

August 29, 2024

Via Electronic Mail

Mississippi Division of Medicaid Jennifer Wentworth, Deputy Administrator | Administration 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, 2022

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, 2022. 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.

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Kind Regards,

Myers and Stauffer LC





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State of Mississippi Division of Medicaid Jackson, Mississippi

Independent Accountant's Report

We have examined the Adjusted Medical Loss Ratio of Magnolia Health Plan, Inc. (health plan) for the state fiscal year ended June 30, 2022. The health plan's management is responsible for presenting information contained in the Medical Loss Ratio Report for MississippiCAN, which was reported to the Division of Medicaid, in accordance with 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 Report for MississippiCAN 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 minimum requirement of 87.5 percent for the state fiscal year ended June 30, 2022.

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 Atlanta, Georgia July 23, 2024

MYERS AND STAUFFER LC

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Adjusted MSCAN Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through December 31, 2022

	Adjusted MSCAN Medical Loss Ratio for the State Fiscal Year Ended June 30, 2022 Paid Through December 31, 2022						
Line #	Line Description	R	eported Amounts	Ac	djustment Amounts	,	Adjusted Amounts
Capitation	Revenue and Tax Assessments						
1	Total YTD Capitation Revenue (A)	\$	1,209,814,307	\$	(6,771,050)	\$	1,203,043,257
2	Less: Health Insurer Fee (Amount Due to IRS)	\$	-	\$	-	\$	-
3	Less: Premium and State Income Taxes	\$	36,294,429	\$	(203,131)	\$	36,091,298
4	Less: Other taxes and other revenue-based assessments	\$	-	\$	-	\$	-
5	NET Current YTD Adjusted Premium Revenue	\$	1,173,519,878	\$	(6,567,919)	\$	1,166,951,959
MLR Medi	cal and Administrative Expenses						
6a	Net Medical Expenses from Income Statement (A)	\$	823,513,023	\$	(8,830,357)	\$	814,682,666
6b	Mississippi Hospital Access Program (MHAP) Expenses	\$	230,175,436	\$	-	\$	230,175,436
6с	Medicaid Access to Physician Services (MAPS) Expenses	\$	14,227,157	\$	1,116,307	\$	15,343,464
6d	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses	\$	-	\$	-	\$	-
6	Total Net Medical Expenses	\$	1,067,915,616	\$	(7,714,050)	\$	1,060,201,566
	MLR Expense Adjustments as defined in Exhibit C						
7	Incurred claim adjustment additions	\$	7,127,424	\$	-	\$	7,127,424
8	Incurred claim adjustment deductions	\$	5,187,283	\$	-	\$	5,187,283
9	Incurred claim adjustment exclusions	\$	7,486,184	\$	-	\$	7,486,184
10	Adjusted Net Medical Expenses	\$	1,062,369,573	\$	(7,714,050)	\$	1,054,655,523
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses						
11	HCQI and HIT Administrative Expenses from Income Statement	\$	21,404,380	\$	(8,657,941)	\$	12,746,439
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	\$	(14,007)	\$	-	\$	(14,007)
13	Adjusted HCQI/HIT expenses	\$	21,418,387	\$	(8,657,941)	\$	12,760,446
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$	66,343,812	\$	(3,430,126)	\$	62,913,686
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$	4,575,768	\$	-	\$	4,575,768
16	Total Adjusted Current YTD MLR Medical Expenditures	\$	1,083,787,960	\$	(16,371,991)	\$	1,067,415,969
17	Reporting MLR Percentage		92.4%		-0.9%		91.5%
18	MLR percentage requirement for rebate calculation		87.5%				87.5%
19	Percentage below 85% Requirement		0.0%	ļ.,			0.0%
20	Dollar Amount of Rebate Requirement	\$	-	\$	-	\$	-
	Adjustment Applied						
21	MLR Member Months		2,019,452	_	-		2,019,452
22	MLR Member Months (Annualized)		2,019,452	_	-		2,019,452
23	Credibility Adjustment		0.0%	_	0.0%		0.0%
24	Adjusted Reporting MLR Percentage		92.4%		-0.9%		91.5%
25	MLR Percentage Requirement for Rebate Calculation		87.5%				87.5%
26	Percentage below 85% 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.

