MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

July 11, 2025

Via Electronic Mail

Mississippi Division of Medicaid
Lisa Shaw, Director of Managed Care
550 High Street, Suite 1000
Jackson, Mississippi 39201

Re: Adjusted Medical Loss Ratio (MSCAN) examination report for Magnolia Health Plan, Inc. for state fiscal year ended June 30, 2023

This letter is to inform you that Myers and Stauffer LC has completed the examination of the Adjusted Medical Loss Ratio (MSCAN) for Magnolia Health Plan, Inc. (health plan) for state fiscal year ended June 30, 2023. As a courtesy to the Mississippi Division of Medicaid (DOM) and other readers, the health plan's management response letter is included, 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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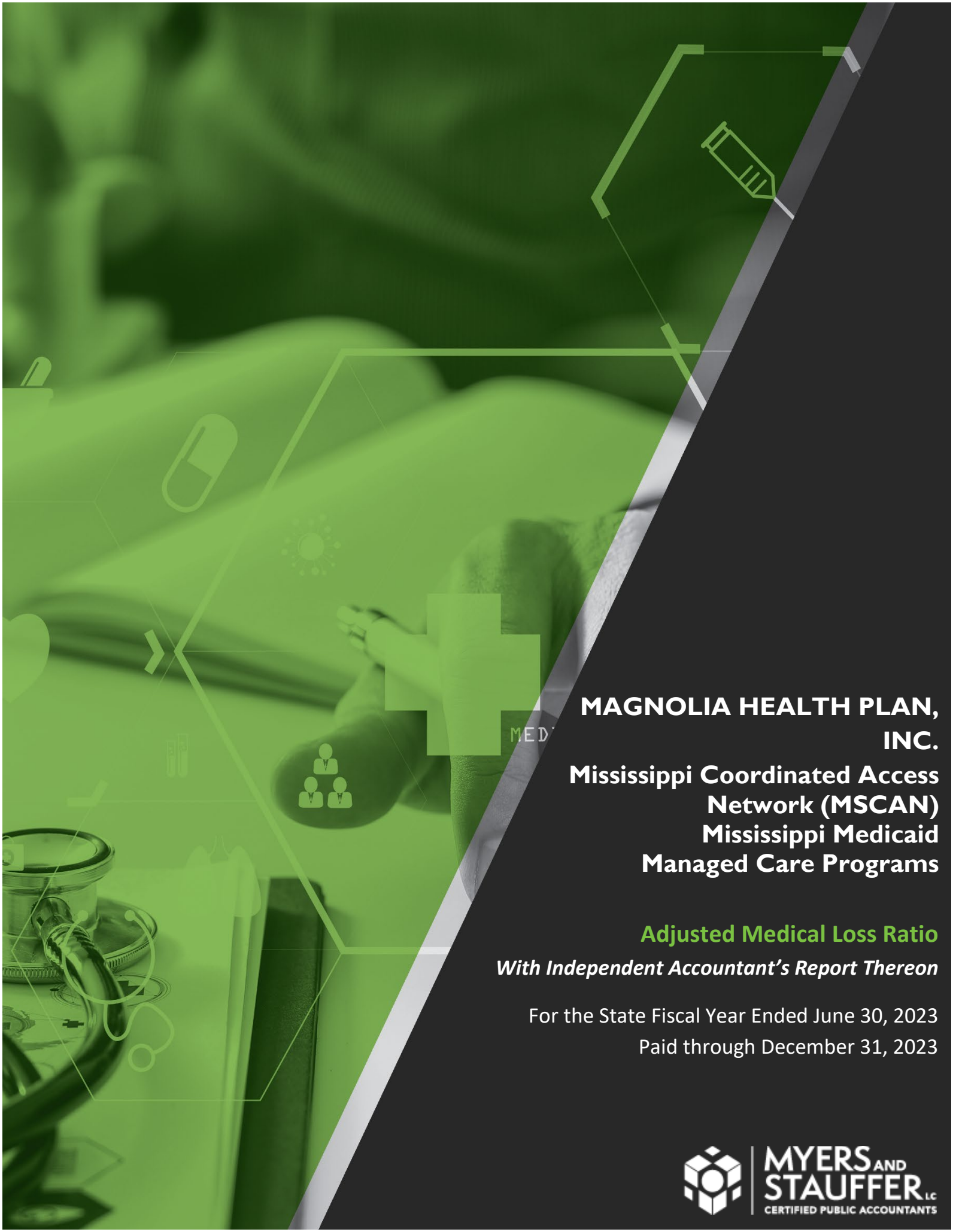

MAGNOLIA HEALTH PLAN, INC.

