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 Simply Healthcare Plans, 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 Simply Healthcare Plans, 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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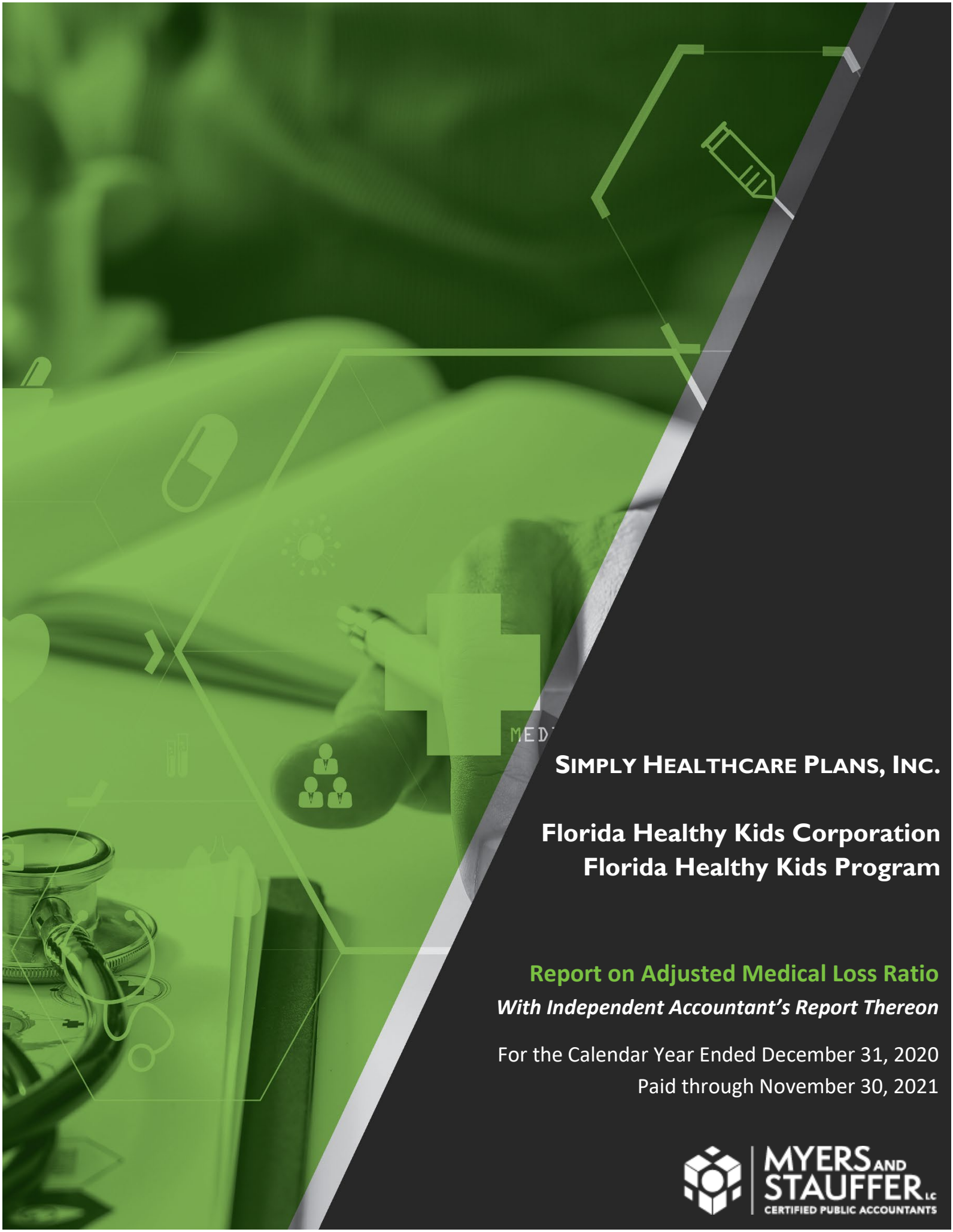

SIMPLY HEALTHCARE PLANS, INC.

