MAGNOLIA HEALTH PLAN, INC.
Mississippi Coordinated Access Network (MSCAN)

Report on Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2021
Paid through December 31, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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State of Mississippi
Division of Medicaid
Jackson, Mississippi

Independent Accountant's Report

We have examined the MSCAN Medical Loss Ratio (MLR) Rebate Calculation of Magnolia Health Plan, Inc. (health plan) for the state fiscal year ended June 30, 2021. The health plan's management is responsible for presenting the MSCAN Medical Loss Ratio (MLR) Rebate Calculation in accordance with the criteria set forth in the Code of Federal Regulations (CFR) 42 § 438.8 and other applicable federal and state 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 Rebate Calculation 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 exceeds the state's requirement of eighty-seven and a half percent (87.5%) for the state fiscal year ended June 30, 2021.

This report is intended solely for the information and use of the Division of Medicaid, 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
Atlanta, Georgia
February 6, 2023

Adjusted MLR Medical Loss Ratio for the State Fiscal Year Ended June 30, 2021 Paid Through December 31, 2021

Adjusted MLR Medical Loss Ratio for the State Fiscal Year Ended June 30, 2021 Paid Through December 31, 2021				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Capitation Revenue and Tax Assessments				
1	Total YTD Capitation Revenue (A)	$ 1,345,090,284	$ (5,171,107)	$ 1,339,919,177
	Tax Components of Reported Revenue			
2	Less: Health Insurer Tax	$ 13,825,697	$ (3,239,538)	$ 10,586,159
3	Less: Premium Taxes	$ 39,937,938	$ 259,638	$ 40,197,576
4	Less: Other taxes and other revenue-based assessments	$ 2,362,901	$ (1,707,936)	$ 654,965
5	NET Current YTD Adjusted Premium Revenue	$ 1,288,963,748	$ (483,271)	$ 1,288,480,477
MLR Medical and Administrative Expenses				
6a	Net Medical Expenses from Income Statement (A)	$ 877,720,739	$ (251,661)	$ 877,469,078
6b	Mississippi Hospital Access Program (MHAP) Expenses	$ 278,185,460	$ (8,333,500)	$ 269,851,960
6c	Medicaid Access to Physician Services (MAPS) Expenses	$ 12,609,400	$ 2,924,986	$ 15,534,386
6	**Total Net Medical Expenses**	$ 1,168,515,599	$ (5,660,175)	$ 1,162,855,424
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claims adjustment additions	$ 14,018,044	$ (5,541,404)	$ 8,476,640
8	Incurred claims adjustment deductions	$ 6,037,336	$ -	$ 6,037,336
9	Incurred claims adjustment exclusions	$ 20,233,182	$ -	$ 20,233,182
10	Adjusted Net Medical Expenses	$ 1,156,263,124	$ (11,201,579)	$ 1,145,061,546
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 12,764,933	$ (2,427,316)	$ 10,337,617
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ (457,290)	$ -	$ (457,290)
13	Adjusted HCQI/HIT Expenses	$ 13,222,223	$ (2,427,316)	$ 10,794,907
14	Other Non-Claims Costs*	$ 76,254,547	$ 5,995,034	$ 82,249,581
15	Program Integrity Costs*	$ 3,230,233	$ (1,828,185)	$ 1,402,048
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 1,169,485,347	$ (13,628,894)	$ 1,155,856,453
17	Reporting MLR Percentage	90.7%	-1.0%	89.7%
18	MLR percentage requirement for rebate calculation	87.5%	0.0%	87.5%
19	**Percentage below 87.5% Requirement**	0.0%	0.0%	0.0%
20	**Dollar Amount of Rebate Requirement**	$ -	$ -	$ -
Credibiltiy Adjustment Applied				
21	MLR Member Months	2,382,557	-	2,382,557
22	**MLR Member Months (Annualized)**	2,382,557	-	2,382,557
23	**Credibility Adjustment**	0.0%	0.0%	0.0%
24	**Adjusted Reporting MLR Percentage**	90.7%	-1.0%	89.7%
25	**MLR Percentage Requirement for Rebate Calculation**	87.5%	0.0%	87.5%
26	**Percentage below 87.5% Requirement**	0.0%	0.0%	0.0%
27	**Dollar Amount of Rebate Required**	$ -	$ -	$ -