Mississippi Coordinated Access Network (MSCAN)
Mississippi Medicaid Managed Care Programs

Adjusted Medical Loss Ratio

With Independent Accountant's Report Thereon

For the State Fiscal Year Ended June 30, 2023
Paid through December 31, 2023

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 accompanying Adjusted Medical Loss Ratio of Magnolia Health Plan, Inc. (health plan) for the state fiscal year ended June 30, 2023. The health plan's management is responsible for presenting the Medical Loss Ratio in accordance with the criteria set forth in 42 Code of Federal Regulations (CFR) § 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 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 meets or exceeds the state requirement of 87.5 percent for the state fiscal year ended June 30, 2023.

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
June 27, 2025

Adjusted MSCAN Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023

Adjusted MSCAN Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023				
Line #	**Line Description**	**Reported Amounts**	**Adjustment Amounts**	**Adjusted Amounts**
Capitation Revenue and Tax Assessments				
1	Total YTD Capitation Revenue (A)	$ 1,242,589,792	$ (6,657,825)	$ 1,235,931,967
2	Less: Health Insurer Fee (Amount Due to IRS)	$ -	$ -	$ -
3	Less: Premium and State Income Taxes	$ 37,279,678	$ (201,719)	$ 37,077,959
4	Less: Other taxes and other revenue-based assessments	$ -	$ -	$ -
5	NET Current YTD Adjusted Premium Revenue	$ 1,205,310,114	$ (6,456,106)	$ 1,198,854,008
MLR Medical and Administrative Expenses				
6a	Net Medical Expenses from Income Statement (A)	$ 821,495,292	$ (8,223,916)	$ 813,271,376
6b	Mississippi Hospital Access Program (MHAP) Expenses	$ 259,201,628	$ (278,784)	$ 258,922,844
6c	Medicaid Access to Physician Services (MAPS) Expenses	$ 15,500,084	$ (748,215)	$ 14,751,869
6d	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses	$ 5,908,875	$ -	$ 5,908,875
6	Total Net Medical Expenses	$ 1,102,105,878	$ (9,250,915)	$ 1,092,854,963
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claim adjustment additions	$ 3,217,119	$ 964,252	$ 4,181,371
8	Incurred claim adjustment deductions	$ 4,173,290	$ (58,966)	$ 4,114,324
9	Incurred claim adjustment exclusions	$ 4,283,798	$ (106,273)	$ 4,177,525
10	Adjusted Net Medical Expenses	$ 1,096,865,909	$ (8,121,424)	$ 1,088,744,485
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 16,853,253	$ (4,629,763)	$ 12,223,490
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ -	$ -	$ -
13	Adjusted HCQI/HIT expenses	$ 16,853,253	$ (4,629,763)	$ 12,223,490
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 76,715,544	$ 1,997,632	$ 78,713,176
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 3,629,132	$ (490,046)	$ 3,139,086
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 1,113,719,161	$ (12,751,187)	$ 1,100,967,975
17	Reporting MLR Percentage	92.4%	-0.6%	91.8%
18	MLR percentage requirement for rebate calculation	87.5%		87.5%
19	**Percentage below 87.5% Requirement**	0.0%		0.0%
20	**Dollar Amount of Rebate Requirement**	$ -	$ -	$ -
Credibility Adjustment Applied				
21	MLR Member Months	1,852,475	-	1,852,475
22	**MLR Member Months (Annualized)**	1,852,475	-	1,852,475
23	**Credibility Adjustment**	0.0%	0.0%	0.0%
24	**Adjusted Reporting MLR Percentage**	92.4%	-0.6%	91.8%
25	**MLR Percentage Requirement for Rebate Calculation**	87.5%		87.5%
26	**Percentage below 87.5% Requirement**	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.*

***Totals may vary slightly due to rounding.*

Schedule of Adjustments

During the course of the engagement, we identified the following adjustment(s).

Adjustment #1 – To adjust pharmacy rebate amounts per PBM supporting documentation.

