MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

November 21, 2024

Via Electronic Mail

Florida Healthy Kids Corporation
Lindsay Lichti, Deputy Director | Plan Management
P.O. Box 980
Tallahassee, FL 32302

Re: Adjusted Medical Loss Ratio examination report for Aetna Better Health of Florida, Inc. for calendar year ended December 31, 2020

This letter is to inform you that Myers and Stauffer LC has completed the examination of the Adjusted Medical Loss Ratio for Aetna Better Health of Florida, Inc. (health plan) for calendar year ended December 31, 2020. As a courtesy to the Florida Health Kids Corporation and other readers, the health plan's management response letter is included, if provided, in addition to our examination report, as part of this transmittal packet. Myers and Stauffer LC, in no manner, expresses an opinion on the accuracy, truthfulness, or validity of the statements presented within the management response letter.

Please contact us at the phone number below if you have questions.

Kind Regards,

Myers and Stauffer LC

Myers and Stauffer LC

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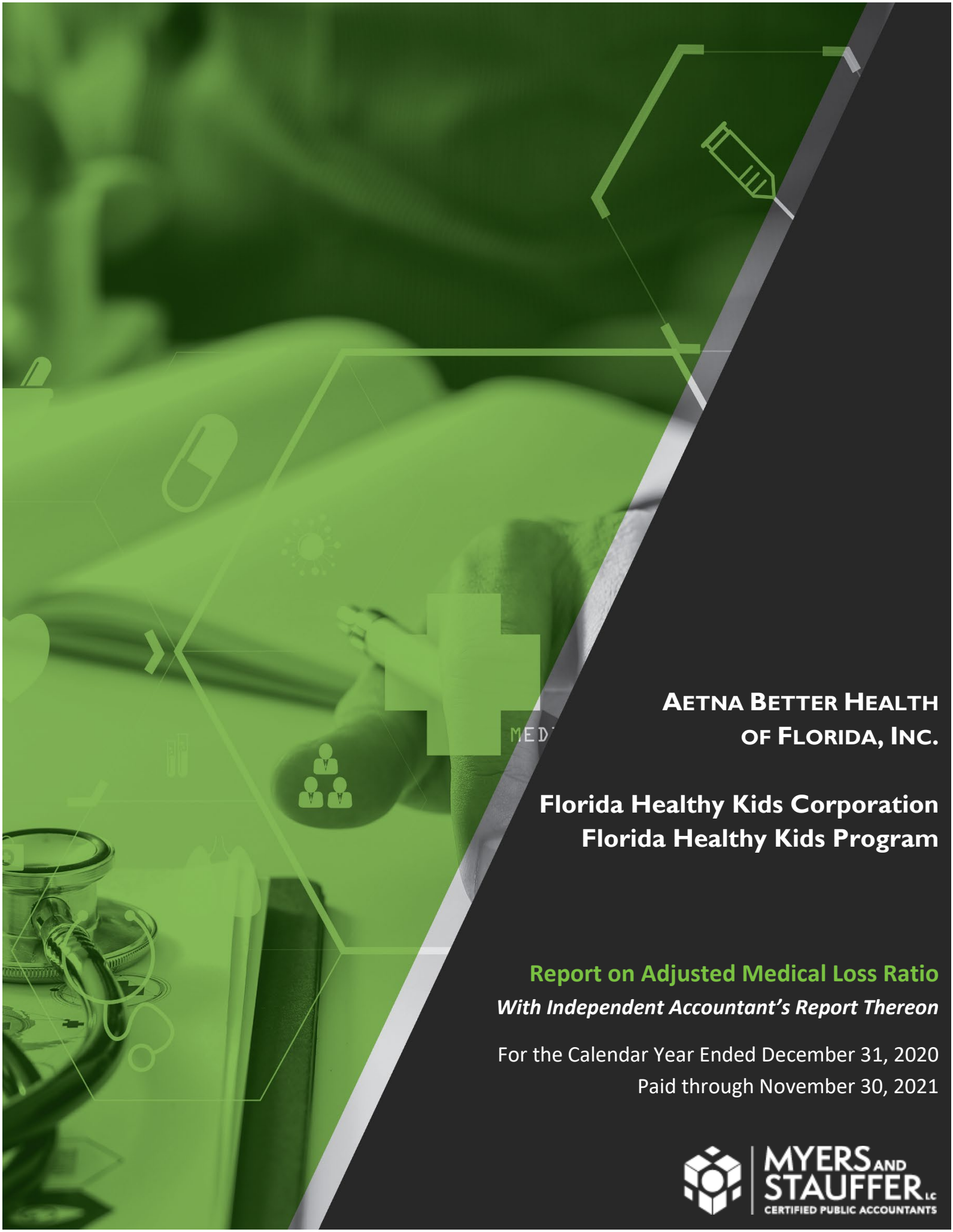