**Lines 14 and 15 above, representing Other Non-Claims Costs and Program Integrity Costs respectively, are excluded from the numerator of the MLR calculation; however, the amounts were tested for allowability and appropriateness based on the state's criteria and are therefore opined upon within the examination report.*

Schedule of Adjustments and Comments for the State Fiscal Year Ended June 30, 2021

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust related party PBM vendor expenses

The health plan's related party Pharmacy Benefit Manager (PBM), Envolve Pharmacy Solutions, contracts with a secondary PBM, RxAdvance, to process claims with pharmacies. The pharmacy expense was reported based on the health plan claims data. Paid claims detail was submitted from RxAdvance to support the amount paid to pharmacies. It was determined the reported pharmacy expense per the health plan was overstated. An adjustment was proposed to decrease the expenses to the supported paid claims per RxAdvance. The 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.

This is a newly identified finding for this examination. We recommend that the health plan report pharmacy expenses utilizing the information from the PBM.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	($527,809)

Adjustment #2 – To reclassify non-qualifying HCQI expenses

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

This is a newly identified finding for this examination. We recommend that the health plan thoroughly review the guidance to ensure the amounts claimed meet the definitions of HCQI.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
11	HCQI and HIT Administrative Expenses from Income Statement	($2,427,316)
14	Other Non-Claims Costs	$2,427,316

Adjustment #3 – To adjust to actual cost for related party

The health plan reported administrative expenses related to dental and vision vendors based on the Per-Member-Per-Month (PMPM) arrangement. The health plan subtracted the actual incurred claims for medical services from the PMPM amount to arrive at the administrative cost claimed. The pharmacy vendor administrative cost was reported based on the per claim admin fee, which was separately recorded from medical services in the general ledger. Based on the test work performed, it was determined the actual cost of the administrative services for each related party vendor exceeded the amounts claimed based on the arrangement reported in the general ledger for the reporting period. An adjustment was proposed to increase each vendor's administrative expense based on the actual cost incurred by the vendors. The related party reporting requirements are addressed in CMS Publication 15-1, Chapter 10.

This is a newly identified finding for this examination. We recommend that the health plan ensure actual costs are reported for any related party vendors.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	$417,096
14	Other Non-Claims Costs	$295,699
14	Other Non-Claims Costs	$581,795

Adjustment #4 – To adjust paid claims to restated lag table amounts

The health plan provided lag tables and restatement tables to adjust the general ledger amounts appropriately for the MLR reporting period. Based on the test work performed, it was noted an error was made in the calculation to the total reported paid claims per the lag tables. An adjustment was proposed to increase the medical expenses for the missing paid claims expense. The medical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

This is a newly identified finding for this examination. We recommend that the health plan ensure all documentation is reconciled to the amounts reported in the MLR.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	$236,157

Adjustment #5 – To remove non-allowable administrative expenses

The health plan reported administrative costs from three different sources in other non-claims costs. During testing, the direct plan costs were sampled, which consisted of legal entity samples and direct administrative samples. Additionally, the corporate costs were also sampled. Our sampling of various accounts identified accounts containing non-allowable items such as: advertising, lobbying, alcoholic beverages, bad debt, and political contributions. Some departments within the corporate allocations were also deemed non-allowable. An adjustment was proposed to remove the amounts from other non-claims costs. The administrative (non-claims) reporting requirements are addressed in the health plan's contract with the Mississippi Division of Medicaid within Section F of the Exhibit C.

This is a newly identified finding for this examination. We recommend that the health plan ensure all non-allowable costs per the state contract are removed from the non-claims cost.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	($290,395)

Adjustment #6 – To adjust revenue to 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 MLR reporting period. An adjustment was proposed to report the revenues per the state data. Capitation Payments, Directed Payments, Mississippi Hospital Access Program (MHAP) expenses, Medicaid Access to Physician Services (MAPS) expense, Withholds, retroactive capitation settlement, and HIF adjustments are included within the total adjustment. The revenue reporting requirements are addressed in the Exhibit C: Medical Loss Ratio (MLR) Requirements and the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(2)(i).

