MAGNOLIA HEALTH PLAN, INC.

Mississippi Coordinated Access Network (MSCAN)
Mississippi Medicaid Managed Care Programs

# Adjusted Medical Loss Ratio

*(With Independent Accountant's Report Thereon)*

For the State Fiscal Year Ended June 30, 2024

Paid Through December 31, 2024

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# Independent Accountant's Report

Mississippi Division of Medicaid
Jackson, Mississippi

We have examined the accompanying Adjusted Medical Loss Ratio of Magnolia Health Plan, Inc. (health plan) for the state fiscal year ended June 30, 2024. 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, 2024.

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
June 4, 2026

# Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2024 Paid Through December 31, 2024

| Adjusted Medical Loss Ratio for the State Fiscal Year Ended June 30, 2024 Paid Through December 31, 2024 | | | | |
|---|---|---|---|---|
| **Line #** | **Line Description** | **Reported Amounts** | **Adjustment Amounts** | **Adjusted Amounts** |
| **Capitation Revenue and Tax Assessments** | | | | |
| **1** | Total YTD Capitation Revenue (A) | $ 1,729,670,919 | $ 10,052,950 | $ 1,739,723,869 |
| | **Tax Components of Reported Revenue** | | | |
| **2** | Less: Health Insurer Fee (Amount Due to IRS) | $ - | $ - | $ - |
| **3** | Less: Premium and State Income Taxes | $ 51,890,128 | $ 301,588 | $ 52,191,716 |
| **4** | Less: Other taxes and other revenue-based assessments | $ 3,468,181 | $ - | $ 3,468,181 |
| **5** | **NET Current YTD Adjusted Premium Revenue** | $ 1,674,312,611 | $ 9,751,362 | $ 1,684,063,972 |
| **MLR Medical and Administrative Expenses** | | | | |
| **6a** | Net Medical Expenses from Income Statement (A) | $ 897,566,125 | $ (5,768,287) | $ 891,797,838 |
| **6b** | Mississippi Hospital Access Program (MHAP) Expenses | $ 657,456,951 | $ 8,123,735 | $ 665,580,686 |
| **6c** | Medicaid Access to Physician Services (MAPS) Expenses | $ 15,545,687 | $ - | $ 15,545,687 |
| **6d** | Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses | $ 7,724,077 | $ - | $ 7,724,077 |
| **6** | **Total Net Medical Expenses** | $ 1,578,292,840 | $ 2,355,448 | $ 1,580,648,288 |
| | **MLR Expense Adjustments as defined in Exhibit C** | | | |
| **7** | Incurred claim adjustment additions | $ 894,330 | $ (10,406) | $ 883,924 |
| **8** | Incurred claim adjustment deductions | $ 4,449,118 | $ 61,067 | $ 4,510,185 |
| **9** | Incurred claim adjustment exclusions | $ 4,436,797 | $ - | $ 4,436,797 |
| **10** | **Adjusted Net Medical Expenses** | $ 1,570,301,255 | $ 2,283,975 | $ 1,572,585,230 |
| | **Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses** | | | |
| **11** | HCQI and HIT Administrative Expenses from Income Statement | $ 16,556,238 | $ (3,131,128) | $ 13,425,110 |
| **12** | Adjustments or exclusions to HCQI/HIT meaningful use expenses | $ 1,162,923 | $ - | $ 1,162,923 |
| **13** | **Adjusted HCQI/HIT expenses** | $ 15,393,315 | $ (3,131,128) | $ 12,262,187 |
| **14** | Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)* | $ 61,385,939 | $ 1,584,730 | $ 62,970,669 |
| **15** | Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)* | $ 2,754,508 | $ - | $ 2,754,508 |
| **16** | **Total Adjusted Current YTD MLR Medical Expenditures** | $ 1,585,694,570 | $ (847,153) | $ 1,584,847,417 |
| **17** | Reporting MLR Percentage | 94.7% | -0.6% | 94.1% |
| **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 | 1,973,377 | - | 1,973,377 |
| **22** | MLR Member Months (Annualized) | 1,973,377 | - | 1,973,377 |
| **23** | Credibility Adjustment | 0.0% | 0.0% | 0.0% |
| **24** | Adjusted Reporting MLR Percentage | 94.7% | -0.6% | 94.1% |
| **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.*

