Molina Healthcare of Mississippi, 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 Molina Healthcare of Mississippi, 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 10, 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)	$ 475,436,099	$ (2,241,638)	$ 473,194,461
	Tax Components of Reported Revenue			
2	Less: Health Insurer Tax	$ 3,144,500	$ -	$ 3,144,500
3	Less: Premium Taxes	$ 13,969,286	$ 226,548	$ 14,195,834
4	Less: Other taxes and other revenue-based assessments	$ 7,077,359	$ (991,121)	$ 6,086,238
5	NET Current YTD Adjusted Premium Revenue	$ 451,244,953	$ (1,477,064)	$ 449,767,889
MLR Medical and Administrative Expenses				
6a	Net Medical Expenses from Income Statement (A)	$ 349,235,093	$ -	$ 349,235,093
6b	Mississippi Hospital Access Program (MHAP) Expenses	$ 37,857,131	$ (1,135,714)	$ 36,721,417
6c	Medicaid Access to Physician Services (MAPS) Expenses	$ 7,727,837	$ (231,835)	$ 7,496,002
6	**Total Net Medical Expenses**	$ 394,820,062	$ (1,367,549)	$ 393,452,512
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claims adjustment additions	$ 6,380,359	$ 179,024	$ 6,559,383
8	Incurred claims adjustment deductions	$ 1,317,322	$ 139,894	$ 1,457,216
9	Incurred claims adjustment exclusions	$ 4,442,427	$ (679,614)	$ 3,762,813
10	Adjusted Net Medical Expenses	$ 395,440,671	$ (648,805)	$ 394,791,866
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 5,819,684	$ (1,256,284)	$ 4,563,400
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ -	$ -	$ -
13	Adjusted HCQI/HIT Expenses	$ 5,819,684	$ (1,256,284)	$ 4,563,400
14	Other Non-Claims Costs (FOR REPORTING PURPOSES ONLY. NOT INCLUDED IN NUMERATOR.)	$ 41,303,102	$ 39,397	$ 41,342,498
15	Program Integrity Costs (FOR REPORTING PURPOSES ONLY. NOT INCLUDED IN NUMERATOR.)	$ 239,263	$ 27,322	$ 266,585
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 401,260,356	$ (1,905,090)	$ 399,355,266
17	Reporting MLR Percentage	88.9%	-0.1%	88.8%
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	1,111,329	-	1,111,329
22	**MLR Member Months (Annualized)**	1,111,329	-	1,111,329
23	**Credibility Adjustment**	0.0%	0.0%	0.0%
24	**Adjusted Reporting MLR Percentage**	88.9%	-0.1%	88.8%
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 are not included in the numerator of the MLR calculation, however, the amounts were tested for allowability and appropriateness based on state criteria and are therefore, included in the report opinion.*

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

During our examination, we identified the following adjustments.

Adjustment #1 – To adjust capitation revenues per 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, retroactive capitation settlement, and Health Insurer Fee (HIF) payments are included within the total adjustment. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(2).

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)	$1,099,119

Adjustment #2 – To adjust Risk Corridor settlement per state data

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 risk corridor requirements are addressed in the state contract and the Medicaid Managed Care Final Rule 42 CFR §438.8(f)(2)(vi).

This is not a newly identified finding for this examination, however, the health plan utilized the appropriate known amounts at the time of the MLR template submission. We expect the health plan to include any risk corridor amounts in future MLR template submissions, upon request by the Division.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Total YTD Capitation Revenue (A)	($3,340,757)

Adjustment #3 – To adjust allowable Premium Taxes

The health plan appropriately reported premium taxes that agreed to an amount equal to three percent of the total reported premium revenue. However, in correlation with Adjustment #1 and Adjustment #2, this calculation required an adjustment. An adjustment was proposed to recalculate the allowable premium tax based on the adjusted premium revenues. The premium tax and income tax expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

This is not a newly identified finding for this examination, however, the health plan appropriately calculated the premium taxes based on the reported revenue amounts at the time of the MLR template submission. We recommend the plan continue to calculate premium tax based upon the reported revenue amounts.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3	Less: Premium Taxes	$226,548

Adjustment #4 – To remove state income tax per state guidance

The health plan reported state taxes in addition to premium taxes on the MLR. Mississippi tax code requires that insurance companies pay an annual license or privilege tax of three percent (3%) of the gross premiums received, in addition to state income taxes payable on net income. Both tax types are allowed to be reported as a deduction within the MLR's denominator calculation. However, further review of the Mississippi tax code dictates that the premium tax remittance amount shall be reduced by the net income tax paid to the state for the preceding calendar year. Three-percent of gross revenues typically results in the maximum combined accrued premium tax and state income tax liability, which should be recognized as expense for the period under review. Annual variations in the credits applied against the privilege taxes, due to state income tax liability, should be recognized as a deferred tax asset.

As a result, we have recalculated the allowable combined premium tax and state income tax amounts to be three-percent (3%) of the allowable premiums. For reporting purposes, since the health plan has already reported three percent for premium taxes on Line 3, we have removed the state income taxes reported as part of Line 4 of the MLR. The premium tax and income tax expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3) and Mississippi Code § 27-15-109 and § 27-15-103.