The health plan reported risk corridor settlements based on preliminary amounts, however, it was necessary for Milliman to incorporate all applicable Medical Loss Ratio examination adjustments contained within this report and to provide a final risk corridor settlement calculation. The proposed adjustment incorporates this final risk corridor settlement calculation. The Denominator requirements are addressed in the Exhibit C: Medical Loss Ratio (MLR) Requirements and the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(2)(vi).

This is a newly identified finding for this examination. We recommend that the health plan ensure the reporting of revenues is based on the most updated information available.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Total YTD Capitation Revenue (A)	$3,205,452
1	Total YTD Capitation Revenue (A)	($8,376,559)

Adjustment #7 – To adjust Health Insurer's Fee (HIF) expense per state data

The HIF expense reported by the health plan did not agree with the state data for the MLR reporting period. An adjustment was proposed to reduce HIF expense to reflect state data amounts. The taxes and fees reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and the CMS Health Insurance Providers Fee for Medicaid Managed Care Plans FAQ dated October 2014.

This is a newly identified finding for this examination. We recommend that the health plan ensure that only the HIF expenses are reported as the tax gross-up should be reported with the taxes and fees line of the template.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
2	Less: Health Insurer Tax	($3,239,538)

Adjustment #8 – To adjust MHAP expenses to correct a template formula error

The health plan completed the MLR based on the allowable inputs within the template. After submission, it was noted that the MLR contained a formula error for the expense side of the direct payments. The amount reported was the revenue amount, which included premium taxes. To ensure the amounts appropriately agree between the numerator and the denominator respectively, the expenses should have excluded the premium tax gross-up. An adjustment was proposed to reduce the directed payment expenses related to MHAP down to the actual payment excluding premium taxes. The directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and § 438.6(c).

This is a newly identified finding for this examination. We have recommended a correction to future state MLR templates to address this error.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6b	Mississippi Hospital Access Program (MHAP) Expenses	($8,333,500)

Adjustment #9 – To adjust MAPS expenses to correct a template formula error and to adjust to the incurred claim amounts

The health plan completed the MLR based on the allowable inputs within the template. After submission, it was noted that the MLR contained a formula error for the expense side of the direct payments. The amount reported was the revenue amount, which included premium taxes. To ensure the amounts appropriately agree between the numerator and the denominator respectively, the expenses should have excluded the premium tax gross-up. An adjustment was proposed to reduce the directed payment expenses related to MAPS down to the actual payment excluding premium taxes. Additionally, the health plan reported MAPS amounts received during the state fiscal year rather than the incurred date amounts applicable to the MLR reporting period. An adjustment was made to adjust the incurred expense to align with the adjusted revenue amounts. The directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and § 438.6(c).

This is a newly identified finding for this examination. We have recommended a correction to future state MLR templates to address this error. We also recommend that the health plan report the payments received that are for service dates or incurred dates during the applicable MLR reporting period rather than reporting the amounts that were received during the MLR reporting period.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6c	Medicaid Access to Physician Service (MAPS) Expenses	$2,924,986

Adjustment #10 – To adjust premium tax amounts based on state requirements

The health plan reported premium taxes based on three percent of premiums reported on the MLR. After the test work performed, it was determined revenue adjustments were necessary per a reconciliation to the state data. The revenue adjustments were proposed above in Adjustment #6. Therefore, a recalculation of premium taxes was necessary to determine the amounts to be reported based on total premiums received per state data. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

This is a newly identified finding for this examination. We recommend that the health plan ensure that three percent of premium revenues is claimed on the MLR.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3	Less: Premium Taxes	$259,638

Adjustment #11 – To adjust income taxes per the audited financial statements

The health plan reported income taxes that did not reconcile to the supporting documentation. It was determined the health plan appropriately removed taxes for investment income , but failed to factored in the change in deferred tax assets noted in the audited financial statements. An adjustment was proposed to decrease taxes to the appropriate amounts per the revised calculation utilizing the audited financial statements. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and Centers for Medicare & Medicaid Services Medical Loss Ratio Annual Reporting Form Filing Instructions.