The health plan reported their pharmacy rebate amounts as a deduction on Line 8 of the MLR report template. However, the amount did not reconcile to the amount included within the submitted pharmacy benefit manager (PBM) certification statement. An adjustment was proposed to adjust the reported total to the PBM's certified amount. The pharmacy 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 review the amounts per the PBM to ensure the MLR reporting aligns with the pharmacy rebate amounts reported by the PBM.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
8	Incurred claims adjustment deductions	($58,966)

Adjustment #2 – To adjust incurred claims for the health plan's radiology vendor

The health plan intended to restate the incurred claims amounts to zero for their former radiological services third party provider National Imaging Associates (NIA) for the current reporting period. However, through a series of restatement and exclusion adjustments, the health plan removed more expense than necessary. Adjustments were proposed to reflect zero expense for this vendor based on supporting documentation. The incurred claims and IBNR 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 all reported amounts are appropriately classified based on supporting documentation.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	$7,228
9	Incurred claims adjustment exclusions	($106,273)

Adjustment #3 – To adjust third party expenses per supporting documentation.

The health plan reported services for third party vendor, Medical Transportation Management (MTM) based on a capitated 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. The health plan made a partial adjustment to remove the administrative components of the capitated amount from incurred claims, but the health plan's analysis did not consider amounts included within one of their restatement adjustments for this vendor, nor the amounts paid to out-of-state providers and reported in a different general ledger account. An adjustment was proposed to reclassify these additional amounts to non-claims costs since the vendor certification statement received indicated that it was inclusive of these amounts. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2), Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

The inclusion of the administrative components of the capitated vendor payment amount is a repeat finding for this examination. However, this year's adjustment appears to be the result of the health plan not identifying additional amounts included within other MLR accounts. We recommend the health plan ensure all reported amounts are appropriately classified based on supporting documentation.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	($1,071,500)
14	Other Non-Claims Costs	$1,071,500

Adjustment #4 – To adjust provider incentive expense to health plan supporting documentation.

The health plan reclassified a portion of their value based incentive payments to non-claims expense. During the examination it was determined that a portion of these payments paid to external party, Aledade Accountable Care 73 LLC, would qualify as provider incentive payments within the MLR numerator of the MLR calculation based upon a review of Exhibit C of the health plan's SFY 2023 contract with the Mississippi Division of Medicaid and the Medicaid final rule regulations effective for this reporting period. An adjustment was made to increase provider incentives based on the payment amounts, with an offsetting decreasing adjustment from non-claims costs included within the adjustment determination for non-claims detailed in Adjustment #12. However, it should be noted that these incentive amounts will not qualify in subsequent MLR reporting periods due to revisions to the health plan's SFY 2024 contract with the Mississippi Division of Medicaid, which specifically excludes any incentive payments not tied to quality. These contract revisions now align with the most recent Medicaid final rule regulations. The provider incentive reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2); 45 CFR § 158.140(b)(2)(iii).

This is a newly identified finding for this examination. We recommend the health plan ensure all reported amounts are appropriately classified based on supporting documentation.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
7	Incurred claims adjustment additions	$964,252

Adjustment #5 – To reclassify unsupported and non-qualifying Healthcare Quality Improvement (HCQI) and HIT expenses.

The health plan reported HCQI and health information technology (HIT) expenses based on salaries and benefits, vendor costs, and 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, benefits, vendor costs, and overhead. The HCQI/ HIT reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150(a), (b), and (c).

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

Proposed Adjustment		
Line #	**Line Description**	**Amount**
11	HCQI and HIT Administrative Expenses	($4,629,763)
14	Other Non-Claims Costs	$4,629,763

Adjustment #6 – To remove recovery restatement adjustment amount

The health plan included a restatement adjustment for claim recovery amounts received through lockbox activities that could not be assigned to specific claims. The intention of this adjustment was to allocate these received amounts across numerous estimated incurred dates, including periods prior to the MLR reporting period. As part of this analysis, Magnolia included recoveries received during the state fiscal year, as well as through the additional runout period of December 31, 2023. However, this allocation methodology will result in the underreporting of recovery amounts received subsequent to December 31st runout; which may be applicable to the current and prior MLR reporting periods. As a result, the health plan is continuously understating the final recovery amounts and these amounts are likely never captured within a future reporting period. An adjustment was proposed to decrease incurred claims per health plan supporting documentation to remove the restatement adjustment captured in the updated paid lag table. The incurred claims and IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

This is a repeat finding for this examination. We recommend that the health plan work to identify the best known information related to incurred claims at the time of filing and recommend that the health plan report the recovery amounts based upon either the estimated anticipated recoveries for the service date period and any changes to this reserve account balance or the receipt dates of recoveries received during the state fiscal year period to ensure that all recovery amounts are reported.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	($1,948,634)

Adjustment #7 – To adjust revenues per state 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 state data for capitation and withhold payments earned.

