Aetna Better Health of Virginia
Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations for Family Access to Medical Insurance Security Plan
(With Independent Accountant's Report Thereon)

Virginia Department of Medical Assistance Services
Richmond, Virginia

For the period of July 1, 2017 through
November 30, 2018

Prepared by:

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Independent Accountant's Report

Virginia Department of Medical Assistance Services
Richmond, Virginia

We have examined the accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations of Aetna Better Health of Virginia (Aetna) related to the Family Access to Medical Insurance Security Plan (FAMIS) Program for the period of July 1, 2017 through November 30, 2018. Aetna's management is responsible for presenting the Medical Loss Ratio and Underwriting Gain Rebate Calculations in accordance with the criteria set forth in FAMIS contract and Centers for Medicare & Medicaid Services (CMS) federal guidance 42 CFR 438.8. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations are in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

The accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain were prepared for the purpose of complying with the criteria, and are not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the above referenced accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations of Aetna are presented in accordance with the above referenced criteria, in all material respects, the Adjusted MLR Percentage Achieved does not exceed the minimum requirement of eighty-five percent (85%), and the Adjusted Underwriting Gain is not applicable as the member month requirement was not met for the period of July 1, 2017 through November 30, 2018. In accordance with contractual obligations, a MLR remittance amount is due to the Department of Medical Assistance Services.

This report is intended solely for the information and use of the Virginia Department of Medical Assistance Services and Aetna and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC

Myers and Stauffer LC
Glen Allen, VA
February 2, 2021

Adjusted Medical Loss Ratio for the Period Ending November 30, 2018

Adjusted Medical Loss Ratio for the Period Ending November 30, 2018				
Line #	**Revenue or Expense**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Medical Loss Ratio Numerator				
1.1	Claims	$ 5,794,251	$ (197,421)	$ 5,596,830
1.2	Improving health care quality expenses	$ 162,288	$ 57,263	$ 219,551
1.3	**Total Adjusted MLR Numerator**	**$ 5,956,539**	**$ (140,158)**	**$ 5,816,381**
Medical Loss Ratio Denominator				
2.1	Revenue	$ 7,675,519	$ 31,264	$ 7,706,783
2.2	Federal and State taxes and licensing or regulatory fees	$ 221,752	$ 192,573	$ 414,325
2.3	**Total Adjusted MLR Denominator**	**$ 7,453,767**	**$ (161,309)**	**$ 7,292,458**
Credibility Adjustment				
3.1	Member Months to determine credibility	225,770	(195,690)	30,080
3.2	Credibility adjustment	1.4%	2.3%	3.7%
MLR Calculation				
4.1	Unadjusted MLR	79.9%	-0.1%	79.8%
4.2	Credibility adjustment	1.4%	2.3%	3.7%
4.3	**Adjusted MLR**	**81.3%**	**2.2%**	**83.5%**
Remittance Calculation				
5.1	Is plan membership above the minimum credibility value? (Y/N)	Y		Y
5.2	MLR standard	85.0%		85.0%
5.3	Adjusted MLR	81.3%	2.2%	83.5%
5.4	MLR denominator	$ 7,453,767	$ (161,309)	$ 7,292,458
5.5	**Remittance amount due to State for Coverage Year**	**$ 274,810**	**$ (165,423)**	**$ 109,387**

Adjusted Underwriting Gain for the Period Ending November 30, 2018

Adjusted Underwriting Gain for the Period Ending November 30, 2018				
Line #	**Revenue or Expense**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Medical Loss Ratio Denominator				
1.1	Revenue	$ 7,675,519	$ 31,264	$ 7,706,783
1.2	ACA Health Insurer Fee Tax Gross-up included in 1.1	$ 260,500	$ (221,162)	$ 39,338
1.3	Federal and State taxes and licensing or regulatory fees	$ 221,752	$ 192,573	$ 414,325
1.4	**Total Adjusted Underwriting Gain Denominator**	**$ 7,193,267**	**$ 59,853**	**$ 7,253,120**
Medical Expenses				
2.1	Claims	$ 5,771,468	$ (174,638)	$ 5,596,830
2.2	Improving health care quality expenses	$ 162,288	$ 57,263	$ 219,551
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$ 5,933,756**	**$ (117,375)**	**$ 5,816,381**
Non-Claims Costs				
3.1	Administrative Expenses	$ 587,114	$ 94,746	$ 681,860
3.2	Less: Unallowable Expenses	$ -	$ (6,822)	$ (6,822)
3.3	**Allowable Administrative Expenses**	**$ 587,114**	**$ 87,924**	**$ 675,038**
Underwriting Gain				
4.1	Underwriting Gain $	$ 672,397	$ 89,304	$ 761,701
4.1	Less: Remittance Amount Due to State for Coverage Year	$ (274,810)	$ 165,423	$ (109,387)
4.2	Adjusted Underwriting Gain $	$ 397,587	$ 254,727	$ 652,314
4.3	**Underwriting Gain %**	**5.5%**	**3.5%**	**9.0%**
Underwriting Gain Remittance Calculation				
5.1	Member Month Requirement Met?	Y		N
5.2	At least 12 months contract experience at the beginning of the Contract Year?	Y		Y
5.3	Percent to Remit	1.3%	N/A	N/A
5.4	**Amount to Remit**	**$ 90,894**	**N/A**	**N/A**

Schedule of Adjustments and Comments for the Period Ending November 30, 2018

During our examination we noted certain matters involving costs, that in our determination did not meet the definitions of allowable medical expenses and other operational matters that are presented for your consideration.