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Schedule of Adjustments and Comments for the State Fiscal Year Ended June 30, 2022

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 expenses based on the specified report completion runout period, estimated incurred but not reported (IBNR) claims, restated estimated claim projects not yet adjudicated, restated claims held in statistical suspense not yet adjudicated, and provider negative balance transactions not yet re-adjudicated as of December 31, 2022 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 November 2023, plus the IBNR totals as of November 2023 to the MLR reported totals. This analysis indicated that the initial estimates reported for IBNR claims, restated estimated claim projects not yet adjudicated, restated claims held in statistical suspense not yet adjudicated, and provider negative balance transactions not yet re-adjudicated reported within total incurred claims were 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 2022 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 newly identified finding for this examination; however, it is based on data that was not available to the health plan at the time of filing. 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#	ne # Line Description Amount			
6a	Net Medical Expenses from Income Statement (A)	(\$6,469,946)		

Adjustment #2 - 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 payments. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). 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 # Line Description Amount			
1	Total YTD Capitation Revenue (A)	\$268,556		

Adjustment #3 – 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 Medicaid Access to Physician Services (MAPS) Expenses. An adjustment was proposed to increase the state directed payments 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)	\$1,150,832	
6c	Medicaid Access to Physician Services (MAPS) Expenses	\$1,116,307	

Adjustment #4 – To adjust risk corridor settlements per state data

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).



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 report the best estimate at the time of filing.

Proposed Adjustment				
Line#	Line # Line Description Amount			
1	Total YTD Capitation Revenue (A)	(\$11,091,239)		

Adjustment #5 - To adjust premium taxes per recalculation to adjusted premium revenue

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 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) and Centers for Medicare & Medicaid Services Medical Loss Ratio Annual Reporting Form Filing 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 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 and State Income Taxes	(\$203,131)		

Adjustment #6 – To adjust premium revenues to incorporate the state approved MYPAC/SED capitation payment settlement for SFY 2022

The Division of Medicaid approved a calculated settlement after determining that an underpayment existed for members who were not paid in the MYPAC/SED rate cell at the time of the capitation payment. An adjustment was proposed to increase premium revenues to include the settlement amounts related to SFY 2022. The revenue reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(f)(2). The health plan completed the MSCAN MLR Rebate Calculation based on the template instructions.

This is a newly identified finding 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 report the best estimate at the time of filing.

Proposed Adjustment				
Line # Line Description Amount				
1	Total YTD Capitation Revenue (A)	\$2,900,801		

Adjustment #7 - To reclassify costs claimed as provider care coordination expenses

The health plan reported provider care coordination expenses within incurred claims as other medical expenses. It was determined, based on comments from the health plan, these payments were related to care coordination services. The health plan pays a PMPM payment to providers for performing care coordination services and are not based on clinical or quality metrics, therefore, the amounts did not qualify as provider incentive payments or other medical expenses to be included as incurred claims. Subsequently, the health plan obtained actual cost details from the provider related to these services, and a portion of the amounts are supported as healthcare quality improvement (HCQI) expenses. The portion that was supported was reclassified to HCQI with the remainder being reclassified to Other Non-Claims Costs. An adjustment was proposed to reclassify these expenses from incurred claims. The incurred claims reporting and HCQI/HIT requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and 45 CFR § 158.150(b) and (c).

This is a newly identified finding for this examination as the guidance from prior year has changed. We recommend that the health plan thoroughly review the new codified guidance to ensure the amounts claimed meet the definitions of HCQI and are supported as such.

	Proposed Adjustment				
Line#	Line Description	Amount			
6a	Net Medical Expenses from Income Statement (A)	(\$240,000)			
11	HCQI and HIT Administrative Expenses from Income Statement	\$138,057			
14	Other Non-Claims Costs	\$101,943			

Adjustment #8 – 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, 2022. 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 newly identified 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)	(\$1,434,812)		

Adjustment #9 – To remove pharmacy rebate amounts

The health plan reported their pharmacy rebate amounts as a deduction on Line 8 of the MLR report template. However, the health plan through two other reconciliation adjustments added these rebate amounts to their incurred claims amounts reported on Line 6a, thereby resulting in the health plan reporting a positive medical expense amount in Line 6a. The net impact resulted in the non-removal of these rebate amounts from the total reported medical expenses. 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 as this appears to have been a reporting error by the health plan. We recommend that the health plan thoroughly review all adjustments and ensure that they reduce incurred clams by the pharmacy rebate amounts.