Additionally, a risk corridor was contractually in effect for the MLR reporting period. The final risk corridor calculation occurred subsequent to the filing of the MSCAN MLR Rebate Calculation. All applicable MLR examination adjustments are reflected within the final risk corridor calculation. An adjustment was proposed to report revenues based on the final risk corridor calculation per state data.

The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MLR based on the template instructions.

This is a repeat adjustment identified for this examination; however, it is based on adjustments to premium revenues per state data, which may not be known to the health plan at the time of filing. We recommend the health plan utilize the best information available at the time of filing.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Total YTD Capitation Revenue (A)	($5,665,191)

Adjustment #8 – To adjust reinsurance amounts reported

The health plan reported reinsurance expense as a reduction to premium revenues. The health plan's contract does not mandate reinsurance; therefore, reinsurance expense should not be claimed. An adjustment was proposed to remove the reduction to premium revenues and to reclassify these amounts as Non-Claims administrative expenses. The revenue reporting requirements are addressed in Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2).

This is a newly identified finding for this examination. We recommend the health plan ensure all reported revenue amounts are appropriately reported based on codified regulations.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Total YTD Capitation Revenue (A)	$66,128
14	Other Non-Claims Costs	$66,128

Adjustment #9 – To adjust premium revenues and incurred claims to incorporate state directed payment programs

The health plan reported state directed payments in the numerator and the denominator for the MLR reporting period. It was determined that both directed expenses and revenues were understated based on comparison to state data for the Mississippi Hospital Access Program (MHAP) Amount Received and Medicaid Access to Physician Services (MAPS) Expenses. An adjustment was proposed to decrease the state directed payment revenues and associated expense per state data. The state directed payment reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR §§ 438.8(e)(2), 438.8(f)(2), and 438.6(c). The health plan completed the MSCAN MLR Rebate Calculation based on the template instructions.

This is a repeat adjustment identified for this examination; however, it is based on adjustments to premium revenues per state data, which may not be known to the health plan at the time of filing. We recommend the health plan utilize the best information available at the time of filing.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Total YTD Capitation Revenue (A)	($1,058,762)
6b	Mississippi Hospital Access Program (MHAP) Expenses	($278,784)
6c	Medicaid Access to Physician Services (MAPS) Expenses	($748,215)

Adjustment #10 – To adjust premium taxes to reflect adjustments to revenue amounts.

The health plan reported premium taxes that reconciled to the original supporting documentation. However, after determining that an incorrect amount of revenues were reported per state data, changes were applied to the premium tax calculation to recalculate based on adjusted premium revenues, including changes to capitation payments, settlement impacts related to the MYPAC/SED capitation payments and the risk corridor calculation adjustments. An adjustment was proposed to decrease taxes to the appropriate amounts per the recalculation. The tax reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(3).

This is a repeat adjustment identified for this examination; however, it is based on adjustments to premium revenues per state data, which may not be known to the health plan at the time of filing. We recommend that the health plan utilize the best information available at the time of filing.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
3	Less: Premium and State Income Taxes	($201,719)

Adjustment #11 – To adjust incurred claims per health plan supporting documentation

The health plan reported incurred claims expenses based on the specified report completion runout period, estimated incurred but not reported (IBNR) claims, provider refunds, provider settlement payments, restated coordination of benefits, restated estimated claim projects not yet adjudicated, restated claims held in statistical suspense not yet adjudicated, estimated Marketplace third party liability settlements, and provider negative balance transactions not yet re-adjudicated as of December 31, 2023 for the medical loss ratio (MLR) reporting period. As part of our procedures to test the reasonableness and accuracy of the amounts reported on the MLR, a comparison was performed between paid lag tables with additional runout through September 2024, plus the IBNR totals as of September 2024 to the MLR reported totals. This analysis indicated that the initial estimates reported for incurred claims was overstated. These material overstatements were the result of additional claim recoveries, a reduction to estimated claim liabilities, adjudication of the claim projects, adjudication of the claims previously held in statistical suspense, and the re-adjudication of the provider negative balance transactions as of the additional runout period. Since the health plan did not make accurate estimated accruals or establish reserves to account for all anticipated changes impacting the SFY 2023 claims amounts, an adjustment was proposed to decrease incurred claims per health plan supporting documentation to reflect the most current and accurate information available at the time of this examination. The incurred claims and IBNR reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2).

