

July 11, 2025

Via Electronic Mail

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

Re: Adjusted Medical Loss Ratio (MSCAN) examination report for UnitedHealthcare 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 (MSCAN) for UnitedHealthcare of Mississippi, Inc. (health plan) for state fiscal year ended June 30, 2023. As a courtesy to the Mississippi Division of Medicaid (DOM) and other readers, the health plan's management response letter is included, in addition to our examination report, as part of this transmittal packet. Myers and Stauffer LC, in no manner, expresses an opinion on the accuracy, truthfulness, or validity of the statements presented within the management response letter.

Please contact us at the	phone number b	elow if you l	have questions.
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Kind Regards,

Myers and Stauffer LC

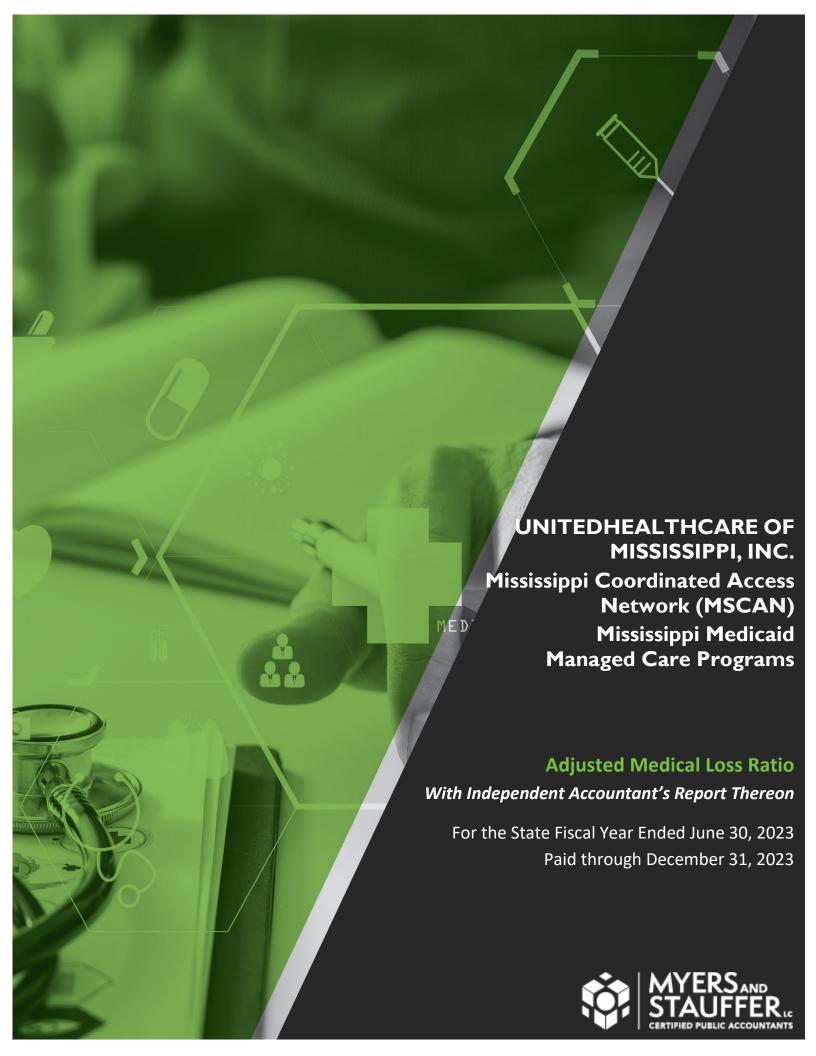




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State of Mississippi Division of Medicaid Jackson, Mississippi

Independent Accountant's Report

We have examined the accompanying Adjusted Medical Loss Ratio of UnitedHealthcare 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 guidance (criteria). This criteria was used to prepare the Adjusted Medical Loss Ratio. Our responsibility is to express an opinion on the Adjusted Medical Loss Ratio based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the Adjusted Medical Loss Ratio is in accordance with the criteria, in all material respects. An examination involves performing procedures to obtain evidence about the Adjusted Medical Loss Ratio. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risk of material misstatement of the Adjusted Medical Loss Ratio, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements related to our engagement.

