

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 (CHIP) examination report for UnitedHealthcare 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 (CHIP) for UnitedHealthcare of Mississippi, 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 UnitedHealthcare 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 CHIP, 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 CHIP 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 Centers for Medicare & Medicaid Services (CMS) and state minimum requirement of 85.0 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 26, 2024

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

	Adjusted MSCHIP 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	Revenue and Tax Assessments					
1	Total YTD Capitation Revenue (A)	\$ 85,659,129	\$ (242,812)	\$ 85,416,317		
2	Less: Health Insurer Fee (Amount Due to IRS)	\$ -	\$ -	\$ -		
3	Less: Premium and State Income Taxes	\$ 2,569,774	\$ (7,284)	\$ 2,562,490		
4	Less: Other taxes and other revenue-based assessments	\$ 400,939	\$ -	\$ 400,939		
5	NET Current YTD Adjusted Premium Revenue	\$ 82,688,416	\$ (235,528)	\$ 82,452,888		
MLR Medi	cal and Administrative Expenses					
6	Total Net Medical Expenses	\$ 71,720,570	\$ 36,614	\$ 71,757,184		
	MLR Expense Adjustments as defined in Exhibit C					
7	Incurred claim adjustment additions	\$ -	\$ -	\$ -		
8	Incurred claim adjustment deductions	\$ 475,506	\$ -	\$ 475,506		
9	Incurred claim adjustment exclusions	\$ -	\$ -	\$ -		
10	Adjusted Net Medical Expenses	\$ 71,245,064	\$ 36,614	\$ 71,281,678		
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses					
11	HCQI and HIT Administrative Expenses from Income Statement	\$ 1,950,855	\$ (1,339,111)	\$ 611,744		
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	\$ 278,797	\$ -	\$ 278,797		
13	Adjusted HCQI/HIT expenses	\$ 1,672,058	\$ (1,339,111)	\$ 332,947		
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$ 6,146,319	\$ 1,217,986	\$ 7,364,305		
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$ 126,407	\$ -	\$ 126,407		
16	Total Adjusted Current YTD MLR Medical Expenditures	\$ 72,917,122	\$ (1,302,497)	\$ 71,614,625		
17	Reporting MLR Percentage	88.2%	-1.3%	86.9%		
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	341,910	-	341,910		
22	MLR Member Months (Annualized)	341,910	-	341,910		
23	Credibility Adjustment	1.1%	0.0%	1.1%		
24	Adjusted Reporting MLR Percentage	89.3%	-1.3%	88.0%		
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.

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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, for the medical loss ratio (MLR) reporting period. A comparison was performed between revised paid lag tables with additional runout through November 2023 to the health plan's reported paid claims, which indicated the reported total incurred claims were understated. An adjustment was proposed to increase incurred claims per 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; 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 any future anticipated recoveries and additional claims.

Proposed Adjustment				
Line#	Line Description	Amount		
6	Net Medical Expenses from Income Statement (A)	\$36,614		

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. 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 CHIP 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)	\$3,367		
1	Total YTD Capitation Revenue (A)	(\$238,463)		

Adjustment #3 – 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 CHIP 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)	(\$7,716)		

Adjustment #4 – 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 the 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	(\$7,284)		

Adjustment #5 – To reclassify non-qualifying Healthcare Quality Improvement (HCQI) expense

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 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	(\$1,339,111)		
14	Other Non-Claims Costs	\$1,339,111		

Adjustment #6 – To adjust related party administrative expenses to actual cost

The health plan utilized related party administrative and profit margin rates to remove non-qualifying expenses from intersegment accounts. The original rates for several accounts were determined to be inaccurate following receipt of actual rates included within supporting documentation submitted by the health plan. An adjustment was proposed to the related party intersegment accounts to correct the related party profit margin to be removed from administrative cost totals. The non-claims costs reporting requirements are addressed in health plan's contract with the Mississippi Division of Medicaid within Section F of the Exhibit D.

This is a repeat finding for this examination. We recommend that the health plan utilize the most up to information possible when calculating administrative cost to remove from the accounts in future MLR reporting.