This is a newly identified finding for this examination. We recommend that the health plan utilize the taxes per the NAIC and audited financial statements to ensure proper removal of taxes related to investments and inclusion of the change in deferred income taxes.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Less: Other taxes and other revenue-based assessments	($1,707,936)

Adjustment #12 – To adjust related party vision vendor expenses

The health plan reported vision services of a related party vendor, Envolve Vision, based the amounts per the general ledger, which reflected Fee For Service (FFS) claims. A paid claims lag was submitted to support the vendor's actual claim payments incurred for medical services performed during the MLR reporting period. An adjustment was proposed to report the amount related to the MLR reporting period. The third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

This is a newly identified finding for this examination. We recommend that the health plan utilize the paid claims lag to report the Envolve vision FFS claims rather than the general ledger.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	$39,991

Adjustment #13 – To reclassify unsupported expenses claimed as provider incentive payments

The health plan reported expenses paid to an external party, Aledade Accountable Care 84 LLC, which were represented by the health plan to be provider incentive payments and included within the MLR numerator of the MLR calculation. Based upon the contract review performed, it was

determined the health plan had a Value-Based Program agreement with Aledade, in which the payment amounts to Aledade were determined and paid out according to the cost savings generated by Aledade and their contracted provider participants. Based on the information submitted, it was purported that Aledade subsequently remitted a portion of the payments received from the health plan with their contracted providers as incentive payments, while retaining the remaining portion that was intended to cover the HCQI/HIT services provided and administrative services incurred by Aledade as part of this arrangement. A request was made to the health plan to obtain documentation from Aledade outlining the actual cost of each of the services provided in order to determine proper expense classification for the MLR template calculation. Aledade provided the appropriate level of documentation to support the portion applicable to be included as incurred claims, however they did not provide sufficient documentation to support the portion of their expenses that that would qualify as HCQI/HIT expenses and includable within the numerator of the MLR calculation. Therefore, an adjustment was proposed to reclassify these expenses to other non-claims. The medical expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2). The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3).

This is a newly identified finding for this examination. We recommend that the health plan request the proper breakdown of expenses to categorize the costs appropriately.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
7	Incurred claims adjustment additions	($5,541,404)
14	Other Non-Claims Costs	$5,541,404

Adjustment #14 – To remove duplicated member incentives from non-claims cost

A review of the health plan's internal reclassification adjustments identified that the health plan reported the same member incentive amount in both the HCQI and non-claims cost MLR lines. Testing was conducted on the amounts and it was determined the member incentives were allowable HCQI, therefore, an adjustment was proposed to remove the duplicated amount from non-claims cost. The HCQI/HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and in the health plan's contract with the Mississippi Division of Medicaid within Section F of the Exhibit C.

This is a newly identified finding for this examination. We recommend that the health plan ensure that all reclassification adjustments are reviewed for duplication of reporting within the MLR template lines.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	($1,575,833)

Adjustment #15 – To remove duplicated program integrity costs from non-claims cost

The health plan reported program integrity costs that were not supported by the health plan's general ledger transactions or reconciling adjustments. Correspondence with the health plan and review of the documentation submitted indicated that these reported program integrity costs were duplicated within the MLR template and reported as non-claims cost and as incurred medical expenses related to fraud reduction expenses. Testing was conducted on these costs and it was determined that the costs included in non-claims were related to program integrity, therefore, an adjustment was proposed to remove the duplicated portion from the non-claims cost. Additionally, it was determined that the amounts reported as fraud reduction expenses should remain in medical expense, therefore, an adjustment was also proposed to remove these amounts from the program integrity amounts. The administrative reporting requirements are addressed in the health plan's contract with the Mississippi Division of Medicaid within Section F of the Exhibit C.

This is a newly identified finding for this examination. We recommend that the health plan ensure that all reclassification adjustments are reviewed for duplication of reporting within the MLR template lines.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	($1,402,048)
15	Program Integrity Costs	($1,828,185)