Adjustment #1 – Agree annualized member months to State data.

The health plan reported member months that did not reflect accurate annualized member months for the reporting period. In review of member months it was determined that member months were incorrectly allocated between FAMIS and Medallion 3.0. Member months were adjusted per the state's data, annualized to consider the number of months in the reporting period. Member months impact the credibility adjustment applied to the MLR. Additionally, adjusted member months are less than 120,000 meaning that the member month requirement is not met for the purposes of the underwriting gain. The general reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8.

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
3.1	Member Months to determine credibility	(195,690)

Adjustment #2 – To adjust income tax expense to verified amounts, based on support received.

The health plan calculated the state and federal taxes utilizing effective tax rates for 2017 and 2018 and applying it to an underwriting gain calculation. The adjusted tax expense was calculated using the adjusted revenues and expense and using a combined tax rate applicable to the period. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	$61,556

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.3	Federal and State taxes and licensing or regulatory fees	$61,556

Adjustment #3 – Adjust to include Health Insurance Fee (HIF) expense within licenses and regulatory fees.

The health plan did not report HIF revenue or expenses on the MLR Report. This expense is allowed within licenses and regulatory fees. Additionally, the Underwriting Gain calculation provides a line to back out revenues related to HIF, Line 1.2 (ACA Health Insurer Fee Tax Gross-up included in 1.1). An adjustment is needed to agree this line to HIF revenues per State data, adjusted through Adjustment #5. The HIF included in the Underwriting Gain calculation, Line 1.1 (Revenue) is backed out in full between Lines 1.2 (Federal and State taxes and licensing or regulatory fees) and 1.3 (Federal and State taxes and licensing or regulatory fees). The adjustment also agrees the 12 months of reported HIF revenue on Ln. 1.2 (ACA Health Insurer Fee Tax Gross-up included in 1.1) to the reporting period. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.89(f)(2). The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.89(f)(3).

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	$131,017

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.2	ACA Health Insurer Fee Tax Gross-up included in 1.1	($221,162)
1.3	Federal and State taxes and licensing or regulatory fees	$131,017

Adjustment #4 – To include paid medical incentive pools and bonuses within the Underwriting Gain Limit Calculation, as these costs were not filed.

The health plan filed expenses related to paid medical incentive pools and bonuses within the MLR Calculation however failed to include these expenses within the Underwriting Gain Limit Calculation. The Underwriting Gain claims expense was adjusted to agree the filed claims cost to the MLR Report. The general reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8.

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	$22,783

Adjustment #5 –Adjust capitation payments and other revenues to agree to amount per State data. Reclassify prescription drug reinsurance payments made by the State.

The health plan reported revenue amounts that did not reflect all payments received for its members applicable to the covered dates of service for the reporting period. Additionally, the health plan reported prescription drug reinsurance revenues as an offset to claims rather than as revenue. Revenue was adjusted per the state's data to reflect all payments, including revenues related to capitation, prescription drug reinsurance, HIF, and performance incentives. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2) and 45 CFR § 158.130.

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	($177,960)
2.1	Revenue	$31,264

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Revenue	$31,264
2.1	Claims	($177,960)

Adjustment #6 – Adjust administrative expenses to remove unallowable expenses identified during the 2017 and 2018 administrative cost procedures.

The health plan included contributions, donations, and lobbying costs as an administrative expense in the underwriting gain. Expense related to contributions, donations, and lobbying costs are not considered an allowable administrative expense. The administrative reporting requirements are addressed at 45 CFR is §75.434 and 45 CFR is §75.450.

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
3.2	Less: Unallowable Expenses	($6,822)

Adjustment #7 – Adjust administrative expenses to the verified amount related to allocation variances.

The health plan prepared separate allocations for health care quality improvement expense (HCQI) and administrative expenses. The administrative expense allocation of cost did not include the same inputs as the HCQI allocation. An adjustment was proposed to add back administrative expenses that were excluded due to the allocation differences. The administrative reporting requirements are addressed at 45 CFR § 75.420.

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
3.1	Administrative Expenses	$88,683

Adjustment #8 – To agree HCQI expenses to verified and allowable amounts.