Proposed Adjustment			
Line#	Line Description	Amount	
14	Other Non-Claims Cost	(\$128,868)	



Adjustment #7 – To remove non-allowable administrative expense

The health plan included non-allowable advertising and internal legal fees in the related parent company accounts used to report administrative cost. An adjustment was proposed to remove the non-allowable costs reported that were identified through sampling procedures. The non-claims costs reporting requirements are addressed in health plan's contract with the Mississippi Division of Medicaid within Section F of the Exhibit D.

This is a repeat adjustment identified for this examination. We recommend that the health plan analyze the parent company accounts allocated to the health plan and included in administrative cost to identify non-allowable costs that should be excluded.

Proposed Adjustment				
Line#	Line Description	Amount		
14	Other Non-Claims Cost	(\$62,693)		

Adjustment #8 - To adjust administrative expense to actual costs reported

The health plan reported management fee totals that did not agree with the final supporting management fee documentation. An adjustment was proposed to adjust the other non-claims costs reported to the final actual costs supported. The non-claims costs reporting requirements are addressed in 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 that the health plan utilize the most up to date management fee information possible in future MLR reporting.

Proposed Adjustment			
Line#	Line Description	Amount	
14	Other Non-Claims Cost	\$70,436	



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.



July 26, 2024

Mr. Randy C. Rehn, CPA, CFE Senior Manager Myers and Stauffer LLC. 1349 W Peachtree Street NE, Suite 1600 Atlanta, GA 30309

RE: MANAGEMENT RESPONSE TO CAN/CHIP MEDICAL LOSS RATIO (MLR) AUDIT ADJUSTMENTS FOR SFY 2022

Dear Mr. Rehn.

Please find below our formal written response to the CAN/CHIP MLR Audit Adjustments for SFY 2022. Our response to the proposed adjustments are as follows:

CAN Adjustments #1 thru #6/CHIP Adjustments #1 thru #4 – Adjustments to state data after MLR submission

Response: UHC agrees that the information in these adjustments became known after the final submission of the MLR reports.

CAN Adjustments #7 and #8/CHIP Adjustment #5 – To reclassify non-qualifying Healthcare Quality Improvement (HCQI) expense

Response: UHC does not agree with this reclassification. M&S cites CMS guidance from 2022 as support for excluding indirect costs from the plan's QIA expenses. However, the support that M&S cites is guidance that applies to ACA plans, which is not applicable to Medicaid managed care plans. The controlling guidance on Medicaid managed care indirect QIA expenses was recently issued on May 10, 2024, in CMS's Medicaid managed care final rule. In its final rule, CMS's interpretation of its own existing regulations is that the Medicaid MLR rules do not exclude indirect QIA expenses:

In Medicaid and separate CHIP regulations at §§ 438.8(e)(3) and 457.1203(c) respectively, we permit the inclusion of QIA expenses for activities that meet the private market MLR requirements. However, we did not include language specifying that managed care plans may only include expenditures directly related to activities that improve health care quality when reporting QIA costs for MLR purposes, in order to align with the private market regulations. As a result, the current Medicaid MLR regulations do not explicitly require managed care plans to exclude indirect or overhead QIA expenditures. (89 FR 41002 at 41130).

CAN Adjustment #9/CHIP Adjustment #6 - To adjust related party administrative expenses to actual cost

Response: UHC agrees to continue working with our related-party vendors to provide the most accurate profit margins for related-party transactions at the time of MLR submission. Please





note that health plan staff do not have direct access to this information and will provide the best estimate possible at the time of future submissions.

CAN Adjustment #10/CHIP Adjustment #7 - To remove non-allowable administrative expense

Response: UHC agrees to continue working with our parent company partners to provide the most accurate estimate of non-allowable expenses to be excluded from future MLR reports.

CAN Adjustment #11 - To adjust administrative expense to actual costs reported

UHC will work with our administrative partners to ensure accurate reporting with the best information that we have at the time of the final MLR submission.

In addition to our responses to the adjustments noted above, we found a discrepancy between the premiums/pass-through revenue less risk corridor of \$883,847.42. Based on our understanding the variance may be an overpayment of the risk corridor calculation or an underpayment of MyPAC/SED payments outside of the capitation payment. We look forward to working with the Department of Medicaid to understand the variance.

As we stated in the exit interview, we appreciate the feedback from M&S in making sure that we report accurate and timely data. We look forward to future audits to collaborate together and continue to refine the process of MLR reporting.

Thank you again for your time and we look forward to working with your team.

Best Regards.

Chandler Ewing

UHC Market Chief Financial Officer