AETNA BETTER HEALTH OF FLORIDA, INC.

Florida Healthy Kids Corporation
Florida Healthy Kids Program

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the Calendar Year Ended December 31, 2020
Paid through November 30, 2021

MYERS AND STAUFFER LC
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MYERS AND STAUFFER LC
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Florida Healthy Kids Corporation
Tallahassee, Florida

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio of Aetna Better Health of Florida, Inc. (health plan) for the calendar year ended December 31, 2020. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio 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 is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. 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, 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 was prepared from information contained in the Medical Loss Ratio 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 Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio does not meet the Centers for Medicare & Medicaid Services (CMS) requirement of 85 percent for the calendar year ended December 31, 2020.

This report is intended solely for the information and use of the Florida Healthy Kids Corporation, Milliman, and the health plan 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
Kansas City, Missouri
July 29, 2024

Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2020 Paid Through November 30, 2021

Adjusted Medical Loss Ratio for the Calendar Year Ended December 31, 2020 Paid Through November 30, 2021				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
1.	**Medical Loss Ratio Numerator**			
1.1	Incurred Claims	$ 115,541,616	$ (6,696,933)	$ 108,844,683
1.2	Activities that Improve Health Care Quality	$ 5,449,259	$ (1,569,159)	$ 3,880,100
1.3	MLR Numerator	$ 120,990,875	$ (8,266,092)	$ 112,724,783
1.4	Non-Claims Costs (Not Included in Numerator)	$ 16,417,984	$ -	$ 16,417,984
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 151,658,148	$ (183,574)	$ 151,474,574
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ 6,206,589	$ (1,093,195)	$ 5,113,394
2.3	MLR Denominator	$ 145,451,559	$ 909,621	$ 146,361,180
3.	**MLR Calculation**			
3.1	Member Months	1,111,666	-	1,111,666
3.2	Unadjusted MLR	83.18%	-6.2%	77.0%
3.3	Credibility Adjustment	0.00%	0.0%	0.0%
3.4	Adjusted MLR	83.18%	-6.2%	77.0%
4.	**Remittance**			
4.1	Contract includes Remittance Requirement	Yes		Yes
4.2	FHKC Minimum MLR Requirement	85.00%		85.0%
4.5	Calculated MLR for Remittance Purposes	83.18%	-6.2%	77.0%
4.6.1	Remittance Dollar Amount Owed for MLR Reporting Period	$ 2,642,950	$ 9,039,270	$ 11,682,220

**The Non-Claims Costs line has not been subjected to the procedures applied in the examination, including testing for allowability of expenses or appropriate allocation to the Medicaid line of business. Adjustments identified during the course of the examination were not tested to determine any impact on Non-Claims Costs. Accordingly, we express no opinion on the Non-Claims Costs line.*

Schedule of Adjustments and Comments for Calendar Year Ended December 31, 2020

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust third party vendor expenses per certification statements

The health plan reported services for third party vendors; iCare Health Solutions, Beacon Health Strategies, Dermatology Network Solutions, Doctors Professional Services, Health Network One, Orthopedix Network Solutions, and Podicare based on a per-member per-month (PMPM) arrangement. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the Medical Loss Ratio (MLR) reporting period. An adjustment was proposed to remove the administrative and profit components of the PMPM amount from incurred claims. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($2,549,243)

Adjustment #2 – To adjust pharmacy rebates per health plan supporting documentation

