

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 Molina Healthcare of Mississippi, 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 Molina Healthcare of Mississippi, Inc. for state fiscal year ended June 30, 2022.

Please contact us at the phone number below if you have questions.

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 Molina Healthcare of Mississippi, 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 25, 2024

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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	Reported Amounts	Adjustment Amounts	Adjusted Amounts		
Capitation	n Revenue and Tax Assessments					
1	Total YTD Capitation Revenue (A)	\$ 526,964,914	\$ (1,501,506)	\$ 525,463,408		
2	Less: Health Insurer Fee (Amount Due to IRS)	\$ -	\$ -	\$ -		
3	Less: Premium and State Income Taxes	\$ 15,808,947	\$ (45,045)	\$ 15,763,902		
4	Less: Other taxes and other revenue-based assessments	\$ 1,972,467	\$ (116,442)	\$ 1,856,025		
5	NET Current YTD Adjusted Premium Revenue	\$ 509,183,500	\$ (1,340,019)	\$ 507,843,481		
MLR Med	ical and Administrative Expenses					
6a	Net Medical Expenses from Income Statement (A)	\$ 355,998,789	\$ 3,242,826	\$ 359,241,615		
6b	Mississippi Hospital Access Program (MHAP) Expenses	\$ 95,648,521	\$ -	\$ 95,648,521		
6c	Medicaid Access to Physician Services (MAPS) Expenses	\$ 7,973,787	\$ (234,295)	\$ 7,739,492		
6d	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses	\$ -	\$ -	\$ -		
6	Total Net Medical Expenses	\$ 459,621,097	\$ 3,008,531	\$ 462,629,628		
	MLR Expense Adjustments as defined in Exhibit C					
7	Incurred claim adjustment additions	\$ 6,498,591	\$ (2,113,001)	\$ 4,385,590		
8	Incurred claim adjustment deductions	\$ 3,839,194	\$ -	\$ 3,839,194		
9	Incurred claim adjustment exclusions	\$ 3,768,006	\$ -	\$ 3,768,006		
10	Adjusted Net Medical Expenses	\$ 458,512,488		\$ 459,408,018		
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses					
11	HCQI and HIT Administrative Expenses from Income Statement	\$ 4,965,148				
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	\$ -	\$ -	\$ -		
13	Adjusted HCQI/HIT expenses	\$ 4,965,148	\$ (2,015,768)	\$ 2,949,380		
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$ 39,595,045	\$ (775,267)	\$ 38,819,778		
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$ 269,746	· .	\$ 269,746		
16	Total Adjusted Current YTD MLR Medical Expenditures	\$ 463,477,636				
17	Reporting MLR Percentage	91.0%		91.0%		
18	MLR percentage requirement for rebate calculation	87.5%		87.5%		
19	Percentage below 85% Requirement	0.0%		0.0%		
20	Dollar Amount of Rebate Requirement	\$ -	\$ -	\$ -		
-	Adjustment Applied					
21	MLR Member Months	1,005,693	-	1,005,693		
22	MLR Member Months (Annualized)	1,005,693	-	1,005,693		
23	Credibility Adjustment	0.0%				
24	Adjusted Reporting MLR Percentage	91.0%		91.0%		
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 paid claims based on the specified runout period, including estimated incurred but not reported (IBNR), for the medical loss ratio (MLR) reporting period. A comparison was performed between a revised paid lag table with additional runout through November 2023 to the health plan's reported paid claims and an IBNR estimate, which indicated the reported total incurred claims were overstated. An adjustment was proposed to decrease incurred claims per health plan 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; 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 estimates for future anticipated recoveries and additional claims.

Proposed Adjustment			
Line#	Line Description	Amount	
7	Incurred Claims Adjustment Additions	(\$2,074,459)	

Adjustment #2 – To adjust claims refunds per supporting documentation

The health plan included claim refunds for the MLR reporting period that did not reconcile to the supporting documentation. It was determined that a keying error was made in the MLR Rebate Calculation template. An adjustment was proposed to include claims refunds based on the health plan supporting documentation. 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 the supporting documentation reconciles.

Proposed Adjustment			
Line#	Line Description	Amount	
6a	Net Medical Expenses from Income Statement (A)	\$1,878,050	



Adjustment #3 - To adjust incurred claims per health plan supporting documentation

The health plan reported paid claims that did not reconcile to the original paid claims lag tables, as of the MLR Rebate Calculation specified runout period. An adjustment was proposed to increase incurred claims based on health plan supporting documentation for the specified runout period. 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 the supporting documentation reconciles.

Proposed Adjustment			
Line # Line Description		Amount	
6a	Net Medical Expenses from Income Statement (A)	\$1,364,776	

Adjustment #4 – To remove IBNR margin per health plan supporting documentation

The health plan reported IBNR expenses that included an amount in excess of the incurred claims contained within the health plan's paid claims lag tables. It was determined the reported amount included a non-allowable reserve margin percentage. An adjustment was proposed to remove the calculated IBNR margin. 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 exclude these expenses in the future from MLR reporting.