The accompanying Adjusted Medical Loss Ratio was prepared from information contained in the Medical Loss Ratio for the purpose of complying with the criteria, and is not intended to be a complete presentation in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the Adjusted Medical Loss Ratio is presented in accordance with the criteria, in all material respects, and the Adjusted Medical Loss Ratio meets or exceeds the state requirement of 87.5 percent for the state fiscal year ended June 30, 2023.

This report is intended solely for the information and use of the Division of Medicaid, Milliman, and the health plan and is not intended to be and should not be used by anyone other than these specified parties.

Myers and Stauffer LC Atlanta, Georgia June 26, 2025

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

Adjusted MSCAN Medical Loss Ratio for the State Fiscal Year Ended June 30, 2023 Paid Through December 31, 2023							
Line #	Line Description	Re	ported Amounts	Ac	ljustment Amounts	А	djusted Amounts
Capitation	Revenue and Tax Assessments						
1	Total YTD Capitation Revenue (A)	\$	1,120,708,599	\$	(5,324,871)	\$	1,115,383,728
2	Less: Health Insurer Fee (Amount Due to IRS)	\$	-	\$	-	\$	-
3	Less: Premium and State Income Taxes	\$	33,621,258	\$	(159,746)	\$	33,461,512
4	Less: Other taxes and other revenue-based assessments	\$	5,297,172	\$	-	\$	5,297,172
5	NET Current YTD Adjusted Premium Revenue	\$	1,081,790,169	\$	(5,165,125)	\$	1,076,625,044
MLR Medi	ical and Administrative Expenses						
6a	Net Medical Expenses from Income Statement (A)	\$	728,435,116	\$	(230,104)	\$	728,205,012
6b	Mississippi Hospital Access Program (MHAP) Expenses	\$	233,426,377	\$	(251,061)	\$	233,175,316
6c	Medicaid Access to Physician Services (MAPS) Expenses	\$	14,777,738	\$	(713,344)	\$	14,064,394
6d	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses	\$	6,049,706	\$	-	\$	6,049,706
6	Total Net Medical Expenses	\$	982,688,938	\$	(1,194,509)	\$	981,494,429
	MLR Expense Adjustments as defined in Exhibit C						
7	Incurred claim adjustment additions	\$	4,650,692	\$	(66,247)	\$	4,584,445
8	Incurred claim adjustment deductions	\$	311,630	\$	-	\$	311,630
9	Incurred claim adjustment exclusions	\$	2,406,491	\$	-	\$	2,406,491
10	Adjusted Net Medical Expenses	\$	984,621,509	\$	(1,260,756)		983,360,753
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses						
11	HCQI and HIT Administrative Expenses from Income Statement	\$	12,848,497	\$	(8,119,676)	\$	4,728,821
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	\$	2,992,848	\$	-	\$	2,992,848
13	Adjusted HCQI/HIT expenses	\$	9,855,649	\$	(8,119,676)	\$	1,735,973
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$	50,157,570	\$	5,928,061	\$	56,085,631
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	\$	1,761,832	\$	-	\$	1,761,832
16	Total Adjusted Current YTD MLR Medical Expenditures	\$	994,477,158	\$	(9,380,432)	\$	985,096,726
17	Reporting MLR Percentage		91.9%		-0.4%		91.5%
18	MLR percentage requirement for rebate calculation		87.5%				87.5%
19	Percentage below 87.5% Requirement		0.0%				0.0%
20	Dollar Amount of Rebate Requirement	\$	-	\$	-	\$	-
Credibility	Adjustment Applied						
21	MLR Member Months		1,785,280		-		1,785,280
22	MLR Member Months (Annualized)		1,785,280		-		1,785,280
23	Credibility Adjustment		0.0%		0.0%		0.0%
24	Adjusted Reporting MLR Percentage		91.9%		-0.4%		91.5%
25	MLR Percentage Requirement for Rebate Calculation		87.5%				87.5%
26	Percentage below 87.5% Requirement		0.0%				0.0%
27	Dollar Amount of Rebate Required	\$	-	\$	-	\$	-

^{*}Lines 14 and 15 above, representing Other Non-Claims Costs and Program Integrity Costs respectively, are excluded from the numerator of the MLR calculation; however, the amounts were tested for allowability and appropriateness based on the state's criteria and are therefore opined upon within the examination report.

