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 (CHIP) examination report for Molina Healthcare of Mississippi, 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 (CHIP) for Molina Healthcare of Mississippi, Inc. (health plan) for state fiscal year ended June 30, 2023.

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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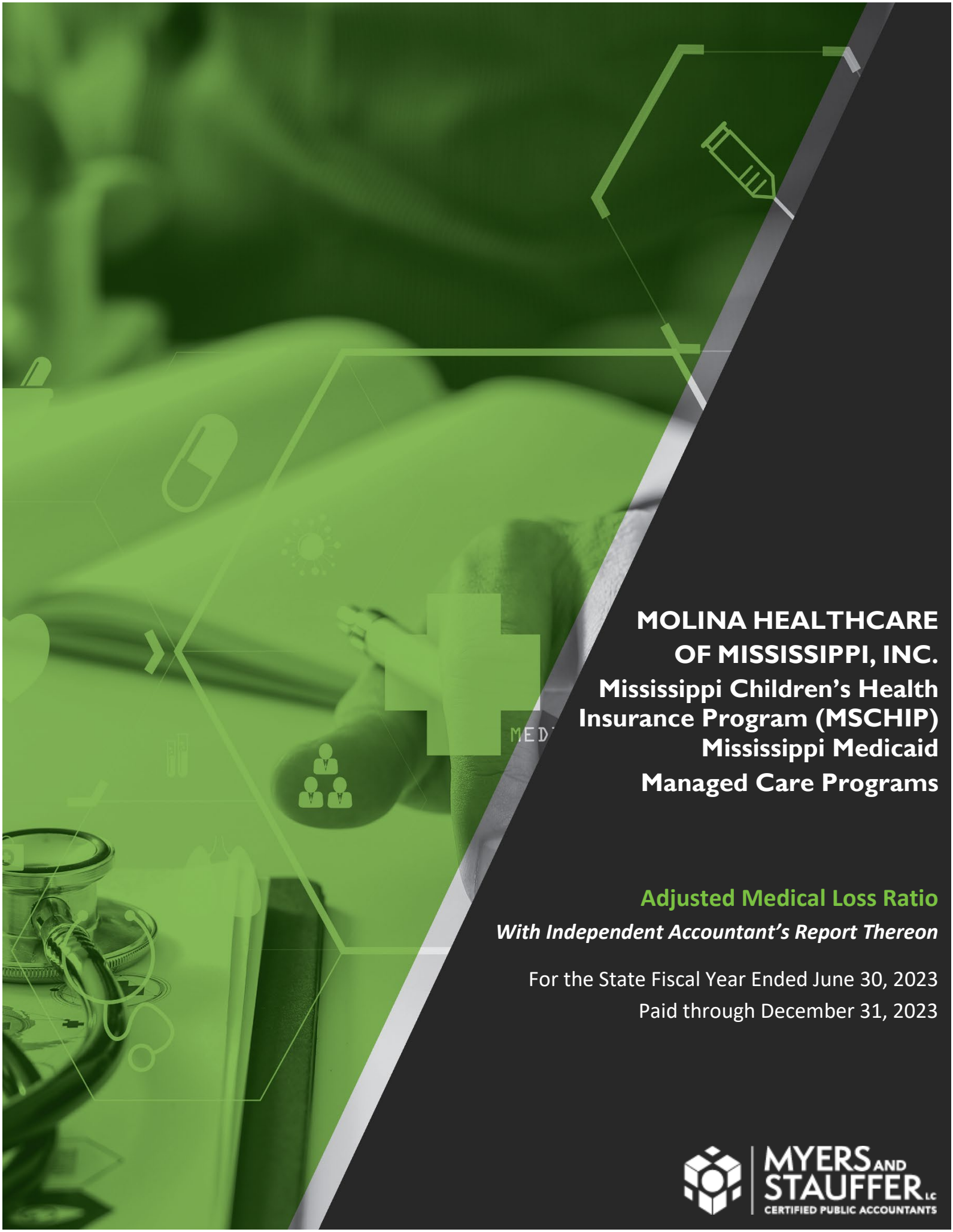

MOLINA HEALTHCARE OF MISSISSIPPI, INC.