# Schedule of Adjustments

During the course of the engagement, 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, provider refunds, provider settlement payments, restated coordination of benefits, restated estimated claim projects not yet adjudicated, restated claims held in statistical suspense not yet adjudicated, estimated Marketplace third party liability settlements, and provider negative balance transactions not yet re-adjudicated as of December 31, 2024 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 October 2025, plus the IBNR totals as of October 2025 to the MLR reported totals. This analysis indicated that the initial estimates reported for incurred claims was 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 2024 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 repeat finding for this examination. While the exact data utilized to make the adjustment was not available to the health plan at the time of filing, the health plan did not utilize an appropriate estimate for these changes. We recommend the health plan utilize the best information available at the time of filing, including the use of estimates for future anticipated recoveries.

| Line # | Line Description | Amount |
|---|---|---|
| 6a | Net Medical Expenses from Income Statement (A) | ($6,943,078) |

**Adjustment #2 – To adjust pharmacy incurred claims and rebate amounts per PBM supporting documentation**

The health plan reported pharmacy vendor expenses for their pharmacy benefit manager (PBM), Envolve Pharmacy Solutions and for Express Scripts, Inc. 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 did not reconcile to the health plan reported amount. An adjustment was proposed to increase incurred claims per the PBM certification statements.

The health plan also reported their pharmacy rebate amounts as a deduction on Line 8 of the MLR report template. However, the amount did not reconcile to the amount included within the submitted pharmacy benefit manager (PBM) certification statements. An adjustment was proposed to adjust the reported total to the PBM's certified amount. The pharmacy 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 amounts per the PBM to ensure the MLR reporting aligns with the pharmacy incurred claims and rebate amounts reported by the PBM.

| Line # | Line Description | Amount |
|---|---|---|
| 6a | Net Medical Expenses from Income Statement (A) | $26,749 |
| 8 | Incurred claims adjustment deductions | $61,067 |

**Adjustment #3 – 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 understated in aggregate. An adjustment was proposed to increase 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.

| Line # | Line Description | Amount |
|---|---|---|
| 6a | Net Medical Expenses from Income Statement (A) | $275,291 |
| 7 | Incurred claims adjustments additions | ($10,406) |

**Adjustment #4 – 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 settlement for their actual MYPAC/SED member population.

Additionally, a high cost drug 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.

| Line # | Line Description | Amount |
|---|---|---|
| 1 | Total YTD Capitation Revenue (A) | $1,677,965 |

**Adjustment #5 – 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 Mississippi Hospital Access Program (MHAP) Expenses. An adjustment was proposed to increase the state directed payments and associated expenses 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.

| Line # | Line Description | Amount |
|---|---|---|
| 1 | Total YTD Capitation Revenue (A) | $8,374,985 |
| 6b | Mississippi Hospital Access Program (MHAP) Expenses | $8,123,735 |

**Adjustment #6 – To adjust premium taxes per recalculation of adjusted premium revenue**

The health plan reported premium taxes that were reconciled to the original supporting documentation. However, after determining that an incorrect amount of revenues was 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 directed payment programs, and the high cost drug risk corridor calculation. An adjustment was proposed to increase 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.

| Line # | Line Description | Amount |
|---|---|---|
| 3 | Less: Premium and State Income Taxes | $301,588 |

**Adjustment #7 – To reclassify utilization management expense based on supporting documentation**

The health plan included general ledger account 5260, Primary care physician cap, within reported incurred claims. It was determined that the costs within this account included amounts related to utilization management. An adjustment was proposed to reduce the incurred claim amounts based on supporting documentation of the utilization management costs and reclassify to non-claims expense. 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 ensure all reported amounts are appropriately classified based on supporting documentation.