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^{**}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 remove IBNR margin per health plan supporting documentation

The health plan reported incurred but not reported (IBNR) expenses that included a negative amount related to margin per the general ledger. It was determined the reported amount was related to a nonallowable 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. While this account may have been included in prior years, it was not material to the examination. We recommend the health plan review the accounts reported per the general ledger to ensure non-allowable amounts are excluded.

Proposed Adjustment			
Line #	# Line Description Amount		
6a	Net Medical Expenses from Income Statement (A)	\$878,238	

Adjustment #2 - To adjust premium taxes related to expenses claimed for high cost drugs

The health plan reported the high cost drug Zolgensma as a revenue and expense within the medical loss ratio (MLR). Per state data, it was determined the revenue amount was grossed-up to account for premium taxes. The health plan's expense reported was overstated by the premium tax amount received. An adjustment was proposed to remove the premium tax amount from incurred claims expenses. 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 review the accounts reported to ensure the proper amounts are reported on each template line.

Proposed Adjustment		
Line #	Line Description	Amount
7	Incurred Claims Adjustment Additions	(\$66,247)



Adjustment #3 – To adjust pharmacy claims per PBM supporting documentation

The health plan reported services for their related party pharmacy benefit manager (PBM), Optum RX. A certification statement and claims data were submitted to support the PBM'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 add incurred claims per the PBM certification statement. 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.

This is a newly identified finding for this examination. We recommend the health plan review the amounts per the PBM to ensure reporting on the MLR aligns with actual claims experience reported by the PBM.

Proposed Adjustment			
Line #	Line Description	Amount	
6a	Net Medical Expenses from Income Statement (A)	\$553,767	

Adjustment #4 - To remove overstated and non-qualifying provider incentive payments per health plan supporting documentation

The health plan reported provider incentive payments for the MLR reporting period. It was determined the health plan amounts reported were overstated, attributed primarily to overstated estimated payments that were ultimately not earned nor paid to providers for the MLR reporting period. Additionally, other amounts were determined to be non-qualifying, as the incentive was not tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards. An adjustment was proposed to reduce provider incentive payments and to reclassify nonqualifying payments to other non-claims costs 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 repeat finding for this examination. We recommend the health plan review the provider incentive detail to ensure accurate accrual estimates owed to providers.

Proposed Adjustment			
Line #	Line Description	Amount	
6a	Net Medical Expenses from Income Statement (A)	(\$1,510,269)	
14	Other Non-Claims Costs	\$286,688	



Adjustment #5 – To reclassify non-qualifying HCQI/HIT expenses

The health plan reported health care 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 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.

This is a repeat finding for this examination. We recommend that the health plan thoroughly review the 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	(\$8,119,676)	
14	Other Non-Claims Costs	\$8,119,676	

Adjustment #6 - To remove related party vendor margin included in incurred claims

The health plan reported a related party vendor based on the per member per month (PMPM) amount reported in the general ledger. In review of the health plan submitted documentation, it was determined the amount included related party margin. The non-allowable margin amount was removed from incurred claims. The incurred claims reporting requirements are addressed in the Medicaid Managed Care Final Rule 42 CFR § 438.8(e)(2) and CMS Publication 15-1, Chapter 10.

This is a repeat finding for this examination. We recommend that the health plan review any related party arrangements to ensure the amounts reported are at cost and do not contain related party margin.

