Insurance Administration. The report is comprised of five sections: 1) Background; 2) Expense and Utilization Structure (Incurred Basis); 3) Major Sub-Capitated Provider Schedule, Specific Federally Qualified Health Center (FQHC), Dental, and Pharmacy Requests; 4a) Services Provided by MCOs That Exceed Services Covered in the Medicaid State Plan; 4b) Components of Incentive Payments; and 5) MCO Financial Reporting Questionnaire on federally qualified health center (FQHC) reimbursement above the market rate, payments from the Trauma Fund, COVID-19 vaccine ingredient costs, COVID-19 vaccine administration payments, COVID-19 pediatric counseling, and payments related to the Maryland Quality Innovation Program (M-QIP) and their impact on HFMR reporting. For the year ended December 31, 2022, the HFMR included run-out of claims paid through September 30, 2023.

The primary emphasis of our test procedures consisted of verifying and reconciling financial data reported on the HFMR for the year ended December 31, 2022 to the MCOs' audited financial statements, the Annual Statement submitted to the Insurance Administration of the state of Maryland (Annual Statement), trial balances, claims databases and supporting documentation. For MCOs with programs other than the Maryland HealthChoice Program, we obtained detailed financial information broken down by operating unit to perform our test procedures.

Other procedures included:

- *Reconciliation of medical expenses paid and incurred per the Annual Statement to the IBNR lag reports, as well as the medical claims payable for known and unknown services to the financial reports.*
- *Selecting a sample of 100 claims to ensure transactions were recorded in the proper period, recorded in the proper region, recorded in the proper RAC, and recorded at the proper amount. Claims errors identified were reviewed to determine whether or not the error was systemic and the total impact on the claims population.*

- *Documenting the procedures performed for receipt, processing, and reconciliation of claims for outside providers including reports on internal controls.*
- *Documenting our understanding of the administration expenses reported on the Annual Statement including allocation of expenses from other lines of business or related entities and reconciling and verifying financial data reported on the Annual Statement for administrative expenses.*
- *Analytically comparing investment income by operating unit to comparable factors and obtaining explanations for any unusual relationships.*
- *Verification and assessment of the business purpose and valuation of related-party transactions.*
- *Verification of pharmacy rebate revenue and proper offset against pharmacy expense.*
- *Verification of the amount of rebate revenue applicable to hepatitis C drugs.*
- *Verification of non-state plan service amounts.*
- *Verification of Federally Qualified Health Center (FQHC) payments, Trauma Fund reimbursement, payments made for COVID vaccine ingredients, COVID vaccine administration, COVID pediatric counseling, and incentive payments, and payments related to Maryland Quality Innovation Program (M-QIP) to ensure revenue and expense is removed.*
- *Reconciliation of third-party liability (TPL) reports and proper recording of recoveries.*
- *Reporting Premium Taxes and ACA Stabilization Fees separately from administration taxes while ensuring ACA fees were not included on the HFMR.*
- *Determination of total submitted Hepatitis C expense including total number of scripts included on the HFMR excluding verified Hepatitis C rebates.*
- *Verification that primary care expense reported on the HFMR meets the CPT codes, taxonomy codes, and place of service (POS) codes included in the HFMR instructions revised as of 9/19/2023.*
- *Determination of High Cost, Low Volume drug reimbursement and remove from both revenue and expense.*
- *Determination of the amount paid for Independent Review Organization (IRO) reviews and remove from expense.*
- *Determination of the amount paid for dues to Maryland MCO Association (MMCOA) and remove from expense.*
- *Verification that the HFMR was prepared in accordance with the risk adjustment category (RAC) definitions effective September 23, 2019.*
- *Verification of pharmacy benefit manager (PBM) expense reported on Section III of the HFMR.*

Summary of MCO Results

The following adjustments were made to the HealthChoice financial data:

Gross Premium Revenue

- *Adjusted to reflect verified incentive/supplemental payments, rural access payments, CY 2022 Population Health Incentive Payments (PHIP), CY 2022 Very Low Birth Rate (VLBW) recoupment, HealthChoice premiums prior to member enrollment into The Rare and Expensive Case Management (REM) program, and include verified CY 2022 finalized risk corridor settlement amounts.*
- *Adjusted to exclude COVID vaccine administration payments, COVID member incentives, trauma fund reimbursement, Maryland Quality Innovation Program (M-QIP) revenue, FQHC payments, and High Cost, Low Volume Drug reimbursement received from MDH.*