This is a repeat finding for this examination. While the exact data utilized to make the adjustment was not available to the health plan at the time of filing, the health plan did not utilize an appropriate estimate for these changes. We recommend the health plan utilize the best information available at the time of filing, including the use of estimates for future anticipated recoveries.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6a	Net Medical Expenses from Income Statement (A)	($5,211,010)

Adjustment #12 – To remove unsupported administrative costs.

The health plan reported administrative costs for vendor payments made in excess of the reported incurred claims, allowable incentive payments, and actual related party costs. During testing, the direct plan costs were reconciled to supporting documentation which identified unsupported costs from four sources: value based care providers (inclusive of a portion of the Aledade payments reclassified to incentive payments in Adjustment #4), MTM transportation, and the health plan's related party dental and vision vendors. An adjustment was proposed to remove the unsupported expenses per submitted 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 the health plan ensure all reported amounts are appropriately classified and reported at the appropriate amounts based on supporting documentation.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	($3,633,310)

Adjustment #13 – To remove non-allowable marketing expenses.

The health plan reported administrative costs from three different entity sources in other non-claims costs consisting of the health plan's direct expenses, their legal entity's expenses, and corporate company allocations. Our sampling of various accounts identified accounts containing non-allowable items such as: alcoholic beverages, marketing expenses, and lobbying expenses. An adjustment was proposed to remove the non-allowable 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 repeat finding identified 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	($136,449)

Adjustment #14 – To adjust program integrity costs based on supporting documentation.

The health plan reported program integrity costs that were not supported by the health plan's general ledger transactions or reconciling adjustments. Review of the documentation submitted

indicated that these reported program integrity costs were unsupported within the MLR template. Therefore, an adjustment was proposed to remove the unsupported portion. 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 repeat finding identified for this examination. We recommend that the health plan ensure that all reported expenses are reviewed accuracy within the MLR template lines.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
15	Program Integrity Costs	($490,046)

Health Plan Responses

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

June 27, 2025

A. Keith Heartsill, CPA, FHFMA
Healthcare Financial Consultant
Office of the Governor, Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

Mr. Heartsill:

Magnolia Health Plan (Magnolia) provides the following management response in connection with the Division of Medicaid's (DOM) examination of Magnolia's medical loss ratio (MLR) report for the period ending June 30th, 2023.

Adjustment 3: To adjust third party expenses per supporting documentation

We disagree that this is a repeat finding. The vendor included out-of-state providers in their vendor certification adjustments for SFY 2023 which was a new finding. For SFY 2024 and beyond, we will remove these expenses from Net Medical Expenses and into Other Non-Claims Costs.

Adjustment 5: To reclassify unsupported and non-qualifying Healthcare Quality Improvement (HCQI) and HIT expenses

Magnolia does not dispute this adjustment. However, while we understand there have been previous adjustments to HCQI costs, Magnolia would disagree that this is a repeat finding. Magnolia has consistently updated their processes to remove any previously identified disallowances of HCQI costs. This adjustment included newly identified items within HCQI. Further the final SFY 2022 report was issued after the SFY 2023 MLR was submitted, not allowing for adjustments based on the previous year's audit. Magnolia has made process improvements to surveys for calendar year 2024 and beyond through additional education of the 4-part test, collaboration with department leaders on the QIA activities and what Magnolia believes would be allowable costs under the guidance.

Adjustment 6: To remove recovery restatement adjustment amount

We disagree that this is a repeat finding. The final SFY 2022 report was issued after SFY 2023 MLR was submitted. We do not disagree with their finding; however, the calculation only supports an adjustment of ($871,163) as outlined in our audit support supplied to M&S on 2/19/25. For SFY

2024, we have adjusted our process to remove all recovery restatements in accordance with M&S recommendations.

Adjustment 7: To adjust revenues per state data

As stated, we completed the MLR based on template instructions and reflected payments known at the time. We disagree this is a repeat finding.

Adjustment 9: To adjust premium revenues and incurred claims to incorporate state directed payment programs

As stated, we completed the MLR based on template instructions and reflected payments known at the time. We disagree this is a repeat finding.

Adjustment 10: To adjust premium taxes to reflect adjustments to revenue amounts

As stated, we completed the MLR based on template instructions and reflected payments known at the time. We disagree this is a repeat finding.