Proposed Adjustment			
Line #	Line # Line Description Amount		
6a	Net Medical Expenses from Income Statement (A)	(\$151,840)	

Adjustment #7 – To adjust revenues per state data

The health plan reported revenue amounts that did not reflect payments received for its members applicable to the covered dates of service for the MLR reporting period. An adjustment was proposed to report the revenues per state data for capitation and withhold payments. This adjustment is also inclusive of the anticipated recoupment for premium tax credits taken by the plan for state income tax.



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

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

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

Proposed Adjustment				
Line #	ine # Line Description Amount			
1	Total YTD Capitation Revenue (A)	(\$4,330,638)		

Adjustment #8 - 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 MYPAC/SED capitation payments, the anticipated recoupments related to the premium tax credits taken for state income taxes, 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 the health plan utilize the best information available at the time of filing.

Proposed Adjustment			
Line #	Line # Line Description Amount		
3	Less: Premium and State Income Taxes	(\$159,746)	

Adjustment #9 - To remove non-allowable and unsupported administrative expenses

The health plan included non-allowable advertising, internal legal fees, and margin in the related parent company accounts used to report administrative cost. Additionally, the health plan was unable to substantiate the actual costs incurred by their related party program integrity vendor for which the



health plan was charged an agreed upon fee for their services. An adjustment was proposed to remove the reported non-allowable and unsupported costs 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 C.

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 and to adjust expenses to the related party's actual costs incurred.

Proposed Adjustment			
Line # Line Description Amount			
14	Other Non-Claims Costs	(\$1,584,734)	

Adjustment #10 – To remove unsupported dental administrative expenses

The health plan included additional dental amounts in the related party intersegment accounts used to report administrative cost. After discussion with the health plan, it was determined that the difference in the vendor support to the reported GL amount was related party margin. An adjustment was proposed to remove the reported non-allowable margin that was identified through testing 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 C.

This is a newly identified adjustment for this examination. We recommend that the health plan analyze all reported accounts included in administrative cost to identify non-allowable costs that should be excluded.

Proposed Adjustment			
Line #	Line Description	Amount	
14	Other Non-Claims Costs	(\$1,365,884)	

Adjustment #11 – 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 C.



This is a repeat adjustment identified 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	\$472,315	

Adjustment #12 - 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 Mississippi Hospital Access Program (MHAP) and 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 MLR based on the template instructions.

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

Proposed Adjustment				
Line #	Line Description	Amount		
1	Total YTD Capitation Revenue (A)	(\$994,233)		
6b	Mississippi Hospital Access Program (MHAP) Expenses	(\$251,061)		
6c	Medicaid Access to Physician Services (MAPS) Expenses	(\$713,344)		



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.



June 26, 2025

Myers and Stauffer LC 1349 W Peachtree Street NE, Suite 1600 Atlanta, Georgia 30309

RE: MANAGEMENT RESPONSE TO CAN/CHIP MEDICAL LOSS RATIO (MLR) AUDIT ADJUSTMENTS FOR SFY 2023

Dear Ms. Parish.

Please find below our formal written response to the CAN/CHIP MLR Audit Adjustments for SFY 2023. Our response to the proposed adjustments are as follows:

CAN/CHIP Adjustment #3 – To reclassify non-qualifying HCQI/HIT expenses

Response: UHC does not agree with this reclassification. The controlling guidance on Medicaid managed care indirect QIA expenses was 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) respec tively, 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 regulat ions. 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 411 30).

CAN/CHIP Adjustment #4 – To adjust revenues per state data

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

CAN/CHIP Adjustment #5 – To adjust member months per state data

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

CAN/CHIP Adjustment #6 – To adjust premium taxes per recalculation to adjusted premium revenue

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

CAN/CHIP Adjustment #7 – To remove non-allowable and unsupported administrative expenses



Response: UHC developed a percentage run rate to be used to determine the amount of legal and advertising expenses to be deducted from the management fee recorded to the subsidiary company for MLR administrative cost reporting. This method was implemented in SFY24 reporting.

We appreciate the feedback from M&S in making sure that we report accurate and timely data. Thank you again for your time and we look forward to working with your team.

Best Regards,

Jack Swift

Jack Swift

UHC Market Chief Financial Officer