Mississippi Children's Health Insurance Program (MSCHIP)
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 Molina Healthcare of Mississippi, 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 reporting guidance (criteria). The 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 Centers for Medicare & Medicaid Services (CMS) and state requirement of 85 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
July 7, 2025

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

Adjusted MSCHIP 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)	$ 45,135,874	$ (250,838)	$ 44,885,036
2	Less: Health Insurer Fee (Amount Due to IRS)	$ -	$ -	$ -
3	Less: Premium and State Income Taxes	$ 1,354,076	$ (7,524)	$ 1,346,552
4	Less: Other taxes and other revenue-based assessments	$ (140,105)	$ (18,197)	$ (158,302)
5	NET Current YTD Adjusted Premium Revenue	$ 43,921,903	$ (225,117)	$ 43,696,786
MLR Medical and Administrative Expenses				
6	Total Net Medical Expenses	$ 39,774,355	$ (127,404)	$ 39,646,951
	MLR Expense Adjustments as defined in Exhibit D			
7	Incurred claim adjustment additions	$ 167,333	$ (19,225)	$ 148,108
8	Incurred claim adjustment deductions	$ 348,871	$ -	$ 348,871
9	Incurred claim adjustment exclusions	$ -	$ -	$ -
10	Adjusted Net Medical Expenses	$ 39,592,817	$ (146,629)	$ 39,446,188
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 241,953	$ 203,481	$ 445,434
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ -	$ -	$ -
13	Adjusted HCQI/HIT expenses	$ 241,953	$ 203,481	$ 445,434
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 3,284,286	$ 847,661	$ 4,131,947
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 35,973	$ (7,161)	$ 28,812
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 39,834,770	$ 56,852	$ 39,891,622
17	Reporting MLR Percentage	90.7%	0.6%	91.3%
18	MLR percentage requirement for rebate calculation	85.0%		85.0%
19	**Percentage below 85% Requirement**	0.0%		0.0%
20	**Dollar Amount of Rebate Requirement**	$ -	$ -	$ -
Credibility Adjustment Applied				
21	MLR Member Months	174,365	196	174,561
22	**MLR Member Months (Annualized)**	174,365	196	174,561
23	**Credibility Adjustment**	1.6%	0.0%	1.6%
24	**Adjusted Reporting MLR Percentage**	92.3%	0.6%	92.9%
25	**MLR Percentage Requirement for Rebate Calculation**	85.0%		85.0%
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.*

***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 provider incentives based on supporting documentation

The health plan reported provider incentive payments for the MLR reporting period. It was determined the health plan amounts reported were overstated. An adjustment was proposed to decrease provider incentive payments per health plan supporting documentation. 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 review the provider incentive detail to ensure accurate accrual estimates owed to providers are reported.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
7	Incurred Claims Adjustment Additions	($26,386)

Adjustment #2 – To add Non-Claims Costs resulting from the health plan's Healthcare Quality Improvement (HCQI) reduction adjustment

The health plan reported an estimated reduction to their SFY 2023 HCQI costs based on the final SFY 2022 examination findings. However, they did not report the offsetting adjustment to non-claims costs. An adjustment was proposed to add the reduction of HCQI costs to non-claims costs. The HCQI reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(3) and 45 CFR § 158.150.

This is a newly identified finding for this examination. We recommend the health plan thoroughly review the amounts reported to ensure the proper amounts are reported on each template line.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
14	Other Non-Claims Costs	$710,442

Adjustment #3 – To reclassify HCQI expenses

The health plan reported HCQI and health information technology (HIT) expenses based on salaries and benefits, vendor costs, and overhead costs. Additionally, the health plan made an estimated adjustment to their HQCI costs based on the SFY 2022 examination results. Our procedures determined the health

plan's adjustment for non-qualifying HCQI expenses based on federal guidance was overstated. An adjustment was proposed to reclassify qualifying salaries, benefits, and vendor costs from the non-claims costs added in Adjustment #2. 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. We recommend the health plan thoroughly review their HCQI expenditures and any adjustment estimates.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
11	HCQI and HIT Administrative Expenses	$203,481
14	Other Non-Claims Costs	($203,481)

Adjustment #4 – To adjust claims refunds per supporting documentation

The health plan represented that general ledger accounts 56440, Inpatient Refund – Non-Lag and 56140, Specialty Refunds – Non-Lag are not captured within the claim lag table amounts reported. An adjustment is proposed to include these amounts in the incurred claims total. 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 the health plan thoroughly review the as-filed amounts reported to ensure that all required transactions are reported.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6	Net Medical Expenses from Income Statement (A)	($820)

Adjustment #5 – 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. This adjustment is also inclusive of the anticipated recoupment for premium tax credits taken by the plan for investments made.

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 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 report the best estimate at the time of filing.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
1	Total YTD Capitation Revenue (A)	($250,838)

Adjustment #6 – To adjust the CHIP Member Months to agree with State's data.

The health plan reported member months that differed from the state data for the MLR reporting period. An adjustment is proposed to increase the member months per state data. Member months reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(k).

This is a newly identified finding for this examination; however, it is based on data that may not be 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.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
21	MLR Member Months	196

Adjustment #7 – To accurately report the Other Non-Claims Costs total.