Medical Expenses Paid

- *Adjusted to exclude claims error impact, verified TPL recoveries, High Cost, Low Volume Drug expense, bad debt expense, related party profit, premium tax exemption value, network fees, Evity Connect expenses, submitted medical management expense, duplicated claims interest, trauma fund reimbursement, COVID vaccine administration expense, COVID vaccine ingredients expense, and FQHC payments.*
- *Adjusted to exclude capitation payments made to care coordination providers which were reclassified to medical management expense.*
- *Adjusted to reflect verified pharmacy rebates and include HealthChoice claims incurred prior to member enrollment into the REM program.*

Medical Management Expense

- *Medical management expense was included with medical expenses paid and/or administrative expenses on the Health Plan Submitted Total column of the Underwriting Exhibit. Verified medical management expense was reclassified to its respective line on the MSLC Adjusted Total column of the Underwriting Exhibit. Medical management expense was reported separately on the Health Plan Submitted Total of the Underwriting Exhibit for presentation purposes only.*
- *Adjusted to exclude non-qualifying salaries and benefits, vendor expenses, overhead expenses, corporate and health plan direct allocations, professional fees and intersegment expenses reclassified to administrative expense.*
- *Adjusted to exclude cost and patient incentives not related to 2022, non-allowable marketing expense, and COVID member incentive expense.*

- *Adjusted to include patient incentives not included on the HFMR and reporting variances between MLR and HFMR.*
- *Adjusted to include capitated payments related to care coordination providers which were included in medical expenses. Excluded the portion of care coordination capitated payments which were not supported by qualifying direct medical management cost and reclassified to administrative expense.*
- *Adjusted to exclude M-QIP payments disbursed to the University of Maryland Faculty Physicians (FPI).*

Administrative Expense

- *Adjusted to exclude non-allowable marketing expenses, COVID member incentives, political contributions and lobbying expense, claims interest expense, claims adjustment expense reporting variance, ACA Individual Market Stabilization Fees not related to 2022, related party profit, patient incentives reclassified to medical management, expenses not related to Maryland HealthChoice, business development and valuation expense, non-allowable grievances and appeals expense, submitted medical management expense, MMCOA dues, and IRO fees paid.*
- *Adjusted to include administrative salaries and benefits included with medical management expense, unreported administrative expenses, professional fees and intersegment expenses reclassified from medical management, reporting variances between MLR and HFMR reclassified from medical management, pharmacy administrative fees, administrative component of dental sub-capitated payments, vision administrative fees, vendor expenses reclassified from medical management, corporate and health plan direct allocations reclassified from medical management, non-qualifying capitated care coordination expense reclassified from medical management, claims adjustment expense, amortization of start-up costs and overhead expense.*
- *Adjusted to exclude Premium Taxes and ACA Individual Market Stabilization Fees submitted with administrative expenses which are reported separately on Exhibit III.*

Taxes

- *Premium taxes were adjusted to agree to the HFMR reported amount.*
- *ACA Individual Market Stabilization Fees were reported separately from Premium Taxes.*

Myers and Stauffer LC

Myers and Stauffer LC
Owings Mills, Maryland
October 21, 2024

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Exhibit I: Schedule of Agreed-Upon Procedures for Participating MCOs

Materiality

For procedures to test claims data by rate cell and categories of service, materiality will be set at 5% and $10,000 for the balance subject to the procedure. For procedures related to the testing of specific claims, materiality will be set at +/- 2% per transaction tested specific to proper amount paid. For all other procedures, materiality will be set at $10,000 for the balance subject to the procedure.

Trial Balance

Obtain the adjusted trial balance as of December 31, 2022 and agree a sample of descriptions, account numbers, and ending balances per the adjusted trial balance to the general ledger for the year ended December 31, 2022. Agree total expenses per the adjusted trial balance as of December 31, 2022 to the HFMR for the year ended December 31, 2022. Agree total expenses per the adjusted trial balance as of December 31, 2022 to the Annual Statement submitted to the Insurance Administration of the State of Maryland for the year ended December 31, 2022. Agree total expenses per the adjusted trial balance as of December 31, 2022 to the audited financial statements for the year ended December 31, 2022.

HealthChoice Financial Monitoring Report

Verify that the HFMR was prepared in accordance with the new RAC definitions included in the HFMR instructions revised as of September 23, 2019.

For each of the categories on the HFMR for the year ended December 31, 2022, perform the following:

Member Months

Agree the line labeled “Total” on each regional HFMR schedule for the column labeled “Member Months” to the query reports. Recalculate the line labeled “Grand Total” on the Statewide HFMR for the column labeled “Member Months” based on the amounts reported on the regional HFMRs. Haphazardly select five categories for “Member Months” from each regional HFMR schedule and agree the balances to the query reports. If errors are noted, MDH will determine if scope should be expanded.