Proposed Adjustment			
Line#	Line Description	Amount	
7	Incurred Claims Adjustment Additions	(\$251,465)	

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 payments. This adjustment is inclusive of the anticipated recoupment for premium tax credits taken by the plan for state income taxes paid. 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 Description	Amount		
1	Total YTD Capitation Revenue (A)	(\$92,708)		
1	Total YTD Capitation Revenue (A)	(\$489,879)		

Adjustment #6 – 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 overstated based on comparison to state data for the Medicaid Access to Physician Services (MAPS) Expenses. An adjustment was proposed to decrease 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)	(\$241,541)		
6c	Medicaid Access to Physician Services (MAPS) Expenses	(\$234,295)		

Adjustment #7 – 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 Description		Amount	
1	Total YTD Capitation Revenue (A)	(\$1,634,174)	

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 settlement impacts related to the anticipated MYPAC/SED capitation payments, the anticipated recoupments related to the premium tax credits taken for state income taxes, 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	(\$45,045)	

Adjustment #9 – 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)	\$956,796	

Adjustment #10 – To remove duplicated Healthcare Quality Improvement (HCQI) costs from administrative expenses

The health plan reported amounts in other non-claims costs that were also reported as HCQI expenses. An adjustment was proposed to remove the duplicated expenses 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 reported amounts are appropriately classified and accounted for based on supporting documentation.

Proposed Adjustment			
Line#	Line Description	Amount	
14	Other Non-Claims Costs	(\$2,612,633)	

Adjustment #11 – To adjust corporate cost allocations to supporting documentation

The health plan reported amounts for the administrative corporate allocation that did not reconcile to supporting documentation submitted. After testing was performed, it was determined that the allocations within the calculation provided were appropriate. Therefore, an adjustment was proposed to the health plan supporting documentation to appropriately reflect the allocation amounts submitted. 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 reported amounts are appropriately classified based on supporting documentation.

Proposed Adjustment		
Line#	Line Description	Amount
14	Other Non-Claims Costs	(\$102,654)



Adjustment #12 – To adjust third party vendor expenses

The health plan reported vision vendor expenses related to March Vision based on a per-member permonth (PMPM) arrangement, with a self-estimated adjustment for the amount of administrative expense included in the arrangement. A certification statement was submitted to support the vendor's actual claim payments incurred for services performed for the MLR reporting period, which demonstrated that the health plan's adjustment was overstated. An adjustment was proposed to include additional paid claims amounts per the certification statement.

The health plan reported dental vendor expenses related to Avesis and Skygen Dental based on paid claims per health plan data. A certification statement was submitted to support each vendor's actual claim payments incurred for services performed for the MLR reporting period, which demonstrated that the health plan's amounts did not reconcile. An adjustment was proposed to the appropriate amounts per each vendor's certification statement.

The health plan reported pharmacy vendor expenses for the pharmacy benefit manager (PBM), CVS 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 demonstrated that the health plan's amounts did not reconcile. An adjustment was proposed to the appropriate amounts per the certification statement.

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.

This is a newly identified finding for this examination. We recommend that the health plan ensure the final amounts claimed agree to the certification statements.

Proposed Adjustment		
Line #	Line Description	Amount
7	Incurred Claims Adjustment Additions	\$212,923

Adjustment #13 – To remove state income tax per state guidance

The health plan reported a combined total of premium taxes and state income taxes that exceeds the maximum allowable incurred tax amounts for the MLR reporting period. 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 when the health plan elects to take this state income tax credit against the premium taxes.

The health plan elected to take this state income tax credit against premium taxes in their calendar year 2021 premium tax filing, but elected to forgo taking this credit in their calendar year 2022 premium tax. Therefore, the health plan is limited to reporting the 3% of premiums received for the first half of state fiscal year 2021, but would be entitled to report both the 3% of premiums received and the state income taxes incurred during the second half of state fiscal year 2022 on the MLR.

The health plan reported the full 3% of all premiums received during state fiscal year 2022 as part of their reported Line 3 MLR amounts and additionally reported the state income taxes for the entire year as part of Line 4 of MLR Rebate Calculation. As a result, we have proposed an adjustment to remove the state income taxes reported during the first half of state fiscal year 2022 as part of the Line 4 totals. Separately, the Division of Medicaid indicated that they would be recouping the state income tax credit claimed for the calendar year 2021 premium tax filing. As a result, the total amount of premiums received were reduced as part of Adjustment #5 to account for this anticipated recoupment. 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 Miss. Code Ann. §§ 27-15-109 and 27-15-103.

This is a partial repeat finding for this examination. However due to the uncertainty of the treatment of the anticipated premium tax credit recoupment, the health plan did not overstate their overall reductions to the MLR denominator as a result of their methodology. We recommend that the health plan properly calculate and report their premium and state income taxes for subsequent MLR filings.

Proposed Adjustment		
Line#	Line Description	Amount
4	Less: Other Taxes and Other Revenue Based Assessments	(\$116,442)

Adjustment #14 – 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 health plan costs were sampled as well as corporate costs. Our sampling of the health plan's direct costs identified accounts containing non-allowable items for promotional marketing. 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 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	(\$75,748)

Adjustment #15 – To reclassify non-qualifying Healthcare Quality Improvement (HCQI) 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(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	(\$2,015,768)	
14	Other Non-Claims Costs	\$2,015,768	