Proposed Adjustment			
Line #	Line Description	Amount	
6a	Net Medical Expenses from Income Statement (A)	(\$69,840)	

Adjustment #10 – To reclassify non-qualifying HCQI/HIT expense

The health plan reported healthcare quality improvement (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 remove 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(b) and (c).

This is a newly identified finding for this examination as the guidance from prior year has changed. We recommend that the health plan thoroughly review the new codified 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	(\$8,795,998)		
14	Other Non-Claims Costs	\$8,795,998		

Adjustment #11 – 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 sampled. Our sampling of various accounts identified accounts containing non-allowable items such as: alcoholic beverages, donations, entertainment, fines, legal settlements, and lobbying expenses. However, the majority of the nonallowable expense was associated with the write-off of a previously anticipated settlement amount with the Division concerning the Health Insurers Fee from prior years. 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 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	(\$11,036,620)		

Adjustment #12 - 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. Review of the documentation submitted indicated that these reported program integrity costs were duplicated within the MLR template and reported as non-claims cost. Therefore, an adjustment was proposed to remove the duplicated portion from the non-claims cost. 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 during the state fiscal year 2021 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	(\$1,291,447)		

Adjustment #13-To remove self-reported expense incurred as a result of members with overlapping Medicaid and Marketplace coverage

The health plan self-reported a third party liability (TPL) processing issue identified during the final quarter of 2023 that impacted members dually enrolled in Centene's Medicaid plan (Magnolia Health Plan) and their Marketplace plan (Ambetter from Magnolia Health). Specifically, their TPL process was not properly configured to trigger the Coordination of Benefits process when their members had overlapping Centene benefit coverage and providers submitted claims to the Medicaid plan. As such these claims were never processed with Ambetter as the primary payor and Medicaid plan as the secondary payor, resulting in overstated incurred claims amounts in the MLR. Magnolia Health is in the process of reprocessing these claims properly, but has provided an estimated overpayment amount for the SFY 2022 incurred claims impacted. An adjustment was proposed to reduce incurred claims by these estimated overpayment totals. The incurred claims 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 properly process all member insurance coverages and report only allowable Medicaid incurred claims.

Proposed Adjustment				
Line#	Line Description	Amount		
6a	Net Medical Expenses from Income Statement (A)	(\$615,759)		



Appendix A: Health Plan Responses

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



1020 Highland Colony Parkway Suite 502 Ridgeland, MS 39157

April 25, 2024

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, 2022. Magnolia notes that as of April 25th, 2024, a final draft MLR report has not been issued by DOM's auditor Myers & Stauffer (M&S).

However, because we understand DOM intends to rely on the M&S MLR audit report as the basis to deduct amounts from Magnolia's May 2024 capitation payment for the MississippiCAN risk corridor for SFY 2022, we are providing this response based on previously issued draft proposed adjustments and comments previously received directly from M&S.

Adjustment101: To adjust incurred claims to paid lag tables and outstanding reserve amounts as of 11/30/23.

MLR Line 6a: (\$6,469,946)

M&S has proposed to extend the run-out period for the MLR report to November 30, 2023. 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 prior MLR reporting, and settlements 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 <u>where a State makes a retroactive change</u> <u>to the capitation payments for a MLR reporting year</u> 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.

Adjustment 108: Removal of additional vendor recovery restatement amount as this methodology would result in the health plan under reporting recoveries year after year. MLR Line 6a: (\$1,434,812)

The move to report vendor recoveries on a reported basis versus a restated basis is resulting in duplication of vendor recoveries that were captured and reduced medical costs in the previous year. For the SFY 21 report, it would have included run-out to include July 2021 – December 2021. These months would have been restated to January 2020. By moving the vendor recoveries to a reported basis Myers and Stauffer (M&S) is capturing the recoveries for January

2020 – June 2020 that were not captured in the SFY 21 MLR report. However, they are also capturing \$989,194.84 in recoveries that were already captured in the SFY 21 MLR report. This duplication is causing an overstatement in this adjustment of \$989,194.84. See workpaper 1710.08 2022 recoveries.

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

