Aetna Better Health of Virginia Commonwealth Coordinated Care Plus Medicaid Managed Care Program

Report on Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations

With Independent Accountant's Report Thereon

For the period of July 1, 2020 through June 30, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

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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 Commonwealth Coordinated Care Plus Program (CCC Plus) for the period of July 1, 2020 through June 30, 2021. Aetna's management is responsible for presenting the Medical Loss Ratio and Underwriting Gain Rebate Calculations in accordance with the criteria set forth in the CCC Plus contract and Centers for Medicare & Medicaid Services (CMS) federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations. 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.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio and Adjusted Underwriting Gain Rebate Calculations were prepared for the purpose of complying with the criteria, and is 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 are presented in accordance with the above referenced criteria, in all material respects, for the period of July 1, 2020 through June 30, 2021. Related to non-expansion, the Adjusted Medical Loss Ratio (MLR) Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Adjusted Underwriting Gain Percentage Achieved exceeds the maximum requirement of three percent (3%). In accordance with contractual obligations, an Underwriting Gain remittance amount is due to the Department of Medical Assistance services. Related to expansion, the Adjusted MLR Percentage Achieved exceeds the minimum requirement of eighty-five percent (85%) and the Underwriting Gain is not applicable per contractual requirements.

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, Virginia
August 1, 2023

Adjusted Medical Loss Ratio for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$673,593,783	($21,929,128)	$651,664,655
1.2	Improving health care quality expenses	$17,286,171	($2,176,272)	$15,109,899
1.3	**Total Adjusted MLR Numerator**	**$690,879,954**	**($24,105,400)**	**$666,774,554**
Medical Loss Ratio Denominator				
2.1	Revenue	$837,532,782	($28,927,118)	$808,605,664
2.2	Federal and State taxes and licensing or regulatory fees	$26,936,999	$0	$26,936,999
2.3	**Total Adjusted MLR Denominator**	**$810,595,783**	**($28,927,118)**	**$781,668,665**
Credibility Adjustment				
3.1	Member Months to determine credibility	412,501	0	412,501
3.2	Credibility adjustment	0.0%		0.0%
MLR Calculation				
4.1	Unadjusted MLR	85.2%		85.3%
4.2	Credibility adjustment	0.0%		0.0%
4.3	**Adjusted MLR**	**85.2%**		**85.3%**
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	85.2%		85.3%
5.4	MLR denominator	$810,595,783		$781,668,665
5.5	**Remittance amount due to State for Coverage Year**	**N/A**		**N/A**

Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Numerator				
1.1	Claims	$108,541,910	$14,267,283	$122,809,193
1.2	Improving health care quality expenses	$2,960,601	$0	$2,960,601
1.3	**Total Adjusted MLR Numerator**	**$111,502,511**	**$14,267,283**	**$125,769,794**
Medical Loss Ratio Denominator				
2.1	Revenue	$150,948,882	($9,053,810)	$141,895,072
2.2	Federal and State taxes and licensing or regulatory fees	$8,331,601	($5,891,026)	$2,440,575
2.3	**Total Adjusted MLR Denominator**	**$142,617,281**	**($3,162,784)**	**$139,454,497**
Credibility Adjustment				
3.1	Member Months to determine credibility	70,649	0	70,649
3.2	Credibility adjustment	2.5%		2.5%
MLR Calculation				
4.1	Unadjusted MLR	78.2%		90.2%
4.2	Credibility adjustment	2.5%		2.5%
4.3	**Adjusted MLR**	**80.7%**		**92.7%**
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	80.7%		92.7%
5.4	MLR denominator	$142,617,281		$139,454,497
5.5	**Remittance amount due to State for Coverage Year**	**N/A**		**N/A**

Adjusted Underwriting Gain for the Period Ending June 30, 2021

Non-Expansion

Line #	Revenue or Expense	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Medical Loss Ratio Denominator				
1.1	Revenue	$837,532,782	($29,079,425)	$808,453,357
1.2	Federal and State taxes and licensing or regulatory fees	$26,936,999	($115,753)	$26,821,246
1.3	**Total Adjusted Underwriting Gain Denominator**	**$810,595,783**	**($28,963,672)**	**$781,632,111**
Medical Expenses				
2.1	Claims	$673,593,783	($21,929,128)	$651,664,655
2.2	Improving health care quality expenses	$17,286,171	($2,176,272)	$15,109,899
2.3	**Total Adjusted Underwriting Gain Claims Expenses**	**$690,879,954**	**($24,105,400)**	**$666,774,554**
Non-Claims Costs				
3.1	Administrative Expenses	$46,969,290	($2,382,692)	$44,586,598
3.2	Less: Unallowable Expenses	($959,330)	$0	($959,330)
3.3	**Allowable Administrative Expenses**	**$46,009,960**	**($2,382,692)**	**$43,627,268**
Underwriting Gain				
4.1	Underwriting Gain $	$73,705,869		$71,230,289
4.1	Less: Remittance Amount Due to State for Coverage Year	$0		$0
4.2	Adjusted Underwriting Gain $	$73,705,869		$71,230,289
4.3	**Underwriting Gain %**	**9.1%**		**9.1%**
Underwriting Gain Remittance Calculation				
5.1	Member Month Requirement Met?	Y		Y
5.2	At least 12 months contract experience at the beginning of the Contract Year?	Y		Y
5.3	Percent to Remit	3.05%		3.06%
5.4	**Amount to Remit**	**$24,693,998**		**$23,890,663**

Schedule of Adjustments and Comments for the Period Ending June 30, 2021

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.