This is a newly identified finding for this examination. We recommend the health plan ensure only three percent of gross premiums are reported on the MLR.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Less: Other taxes and other revenue-based assessments	($991,121)

Adjustment #5 – 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	($1,135,714)

Adjustment #6 – To adjust MAPS 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 MAPS 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**
6c	Medicaid Access to Physician Services (MAPS) Expenses	($231,835)

Adjustment #7 – To correct duplicative reported provider incentives

The health plan reported provider incentives within the Net Medicaid Expenses from Income Statement (A) line of the MLR, but also reported this same incentive amount as part of the Incurred Claims Adjustment Additions line, thereby duplicating the amounts. An adjustment was proposed to remove the duplicated provider incentives. The provider incentive 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 the health plan ensure that any additions added are not already reported in Total Net Medical Expenses.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
7	Incurred claims adjustment additions	($65,700)

Adjustment #8 – To correct for a calculation error related to the Avesis certification statement

The health plan attempted to report the third party dental vendor's (Avesis) amounts based on the vendor certification. Based on the testing performed, it was determined that the health plan started with the paid lag amounts and then proposed subsequent adjustments to the template to arrive at the certification statement amount obtained from the vendor. However, a reconciling step during this process was omitted resulting in amounts being inadvertently excluded from the MLR. Therefore, the final reported amounts disagreed with the certification statement per the vendor. An adjustment was proposed to correct the amount reported to reconcile with the vendor certification statement. The third party vendor 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 the health plan ensure the final amounts claimed agree to the certification statements.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
7	Incurred claims adjustment additions	$244,724

Adjustment #9 – To adjust to the CVS certification statement

The health plan reported pharmacy claims related to the third party Pharmacy Benefit Manager (PBM), CVS per the original certification statement. During testing, a revised certification was provided from CVS, which included a slightly lower paid claims amount. An adjustment was proposed to decrease the

paid claims per the new certification statement by increasing the adjustment deduction line. The third party vendor 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 the health plan ensure the final amounts claimed agree to the certification statements for the most recent information available.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
8	Incurred claims adjustment deductions	$42,304

Adjustment #10 – To adjust for incorrect refunds amounts included in the MLR

The health plan reported the paid claim refunds deduction amounts based on the income statement amounts, however they utilized larger refund amounts when adjusting their incurred claim amounts upward to represent the gross incurred claims expense for the MLR period. An adjustment was proposed to remove the remaining actual refund amounts for the period. 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 the health plan ensure the final amounts reported are based on the paid lag tables for the MLR reporting period.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
8	Incurred claims adjustment deductions	$97,590

Adjustment #11 – To adjust for the calculation errors related to transportation vendor

The health plan reported transportation third party vendor expenses related to Southeast Trans based on the income statement amounts and utilized the template adjustment lines to attempt to reconcile to the vendor certification and to reclassify the administrative portion to non-claims. Based on the testing performed, it was noted that the exclusion adjustments were duplicated and therefore, reclassified additional allowable medical expenses to non-claims. An adjustment was performed to reclassify the expense from non-claims back to medical expenses based on the certification statement total. 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 the health plan ensure the final amounts reported are based on the certification statements.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
9	Incurred claims adjustment exclusions	($679,614)
14	Other Non-Claims Costs	($679,614)

Adjustment #12 – 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	($1,256,284)
14	Other Non-Claims Costs	$1,256,284

Adjustment #13 – To add depreciation expense to non-claims amounts

The health plan reported the administrative expenses per the income statement. Based on the testing performed, it was determined accounts related to depreciation were excluded from Other Non-Claims Cost. An adjustment was proposed to include the depreciation as an allowable expense. 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 allowable administrative expenses are reported in non-claims cost or program integrity cost on the template.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	$131,621

Adjustment #14 – To adjust duplicative non-claims costs

The health plan reported amounts for administrative expenses for certain accounts in both the Other Non-Claims Cost line and the Program Integrity Cost line. Based on the testing performed, it was determined the duplicative expenses were related to program integrity, but were not reclassified out of non-claims. An adjustment was proposed to remove the amount from the Other Non-Claims Cost line. 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 the health plan appropriately separate non-claims cost from program integrity cost.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	($97,671)

Adjustment #15 – To remove non-allowable administrative expenses

The health plan reported administrative costs from two different sources in other non-claims costs. During testing, the direct plan costs were sampled as well as corporate costs. Our sampling of various accounts identified accounts containing non-allowable items such as: Advertising, Employee Relations, Lobbyist Dues, Marketing, and Legal. 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	($571,223)

Adjustment #16 – To adjust to Program Integrity costs to supporting documentation

The health plan reported program integrity costs that did not reconcile to the supporting documentation. Based on the testing performed, it was determined that the calculation submitted by the health plan had been revised and included additional amounts to be considered as allowable. An adjustment was proposed to the health plan's supporting documentation. 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 allowable costs related to program integrity are reported.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
15	Program Integrity Costs	$27,322