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
CERTIFIED PUBLIC ACCOUNTANTS

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 Simply Healthcare Plans, 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 1, 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	$ 119,775,126	$ (5,080,379)	$ 114,694,747
1.2	Activities that Improve Health Care Quality	$ 5,719,952	$ (2,006,143)	$ 3,713,809
1.3	MLR Numerator	$ 125,495,078	$ (7,086,522)	$ 118,408,556
1.4	Non-Claims Costs (Not Included in Numerator)	$ 25,214,538	$ -	$ 25,214,538
2.	**Medical Loss Ratio Denominator**			
2.1	Premium Revenue	$ 147,637,660	$ 2,213,065	$ 149,850,725
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$ (768,918)	$ 1,062,835	$ 293,917
2.3	MLR Denominator	$ 148,406,578	$ 1,150,230	$ 149,556,808
3.	**MLR Calculation**			
3.1	Member Months	1,075,963	-	1,075,963
3.2	Unadjusted MLR	84.56%	-5.4%	79.2%
3.3	Credibility Adjustment	0.00%	0.0%	0.0%
3.4	Adjusted MLR	84.56%	-5.4%	79.2%
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	84.56%	-5.4%	79.2%
4.6.1	Remittance Dollar Amount Owed for MLR Reporting Period	$ 650,514	$ 8,064,218	$ 8,714,731

**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 incurred claims per health plan supporting documentation

The health plan reported incurred claims that did not reconcile to supporting documentation. An adjustment was proposed to report incurred claims based on health plan supporting documentation. The incurred claims 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	($28,601)

Adjustment #2 – To adjust incurred claims for additional paid claims amounts

The health plan reported paid claims based on the specified runout period, including estimated incurred but not reported (IBNR), for the medical loss ratio (MLR) reporting period. A comparison was performed between a revised paid lag table with additional runout through December 2023 to the health plan's reported paid claims and IBNR estimate, which indicated the reported incurred claims, including IBNR were understated. An adjustment was proposed to increase incurred claims per supporting documentation. The incurred claims and IBNR 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	$83,146

Adjustment #3 – To remove spread pricing from pharmacy expense

The health plan reported pharmacy expenses based on internal claims data, which included amounts the health plan paid to the pharmacy benefit manager (PBM), CVS Health. Based on the certification statement provided by the PBM, it was determined variances existed between the paid amounts to retail pharmacies compared to payments reflected in the health plan's data and spread pricing was the majority of the difference in the two data sources. This margin charged to the health plan is considered

PBM profit and administrative cost, and is an unallowable medical expense. An adjustment was proposed to remove the identified spread pricing per the PBM certification statement. The prescription drug spread pricing requirements 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	($1,171,796)

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

The health plan reported pharmacy incurred claims expense for the third 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 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	($71,365)

Adjustment #5 – To adjust pharmacy rebates per PBM certification statement

The health plan reported prescription drug rebates received and accrued. It was determined the amount reported was overstated based on supporting documentation submitted from the PBM, CVS Health. An adjustment was proposed to decrease the prescription drug rebates based on PBM supporting documentation. Pharmacy rebates are a reduction to incurred claims, therefore the decrease in rebates is shown as a positive 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	$230,337

Adjustment #6 – To remove non-qualifying HCQI/HIT expenses per health plan supporting documentation

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	($2,006,143)

Adjustment #7 – To include HIF revenues and expenses per Florida Healthy Kids Corporation (FHKC) data

The health plan excluded health insurer fee (HIF) revenues and expense from the MLR Calculation. An adjustment was proposed to include the HIF revenues and expenses 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	$2,205,732
2.2	Federal, State, and Local Taxes and Licensing and Regulatory Fees	$1,664,811

Adjustment #8 – 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	($601,976)

Adjustment #9 – To remove third party capitated vendor expenses

The health plan reported third party vendor expenses for Integrated Home Care Services. The amount reported included per-member-per-month (PMPM) capitation payments, in addition to fee-for-service (FFS) amounts. The health plan confirmed that the vendor expenses should only include the FFS paid claims that were supported by claims data. An adjustment was proposed to remove the capitation amounts from incurred claims, and to report the FFS amounts per the vendor's 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) 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	($1,047,477)

Adjustment #10 – To adjust third party vendors per the certification statement

The health plan reported services for third party vendor, Health Network One 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	($1,254,084)

Adjustment #11 – To adjust expanded benefits per supporting documentation

The health plan reported expanded benefits expense related to a waived co-pay program. During the review of the sample claims documentation and through conversations with the plan, it was discovered that the amount reported as expanded benefits was included twice in incurred claims. An adjustment was proposed to remove the expanded benefits duplicated within incurred claims and report the waived co-pay amount as revenue based on federal guidance. The incurred claims and waived cost share reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2) and 438.8(f)(2).

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1.1	Incurred Claims	($15,970)
2.1	Premium Revenue	$15,970

Adjustment #12 – 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	($8,637)

Adjustment #13 – To adjust PBM vendor rate guarantee calculation per PBM supporting documentation

The health plan reported pharmacy incurred claims for the third-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	($1,804,569)

Appendix A: Health Plan Responses

The health plan did not provide responses for the calendar year included within the report.