Adjustment 11: To adjust incurred claims per health plan supporting documentation

Magnolia disputes this finding.

M&S has proposed to extend the run-out period for the MLR report to September 30, 2024. This is in direct conflict with the clear and unambiguous language of Exhibit C of Magnolia's contract with DOM, which provides "A run-out period of 180 days is required for the final annual MLR report." It is also in conflict with the reporting instructions issued by DOM which instruct Magnolia to use a 180 day run-out.

Magnolia disputes M&S's application of an arbitrarily extended run-out period that is inconsistent with the DOM's contract and MLR reporting instructions. We also note that M&S's proposed extension of the run-out period ignores the long-established course of dealing between Magnolia and DOM in that all MLR reporting and settlements prior to SFY 2022 have used a 180 day run-out.

M&S has suggested that 42 C.F.R. § 438.8(m) provides the authority to retroactively extend the run-out period under Magnolia's contract with DOM. Magnolia disagrees with M&S's interpretation Section 438.8(m) which provides:

> Recalculation of MLR. In any instance ***where a State makes a retroactive change to the capitation payments for a MLR reporting year*** where the report has already been submitted to the State, the MCO, PIHP, or PAHP must re-calculate the MLR for all MLR reporting years affected by the change and submit a new report meeting the requirements in paragraph (k) of this section.

M&S has completely ignored the relevant language of the statute which provides that MLR should only be recalculated where a State makes a retroactive change to capitation payments for a MLR reporting year. M&S's proposed adjustments are effectively recalculating Magnolia's MLR report.

Magnolia notes that CMS has issued guidance regarding recalculating MLR reports via the CMCS Informational Bulletin (Bulletin) dated June 5, 2020, which provided FAQ's and answers related to MLR reporting.

The Bulletin provides at A.8, "If, and only if, the capitation payments are changed retroactively, the plan will need to recalculate the MLR. Additionally, the bulletin provides:

> **Q10. When should plans recalculate the MLR?**
>
> **A10.** Generally, plans should calculate and report the MLR after the conclusion of the MLR reporting year and **recalculation is not necessary or permitted if the MLR is calculated correctly** using the rules in 42 CFR 438.8. However, under 42 CFR 438.8(m), plans must recalculate the MLR for all MLR reporting years affected where a state makes a permissible retroactive change to capitation payments. If such an adjustment is made, managed care plans must timely submit a new MLR report to the state once the recalculation of the MLR is complete. States should then provide CMS with a revised MLR summary report.
>
> **Managed care plans are only permitted to recalculate the MLR when the state makes a retroactive change to the capitation payments used in the MLR calculation.**

Again, M&S's proposed adjustment completely ignores explicit CMS instructions that recalculation of reported MLR is not necessary or permitted if the MLR is calculated correctly and should only be done when a State makes a permissible retroactive change to capitation payments which requires recalculation and resubmission to CMS.

Further, Magnolia would strongly disagree that this item is a repeat finding. Magnolia utilized the best estimates available at the time the run out period was completed. The MLR report matched the financial statements for Magnolia as instructed by the template.

Adjustment 13: To remove non-allowable marketing expenses

We disagree that this is a repeat finding. The final SFY 2022 report was issued after the SFY 2023 MLR was submitted. Furthermore, per the Corrective Action Plan dated December 3, 2024, for SFY24 and beyond, Magnolia has and will continue to remove certain administrative accounts identified by Myers and Stauffer that were non-allowable. Magnolia will also conduct a sample from various expense reports and other miscellaneous accounts in an attempt to identify any potential non-allowable costs. While Magnolia believes that these steps will exclude the large majority of any non-allowable non-claim costs, it is possible that some individual line items may subsequently be determined to be non-allowable. However, we believe these amounts to be immaterial.

Adjustment 14: To adjust program integrity costs based on supporting documentation

We disagree that this is a repeat finding. In prior years, the finding indicated the reported program integrity costs were duplicated within the MLR template, however in SFY2023, the finding was not related to the same issue. Per the corrective action plan dated December 3, 2024, beginning with the SFY 2024 MLR filing, Magnolia will reconcile the payment integrity costs to the vendor exclusion fees to ensure there is a 1 to 1 match in those costs which will exclude any additional costs from Non-Claims costs.

Magnolia appreciates the DOM and M&S's review and consideration of the above issues. Please let us know if we can provide additional information or support.

Sincerely,

Trip Peeples
Health Plan CFO
Magnolia Health Plan