Earned Premiums

Agree the line labeled “Total” on each regional HFMR schedule for the column labeled “Earned Premiums” to the query reports. Recalculate the line labeled “Grand Total” on the Statewide HFMR for the column labeled “Earned Premiums” based on the amounts reported on the regional HFMRs.

Haphazardly select five categories for "Earned Premiums" from each regional HFMR schedule and agree the balances to the query reports. If errors are noted, MDH will determine if scope should be expanded.

Incentive Payments

Agree the incentive payments balance per Section II – Statewide and Section IVb of the HFMR to supporting documentation.

Reinsurance Premiums

Agree the reinsurance premiums balance per Section II – Statewide of the HFMR to supporting documentation.

Reinsurance Recoveries

Agree the reinsurance recoveries balance per Section II – Statewide of the HFMR to supporting documentation.

Expenses

Agree the line labeled "Total" on each regional HFMR schedule for the columns labeled "Hospital Inpatient Expenses," "Hospital Outpatient: Other than Emergency Expenses," "Hospital Outpatient: Emergency Expenses," "Primary Care Expenses," "Specialty Care Expenses," "Pharmacy Expenses," "Dental Expenses," and "Other Medical Expenses" to the query reports and recalculated to include IBNR amounts.

Recalculate the line labeled "Grand Total" on the Statewide HFMR for the columns labeled "Hospital Inpatient Expenses," "Hospital Outpatient: Other than Emergency Expenses," "Hospital Outpatient: Emergency Expenses," "Primary Care Expenses," "Specialty Care Expenses," "Pharmacy Expenses," "Dental Expenses," and "Other Medical Expenses" based on the amounts reported on the regional HFMRs.

Haphazardly select five categories from the columns labeled "Hospital Inpatient," five categories from the columns labeled "Hospital Outpatient: Other than Emergency," five categories from the columns labeled "Hospital Outpatient: Emergency Department," five categories from the columns labeled "Primary Care," five categories from the columns labeled "Specialty Care," five categories from the columns labeled "Pharmacy," five categories from the columns labeled "Dental," and five categories from the columns labeled "Other Medical" for "Expenses" from each regional HFMR schedule and agree the balances to the query reports and recalculated to include IBNR amounts.

Select 100 claims from the medical claims database. Stratify the sample into five Claim Categories which include Hospital Inpatient, Hospital Outpatient: Other than Emergency, Hospital Outpatient: Emergency Department, Primary Care, and Specialty Care. Select the number of claims for the Claim Categories

based on a percent to total methodology, based on the expense reported in each Claim Category on the HFMR excluding any part of the Claim Category that are paid on a capitated basis and material to the overall sampling methodology. Each strata includes a high dollar sample, GME sample, and a randomly selected sample, including delivery claims. The high dollar sample includes the two highest dollar claim lines in each of the Claim Categories. The GME sample includes one claim from each of the providers included on the GME rate letter. The remaining samples from the Claim Categories are selected at random from the remaining claims listing. To the extent possible, retracted claim lines or claim lines that net to less than $0 are avoided. If these claims are selected inadvertently, replace with a different claim line from the medical claims database.

For non-delivery claims, verify that the transaction was recorded in the proper period, recorded in the proper region, recorded in the proper RAC and recorded at the proper amount.

For delivery claims, verify that the transaction was recorded in the proper period, at the proper amount and properly recorded as a delivery expense as defined in the delivery instructions provided by MDH.

If no claims errors are noted, no further testing is required. If any material variances are noted, discuss variances with the MCO to determine the cause of the variance and any corrective actions taken by the MCO to correct the variance. Based on the cause obtained from the MCO, determine if the error is systemic or non-systemic. If the error is systemic, obtain a claims listing showing the systemic error in the claims data as calculated by the MCO, test claims error listing for reasonableness on a sample basis, calculate the potential exposure of error (if the claim is not corrected/reprocessed), adjust medical expense based on potential exposure of error, and document the MCO's stated corrective actions to ensure the issue does not occur in future HFMR submissions. If the error is non-systemic, verify correction has been made (if the claim is corrected/reprocessed), adjust medical expense based on the potential exposure of error, and document the MCO's stated corrective actions to ensure issue does not occur in future HFMR submissions.

If the MCO is unable to provide a claims listing recalculating the error impact, the error impact will be calculated based on best data available. Notify MDH of non-responsive plans to determine next steps.