The health plan adjusted non-claims costs by adding expenses reported as a supplemental adjustment within the MLR template for incurred claims that exceeded Medicaid Service Limits for Transportation. Since this supplemental adjustment is informational only and not captured within the MLR calculation, no adjustment is necessary. The health plan also 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 lines 13 and 14. Additionally, the health plan reported adjustments to exclude marketing and legal costs from non-claims costs and to reclassify administrative vendor costs to non-claims costs that differed from the supporting documentation submitted. Finally, adjustments were necessary to capture all payments made to their capitated vendors in excess of the allowable incurred claim amounts. Adjustments were proposed to properly report non-claims costs per 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 D.

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**
14	Other Non-claims costs	$246,135

Adjustment #8 – To adjust premium taxes per recalculation of 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 the anticipated recoupments related to the premium tax credits taken for investments made and the risk corridor calculation. 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	($7,524)

Adjustment #9 – To adjust pharmacy claims per PBM supporting documentation

The health plan reported pharmacy vendor expenses for their pharmacy benefit manager (PBM), CaremarkPSC Health, LLC based on paid claims per health plan data. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the MLR reporting period, which did not reconcile to the health plan reported amount. An adjustment was proposed to reduce incurred claims per the PBM certification statement.

Additionally, the health plan did not report pharmacy rebate amounts within the MLR. The submitted PBM certification statement included the amount of rebates that should have been reported. An adjustment was proposed to add rebate amounts as a reduction to incurred claims. The incurred claims

and PBM vendor 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.

The adjustment to reflect the vendor's actual claim payments is a repeat finding for this examination. The adjustment to reflect the pharmacy rebate amounts 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 and the actual claims experience reported by the PBM.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6	Net Medical Expenses from Income Statement (A)	($5,183)

Adjustment #10 – To adjust pharmacy and non-claims costs based on the PBM vendor rate guarantee calculation

The health plan reported pharmacy incurred claims for their third party vendor PBM, CaremarkPCS Health LLC. It was determined contracted rate guarantee calculations were calculated annually for participating pharmacies based on contracts with the PBM. The calculation outlined, at the Medicaid line of business level, the effective rates paid to pharmacies compared to the contracted rate and dispensing fees. The overall impact for the Medicaid line of business was a reduction in reimbursement to pharmacies. An adjustment was proposed to remove the Medicaid calculated amount for the MLR reporting period from incurred claims and reclassify it to non-claims costs. The incurred claims and third party reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and Center for Medicaid & CHIP Services Informational Bulletin: MLR Requirements Related to Third Party Vendors dated May 15, 2019.

This is a newly identified finding for this examination; however, it is based on data that may not be known to the health plan at the time of filing. We recommend the health plan consult with their PBM vendor to obtain the best information available at the time of filing.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6	Net Medical Expenses from Income Statement (A)	($94,565)
14	Other Non-claims costs	$94,565

Adjustment #11 – To adjust settlement payments related to the CHIP program.

The health plan reported amounts for account 56160, Specialty Settlement on the MSCAN MLR Template that was identified as related to the CHIP program. An adjustment was proposed to properly include the expense per supporting documentation. 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 the health plan ensure all reported amounts are appropriately classified and reported for the correct program.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6	Net Medical Expenses from Income Statement (A)	$1,656

Adjustment #12 – To adjust medical rebates per submitted supporting documentation.

The health plan reported incurred claims based on the claims lag tables. We noted several accounts within the general ledger that were identified separately from the incurred claims accounts. The health plan confirmed that the accounts related to rebate amounts were not reflected in the lag tables; therefore, an adjustment was proposed to reduce the incurred claim amounts based on supporting documentation. 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 the health plan thoroughly review the as-filed amounts reported to ensure that all required transactions are reported.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
6	Net Medical Expenses from Income Statement (A)	($28,492)

Adjustment #13 – To reclassify fraud reduction expenses per supporting documentation.

The health plan reported fraud reduction expenses that were less than the fraud recoveries identified within the submitted supporting documentation. An adjustment was proposed to include all allowable fraud reduction expenses, up to the amount of fraud recoveries reported. The fraud reduction expense reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2)(iii)(B).

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	$7,161
15	Program Integrity Costs	($7,161)

Adjustment #14 – To remove state income taxes on investment income.

The health plan reported state income taxes that included amounts for investment income. Per regulations, investment income should be excluded from taxes reported for MLR purposes. An adjustment was proposed to remove the state income taxes attributable to investment income. 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 properly calculate and report their premium, federal, and state income taxes for subsequent MLR filings.

Proposed Adjustment		
Line #	**Line Description**	**Amount**
4	Less: Other Taxes and Revenue Based Assessments	($18,197)