Non-Expansion Adjustment #1 – To adjust to remove Health Insurer Fee (HIF) expense and revenue included in the Underwriting Gain calculation.

The health plan has included HIF expense in taxes and licensing or regulatory fees and HIF revenue in revenues. HIF expense and revenue has been removed from the Underwriting Gain Calculation per the CCC Plus MCO Contract, Section 19.8.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($152,307)
1.2	Federal and State taxes and licensing or regulatory fees	($115,753)

Non-Expansion Adjustment #2 – To adjust revenues to agree with state data.

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. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, clinical efficacy payments, discrete incentive payments, and performance withhold program payments. 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 MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	($2,373,412)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($2,373,412)

Non-Expansion Adjustment #3 – To adjust directed payments included in revenues and claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($26,553,706)
2.1	Revenue	($26,553,706)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
1.1	Revenue	($26,553,706)
2.1	Claims	($26,553,706)

Non-Expansion Adjustment #4 – To adjust to reclassify non-allowable Healthcare Quality Improvement Expenses (HCQI) expenses.

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. The total cost allocated for HCQI included two types of costs, direct costs and intercompany costs. The intercompany expense support was not provided and could not be verified for the 2020 MLR examination. Additionally, 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 expenses have been reclassified from HCQI to administrative expenses through this adjustment. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.2	Improving health care quality expenses	($2,176,272)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.2	Improving health care quality expenses	($2,176,272)
3.1	Administrative Expenses	$2,176,272

Non-Expansion Adjustment #5 – To adjust claims payments made to Public Partnerships LLC (PPL), the consumer directed services vendor, to offset payments received from PPL representing claims payments in excess of vendor payroll.

The health plan reported claims expense for consumer directed services arranged by PPL. During the examination, it was determined that the service payments are reconciled to payroll incurred by PPL on a quarterly basis resulting in a payable to Aetna. This adjustment is to offset these reconciling payments made by PPL to Aetna against the related claims expense.

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 MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($1,834,807)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($1,834,807)

Non-Expansion Adjustment #6 – To adjust Incurred but Not Reported (IBNR) at the time of the MLR filing to IBNR reported as of March, 2023.

The reported IBNR of $557,416 was adjusted to agree to the March, 2023 lag table. We have made an adjustment for the difference of $531,056 to Medical Loss Ratio line 1.1 and Underwriting Gain line 2.1. The IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.140.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	($531,056)

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	($531,056)

Non-Expansion Adjustment #7 – To adjust administrative expenses to agree to supporting documentation.

Reported administrative costs were incorrectly separated between Medallion 4.0 and CCC Plus. Temporary Assistance for Needy Families (TANF) was incorrectly included in CCC Plus resulting in Medallion 4.0 administrative costs being understated. The plan provided support for the correct split, which tied to support provided during the administrative cost procedures, a separate engagement. Administrative cost principles are addressed in 45 CFR § 75.420 through 75.475.

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
3.1	Administrative Expense	($4,558,964)

Non-Expansion Adjustment #8 – To adjust to include consumer directed services claims expense arranged by Consumer Direct Care Network (CDCN) that was erroneously excluded by the plan.

The health plan did not report claims expense for consumer directed services arranged by CDCN. Based on trial balance documentation and support received from CDCN, allowable incurred claims expenses were determined to be $6,990,441. The expenses were adjusted to agree to the provided 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 MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$6,990,441

Proposed Underwriting Gain Adjustment		
Line #	**Line Description**	**Amount**
2.1	Claims	$6,990,441

Expansion Adjustment #1 – To adjust revenues to agree with state data.

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. Revenue was adjusted per the state's data to reflect all payments, including capitation payments, maternity kick payments, clinical efficacy payments, discrete incentive payments, risk corridor recoupments, and performance withhold program payments. 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 MLR Adjustment		
Line #	**Line Description**	**Amount**
2.1	Revenue	($23,321,093)

Expansion Adjustment #2 – To adjust directed payments included in revenues and claims to agree with state data.

The health plan properly included directed payments in the numerator and the denominator of the MLR calculation. The associated revenues and expenses were adjusted to agree with state data. The revenue and claims reporting requirements are addressed in the Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), CFR § 438.8(f)(2), and 45 CFR § 158.130.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
1.1	Claims	$14,267,283
2.1	Revenue	$14,267,283

Expansion Adjustment #3 – To adjust income tax expense to verified amounts.

The health plan calculated the state and federal taxes utilizing effective tax rates for 2021 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 Medical Loss Ratio (MLR) Requirements, the Medicaid Managed Care Final Rule 42 § 438.8(f)(3) and 45 § CFR 158.162.

Proposed MLR Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal and State taxes and licensing or regulatory fees	($5,891,026)