The health plan reported HCQI expenses based on an analysis of cost centers determined to relate in whole or in part to HCQI. These costs centers were allocated to HCQI based on employee full time equivalent reports and job duties. During the examination, it was noted several of the job titles and duties included in HCQI allocation of costs did not meet the definitions of HCQI for MLR reporting purposes. Amounts were found at the cost center level, account level, and within the salaries review of job descriptions. These job titles and duties were removed to recalculate the percentage of each cost center related to HCQI. These expenses have been reclassified to HCQI from administrative expenses. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and Medicaid Managed Care Final Rule 45 CFR § 158.150.

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	$57,263

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	$57,263
3.1	Administrative Expenses	($57,263)

Adjustment #9 – Adjust to include vision services arranged by VSP that were not reported within submitted claims.

The health plan filed claims expense on a reinstated basis and mistakenly did not include expenses related to vendors, including those for vision services arranged by VSP. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation.

The third party requirements are addressed in CMS MLR Guidance issued 7/18/11 (Q and A #19), 5/13/11 (Q and A #12), and 2/10/12 (Q and A #20). CMS Guidance states that "an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees". Question #12 recognizes items for inclusion in the non-claims cost component. Additionally, the third party reporting requirements are also stated in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k)(3), 45 CFR 158.140(b)(3)(ii), and CMCS Informational Bulletin: Medicaid Managed Care FAQ – Medical Loss Ratio 06/05/2020.

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	$43,865

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	$43,865

Adjustment #10 – Adjust prescription drug expenses to actual cost incurred.

The health plan reported expenses for pharmacy services arranged by CVS. The contractual payment structure is a pass through cost agreement. During the examination, it was determined that the filed claims expense was greater than the actual claims incurred and paid by CVS. Since these claims were incurred for members of the Virginia Medicaid program, the expense was adjusted to actual claims cost utilizing supporting documentation. The variance between filed and verified PBM claims expense was reclassified to administrative costs.

The third party requirements have been previously referenced within the Adjustment #9 description. Additionally, CMCS Information Bulletin: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors 05/15/2019 speaks specifically to PBMs.

Proposed Medical Loss Ratio Adjustment:		
Line #	**Line Description**	**Amount**
1.1	Claims	($63,327)

Proposed Underwriting Gain Adjustment:		
Line #	**Line Description**	**Amount**
2.1	Claims	($63,327)
3.1	Administrative Expenses	$63,327

The Virginia Department of Medical Assistance Services had no comments on the draft report.

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

September 8, 2020

Karl Loewe, CFO
Aetna Better Health of Virginia
9881 Mayland Drive
Richmond, VA 23233

Dear Mr. Loewe:

Please acknowledge whether you accept or disagree with our proposed adjustments summarized below and applicable to our examination of Aetna Better Health of Virginia's FAMIS MLR and Underwriting Gain rebate calculations for the period of July 1, 2017 through November 30, 2018. Also, please explain any disagreement you may have with the proposed issues.

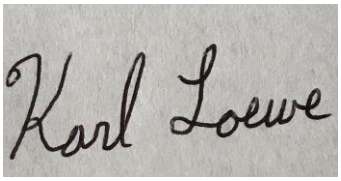
Please provide your response by September 22, 2020.

Aetna Better Health of Virginia FAMIS
July 1, 2017 through November 30, 2020

	Adjustment	MCO's Response	
1.	To adjust FAMIS member months to agree to the annualized State data. Adjusted member months are less than 120,000 meaning that the member month requirement is not met for the purposes of the underwriting gain.	Accept X	Disagree
2.	To adjust income tax expense to verified amounts, as no support was received to validate filed expense.	Accept X	Disagree
3.	To add back verified HIF expense as the costs were not included within the filed tax expenses. To agree filed HIF gross up to the verified amount as total revenues were filed.	Accept X	Disagree
4.	To include paid medical incentive pools and bonuses MLR Reporting year in the UG Limit Claims costs, as this cost was not included.	Accept X	Disagree

5.	Adjust to reclassify Rx reinsurance payments made by the State from Claims to Revenues. Adjust capitation payments and other revenues to agree to amount per State data.	Accept X_____	Disagree _____
6.	To remove non-allowable Contributions/Donation and Lobbying costs from the administrative costs filed on MLR.	Accept X_____	Disagree _____
7.	To adjust Administrative cost to include administrative costs to verified amount related to allocation variances.	Accept X_____	Disagree _____
8.	To remove non-allowable cost centers, accounts, and job descriptions found during testing.	Accept X_____	Disagree _____
9.	To include VSP Delegated Vendor Claims Costs that were not reported within filed claims.	Accept X_____	Disagree _____
10.	To agree filed Rx Delegated Vendor Claims Costs to the PBM certification Statement.	Accept X_____	Disagree _____

Acknowledged by:
Aetna Better Health of Virginia



Officer or other Authorized Person

11-16-2020

Date