Obtain a list of medical payments to or costs allocated from affiliates of parent companies. Compare medical payments made to affiliates and non-affiliates to determine whether payments to affiliates for equivalent services are equal to or less than those made to non-affiliates.

Admissions/Days/Visits/Scripts

Agree the line labeled "Total" on each regional HFMR schedule for the columns labeled "Visits," "Admissions," "Days," and "Scripts" to the query reports.

Recalculate the line labeled "Grand Total" on the statewide HFMR for the columns labeled "Visits," "Admissions," "Days," and "Scripts" for all categories based on the amounts reported on the regional HFMRs. Haphazardly select five hospital inpatient categories for "Admission," five hospital inpatient categories for "Days," five hospital outpatient: other than emergency categories for "Visits," five hospital outpatient: emergency department categories for "Visits," five primary care categories for "Visits," five specialty care categories for "Visits," five pharmacy categories for "Scripts," and five dental categories for "Visits" from each regional HFMR schedule and agree the balances to the query reports. If errors are noted in previous steps, and MDH determines scope should be expanded, select an additional five transactions per applicable HFMR category and agree balances to query reports.

Delivery-Related Expenses

Obtain a narrative that summarizes the methodology for reporting delivery-related expenses on the HFMR.

Administrative Component of Dental Sub-Capitated Payment

Agree the administrative component of dental sub-capitated payments per Section III of the HFMR to supporting documentation.

Medical Management Expense

Agree the line labeled "Medical Management Expense" per Section II – Statewide of the HFMR to supporting documentation. Ensure that medical management expense is reported in accordance with NAIC guidelines.

Pharmacy Rebates

Review Section III of the HFMR to verify that the rebate revenue reported is accurate. Verify the amount of the rebate revenue that relates to Hepatitis C drugs. Verify that rebate revenue has been properly offset against pharmacy expense.

Pharmacy Benefit Manager (PBM) Expense

Review Section III, Part E of the HFMR to verify if PBM expense information reported is accurate.

Non-State Plan Services

Document the procedures used to determine the amounts reported on Section IVa of the HFMR for Non-State Plan Services and verify the amounts reported are correct.

Federally Qualified Health Center (FQHC) Visits

Determine that the State-paid portion of FQHC visit payments were properly reflected on Section V of the HFMR.

Trauma Fund

Determine that the costs reimbursed through the Trauma Fund were properly reflected on Section V of the HFMR.

COVID Vaccine Ingredients

Determine that payments made for COVID Vaccine ingredients were properly reflected on Section V of the HFMR.

COVID Vaccine Administration

Determine that payments made for COVID Vaccine Administration practices were properly reflected on Section V of the HFMR.

COVID Pediatric Counseling

Determine that payments made for COVID pediatric counseling were properly reflected on Section V of the HFMR.

Maryland Quality Innovation Program (M-QIP)

Determine that payments related to the M-QIP were properly reflected on Section V of the HFMR.

Investments

Agree the investment income balance per the trial balance for the year ended December 31, 2022 to the annual statement and audited financial statements and explain any variances. Review the investments that produce investment income reported by the MCO and determine if investment income has been properly allocated among the various payor sources and the amount allocated to the HealthChoice program is correct.

Administrative Expenses

Obtain an understanding of the nature of the administration expenses reported on the analysis of operation of lines of business on the annual statement. Compare administration expenses for the year ended December 31, 2022 to the prior year and obtain explanations for any changes greater than 10%. Obtain an understanding of any trial balance account allocated between administration and medical expenses, and document the procedure for the allocation. Obtain a listing of payments to or costs

allocated from affiliates or parent companies, and agree this list to the audited financial statements prepared by the health plan's independent accountant for the year ended December 31, 2022.

Medical Expenses/Incurred But Not Reported (IBNR)

Obtain documentation of the procedures regarding the receipt, processing, and reconciliation of claims from outside providers. Obtain and review the independent internal control reports, if applicable. Agree unpaid expense per Section II – Statewide of the HFMR to supporting documentation. Determine if unpaid expenses include items other than IBNR. Obtain IBNR report and opinion from independent actuarial firm.

Cost Avoidance and Third-Party Liability (TPL) Recoveries

Review the policies and procedures for cost-avoidance and post-payment recoveries to assess the compliance of effort to maximize third-party payments. Test the accuracy of the quarterly TPL reports submitted by the health plan and verify that recoveries are properly recorded in Section II - Statewide of the HFMR. Report the total TPL recovery amount received for services provided during Fiscal Year (FY) 2022, collected during 2022, and the total TPL recovery amount received for services provided during FY 2022 collected through September 30, 2023.