The health plan reported prescription drug rebates received and accrued. It was determined the amount reported was understated based on supporting documentation submitted from the health plan. An adjustment was proposed to increase the prescription drug rebates based on health plan supporting documentation. Pharmacy rebates are a reduction to incurred claims, therefore the increase in rebates is shown as a negative adjustment. The prescription drug rebates received and accrued reporting requirement are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(ii)(B) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($314,518)

Adjustment #3 – To adjust to pharmacy paid claims per PBM certification statement

The health plan reported pharmacy paid claims for related party pharmacy benefit manager (PBM), CVS Health. It was determined that the pharmacy amount reported within the MLR was less than the paid claims amount certified by the PBM. An adjustment was proposed to report pharmacy paid claims per the PBM certification statement. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	$113,957

Adjustment #4 – To adjust incurred claims expense to final net payments to pharmacies

The health plan reported pharmacy incurred claims expense for the related party PBM, CVS Health, based on paid claims detail only reflecting ingredient cost and dispensing fees. It was determined the reported pharmacy incurred claims expense was overstated due to excluding the transmission fees assessed to the pharmacies by the PBM. An adjustment was proposed to reduce incurred claims expense by the amount related to the transaction fees in order to reflect the final amount paid to pharmacies. The incurred claims and third and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($122,532)

Adjustment #5 – To remove performance guarantees between the PBM and the health plan from pharmacy incurred claims expense

The health plan reported pharmacy incurred claims for the related party PBM, CVS Health. As part of the contract between the PBM and the health plan, a yearly reconciliation to calculate the difference between the amount the health plan paid to the PBM and the contract's guaranteed rates was completed. The PBM reimburses the health plan for the difference if the amount the health plan paid the PBM is greater than the guaranteed rates. An adjustment was proposed to reduce incurred claims by the rebate the health plan received from the PBM. The incurred claims and third and related party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($65,610)

Adjustment #6 – To adjust PBM vendor rate guarantee calculation per PBM supporting documentation

The health plan reported pharmacy incurred claims for the related party PBM, CVS Health. It was determined contracted rate guarantee calculations were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact of the rate guarantee on the Medicaid line of business was a reduction in reimbursement to pharmacies. An adjustment was proposed to remove the Medicaid calculated amount for the MLR reporting period from incurred claims. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($3,758,987)

Adjustment #7 – To remove non-qualifying HCQI/HIT expenses

The health plan reported health care quality improvement (HCQI)/health information technology (HIT) expenses related to salaries and benefits, as well as vendor costs. It was determined the health plan included non-qualifying HCQI/HIT expenses based on federal guidance. An adjustment was proposed to remove non-qualifying salaries and benefits and vendor costs. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.2	Activities that Improve Health Care Quality	($1,569,159)

Adjustment #8 – To adjust revenues per Florida Healthy Kids Corporation (FHKC) data

The health plan reported revenue amounts that did not reflect payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the revenues per the FHKC data for capitation payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	$110,909

Adjustment #9 – To adjust income taxes per recalculation to audited financial statements

The health plan reported income taxes that were calculated utilizing amounts from the Medical Loss Ratio report rather than audited tax information. An adjustment was proposed to the recalculation of taxes utilizing the audited financial statements. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	($875,990)

Adjustment #10 – To adjust HIF revenues and expenses per Florida Healthy Kids Corporation (FHKC) data

The health insurer fee revenue and expense amounts reported did not reconcile to the FHKC's data. An adjustment was proposed to report the health insurer fee (HIF) revenue and expense per the FHKC data. The HIF reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and CMS Health Insurance Providers Fee for Medicaid Managed Care Plans FAQ dated October 2014.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2.1	Premium Revenue	($294,483)
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	($217,205)

Appendix A: Health Plan Responses

The health plan responses are attached below. The responses have been reviewed by Myers and Stauffer prior to finalization of the examination report, and have been incorporated into the adjustments if deemed necessary by Myers and Stauffer.