Non-allowable Expenses

Independent Review Organization (IRO) Review Expense

Determine the amount paid for IRO reviews, if any, and remove from expense.

Maryland Managed Care Organization Association (MMCOA) Dues

Determine the amount paid for dues to the MMCOA and remove from expense.

Special Projects

Taxes

Report submitted Premium Taxes and ACA Stabilization Fees (also known as Maryland Health Care Assessment Fees) separately from Administrative Expenses. Ensure ACA Insurer Fees are not included on the HFMR since these were repealed effective January 1, 2021.

Hepatitis C

Report total submitted Hepatitis C expense including the number of scripts as reported on the HFMR. Ensure that Hepatitis C expense is net of any rebates received.

Primary Care Expenses

Verify the primary care expense reported on the HFMR meets the 115 CPT codes, 29 taxonomy codes, and 23 place of service (POS) codes included in the HFMR instructions revised as of 9/19/2023.

High Cost Low Volume Drugs

Determine if High Cost, Low Volume drug reimbursement and/or expense was included on the HFMR. If included propose an adjustment to remove both revenue and expense.

Exhibit II: Consolidated Underwriting Exhibit

Consolidated Underwriting Exhibit Services for the Calendar Year Ending December 31, 2022 Experience through September 30, 2023 (MARYLAND HEALTHCHOICE BUSINESS ONLY)					
			Health Plan Submitted Total		**MSLC Adjusted Total**
Revenues					
	Gross Premium Revenue		$ 7,511,560,223		$ 7,472,079,434
	Less Reinsurance Premiums		$ (7,422,425)		$ (7,434,669)
	Net Premium Revenue		$ 7,504,137,798		$ 7,464,644,765
Medical Expenses					
	Medical Expenses Paid		$ 6,306,339,754		$ 6,220,539,419
	Medical Expenses Unpaid		$ 19,535,625		$ 19,522,510
	Gross Medical Expenses		$ 6,325,875,379		$ 6,240,061,929
	Less Reinsurance Recoveries		$ (6,644,003)		$ (6,644,003)
	Net Medical Expenses		$ 6,319,231,376		$ 6,233,417,926
Medical Management Expenses					
	Medical Management Expense		$ 107,939,401	*	$ 66,135,049
Administrative Expenses					
	Administrative Expenses		$ 546,742,338		$ 526,429,015
Taxes					
	Premium Taxes		$ 153,905,517		$ 151,738,461
	ACA Ind. Market Stabilization Fees		$ 71,781,611		$ 73,948,667
Net Underwriting Gain (Loss)					
	Net Underwriting Gain (Loss)		$ 412,476,956		$ 412,975,647
Additional Data					
	Member Months		17,826,165		17,826,165
	Total Deliveries		21,945		21,945

**Medical Management is included in submitted Medical and/or Administrative Expenses. Shown separately for presentation purposes.*

Exhibit III: Comparison of IBNR Independent Estimate

Comparison of IBNR Independent Estimate
Services for the Calendar Year Ending December 31, 2022
Experience through September 30, 2023

	Health Plan Submitted	Miller & Newberg, Inc. Actuarial Estimate
Total (9 Plans)	**$ 19,535,625**	**$ 19,270,741**

The estimates prepared by Miller & Newberg, Inc. were based upon statutory accounting practices. Estimates were made only of Incurred But Not Reported (IBNR) claims, which are the liability for future payments on claims which have already occurred, but have not yet been reported to the MCO's. IBNR may also include future development (or additional costs) associated with reported claims. IBNR does not include known or identifiable claims that remain unpaid as of the valuation date.

Note: Variances between submitted IBNR on Exhibits II and III are as follows:

	Submitted per Financial Template	Actuarial Estimate	Variance
MCO A	$ 6,938,520	$ 6,506,024	$ (432,496)
MCO B	$ 1,928,694	$ 1,278,513	$ (650,181)
MCO C	$ 842,653	$ 986,714	$ 144,061
MCO D	$ 50,000	$ 62,294	$ 12,294
MCO E	$ 3,105,923	$ 3,134,671	$ 28,748
MCO F	$ -	$ 2,005,658	$ 2,005,658
MCO G	$ 960,792	$ 903,497	$ (57,295)
MCO H	$ 4,101,305	$ 3,552,468	$ (548,837)
MCO I	$ 1,607,738	$ 840,902	$ (766,836)
Total	**$ 19,535,625**	**$ 19,270,741**	**$ (264,884)**