Florida Healthy Kids Corporation
661 E. Jefferson St.
Tallahassee, FL 32301

August 20, 2024

Re: MLR Management Response Letter

Attention: Florida Healthy Kids Corporation (FHKC)

In response to the Myers & Stauffer proposed audit adjustments to ABH of FL experience reports for CY 2020 and CY 2021, Aetna does not agree with several of the proposed adjustments, as stated in an earlier communication. While we can agree with some adjustments, of most concern to us are the following items with our reasoning and position on each:

Pharmacy transmission fees

The regulation at 42 CFR 438(e)(2) does not support reducing incurred claims by transmission fees. 42 CFR 438(e)(2)(v)(A) explicitly states which amounts must be excluded from incurred claims and does not include transmission fees. This is appropriate as these payments are neither prescription drug rebates nor fees charged to the plan for administrative services performed for the plan by the PBM. Instead, they are bona fide service fees paid by pharmacies to the PBM for services provided to the pharmacy by the PBM. Should CMS wish to exclude them from incurred claims, it would need to undertake notice and comment rulemaking to do so, explaining the rationale for its approach and allowing public comment before codifying this position in regulation. We also note that the May 19, 2019 CMS Informational Bulletin makes no reference whatsoever to pharmacy transmission fees. Aetna does not agree with this adjustment for that reason.

Pharmacy global rate guarantees

In order for amounts retained by Caremark to be deducted from a managed care plan's incurred claims, the amounts must meet the following two-part test:

- Qualify as "prescription drug rebates" by virtue of being something of value Caremark retains "for the provision of a Medicaid covered outpatient drug"
- Be retained by Caremark for performing "an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development."

Effective rate guarantees between Caremark and certain network pharmacies do not qualify as prescription drug rebates since they are not paid to Caremark "for the provision of a Medicaid covered outpatient drug." If amounts are owed to Caremark (sometimes Caremark owes money to the pharmacies based on reconciliation) these amounts are not in any way related to prescription drug rebates.

The May 15, 2019 CMCS Informational Bulletin states that Medicaid requirements to account for third-party vendor expenditures are "subject to the requirements in 45 CFR Part 158." In 45 CFR 158.103, CMS specifically defines "prescription drug rebates and other price concessions" to include price

concessions only "to the extent the value of these items reduce costs for the issuer." This makes sense since the policy rationale for requiring rebates to be deducted from incurred claims is that they represent a reduction in a managed care plan's expenses. We note that CMS failed to undertake the required notice and comment rulemaking to formally adopt a definition of "prescription drug rebates" for the Medicaid MLR standards, but the commercial market standards incorporated by CMS by cross-reference nonetheless support Caremark's decision not to deduct transmission fees from incurred claims.

In this case, any amounts collected by Caremark based on effective rate guarantees do not reduce the drug costs for the managed care plan since (i) they are not passed through to the managed care plan and (ii) Caremark does not reduce its administrative fee to the managed care plan as a result of these amounts. As a result, amounts paid to Caremark by pharmacies based on effective rate guarantees/reconciliation do not meet the sub-regulatory guidance definition of "prescription drug rebates" upon which the Medicaid MLR reporting standards are based.

CMS's third-party vendor reporting standards are meant to ensure that any rebate revenue retained by the PBM as an alternative to charging an administrative fee is appropriately treated by the managed care plan as an administrative expense rather than an incurred claims expense. This regulatory requirement in 42 CFR 438.8(e)(2)(v)(A) is based on the pre-existing rule from the commercial MLR regulations. This regulation only applies, however, where the revenue being retained by the third-party vendor is for the provision of administrative services to the issuer. Amounts collected by Caremark for effective rate guarantees/reconciliation are not revenue that Caremark retains in exchange for providing administrative services to the managed care plan such as eligibility and coverage verification, claims processing, utilization review, or network development services. Based on this, Aetna does not agree with this proposed adjustment.

HCQI expense

In an effort to further support the value of HCQI expenses reported, Aetna replicated the M&S approach to evaluating that amount, after having supplied a significant amount of data and information around our internal process for identifying and tracking those costs. In doing so and using CY 2020 as the evaluation period, we were able to support what we filed less $406,000 using our knowledge of those HCQI activities applied to their methodology.

As a result, we do not agree with the proposed adjustment for this item.

Best regards,

George Yokley
Chief Financial Officer
Aetna Better Health of Florida Inc.

CC: Myers & Stauffer LC