| Line # | Line Description | Amount |
|---|---|---|
| 6a | Net Medical Expenses from Income Statement (A) | ($230,316) |
| 14 | Other Non-Claims Costs | $230,316 |

**Adjustment #8 – To adjust incurred claims for the health plan's radiology vendor**

The health plan intended to restate the incurred claims amounts to zero for their former radiological services third party provider National Imaging Associates (NIA) for the current reporting period. However, the health plan removed the expense twice as part of their prior period adjustment and other medical restatement adjustment. An adjustment was proposed to reflect zero expense for this vendor based on 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 repeat adjustment identified for this examination. We recommend the health plan ensure all reported amounts are appropriately reported and classified based on supporting documentation.

| Line # | Line Description | Amount |
|---|---|---|
| 6a | Net Medical Expenses from Income Statement (A) | $115,735 |

**Adjustment #9 – To correct the health plan's reclassification of member incentives from incurred claims to Healthcare Quality Improvement (HCQI)**

The health plan made an adjustment to remove member incentives as prior period expense from their incurred claims. However, they subsequently reclassified these same member incentive costs from incurred claims costs to HCQI. An adjustment was proposed to reverse the health plan's reclassification from incurred claims costs to HCQI since these costs were previously removed. 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 ensure all reported amounts are appropriately reported and classified based on supporting documentation.

| Line # | Line Description | Amount |
|---|---|---|
| 6a | Net Medical Expenses from Income Statement (A) | $987,332 |
| 11 | HCQI and HIT Administrative Expenses from Income Statement | ($987,332) |

**Adjustment #10 – To reclassify unsupported and non-qualifying HCQI and HIT 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 HCQI expenses based on federal guidance. An adjustment was proposed to reclassify non-qualifying salaries, benefits, vendor costs, and overhead to other non-claims costs. 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 repeat adjustment identified for this examination. We recommend the health plan thoroughly review their HCQI expenditures and any adjustment estimates.

| Line # | Line Description | Amount |
|---|---|---|
| 11 | HCQI and HIT Administrative Expenses | ($2,143,796) |
| 14 | Other Non-Claims Costs | $2,143,796 |

**Adjustment #11 – To adjust administrative costs to supporting documentation**

The health plan reported administrative costs from three different entity sources in other non-claims costs consisting of the health plan's direct expenses, their legal entity's expenses, and corporate company allocations. It was determined that the supporting documentation provided for the health plan direct expenses did not agree with the amount reported. An adjustment was proposed to increase non-claims costs based on 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 C.

This is a newly identified adjustment for this examination. We recommend the health plan ensure all reported amounts are appropriately reported and classified based on supporting documentation.

| Line # | Line Description | Amount |
|---|---|---|
| 14 | Other Non-Claims Costs | $191,678 |

**Adjustment #12 – To remove non-allowable expenses.**

The health plan reported administrative costs from three different entity sources in other non-claims costs consisting of the health plan's direct expenses, their legal entity's expenses, and corporate company allocations. Our sampling of various accounts identified accounts containing non-allowable items such as: alcoholic beverages, charitable contributions, investor relation costs, legal fees, lobbying expenses, and marketing expenses. The health plan made an adjustment to remove a portion of these costs, however additional costs were identified. An adjustment was proposed to remove these additional 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 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.

| Line # | Line Description | Amount |
|---|---|---|
| 14 | Other Non-Claims Costs | ($836,289) |

**Adjustment #13 – To remove unsupported costs identified through administrative expense sampling**

The health plan reported administrative costs from three different entity sources in other non-claims costs consisting of the health plan's direct expenses, their legal entity's expenses, and corporate company allocations. Our sampling of account 6352, SW Application Support, identified a variance between the reported amount and the supporting documentation. An adjustment was proposed to remove the unsupported amount 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 the health plan ensure all reported amounts are appropriately reported and classified based on supporting documentation.

| Line # | Line Description | Amount |
|---|---|---|
| 14 | Other Non-Claims Costs | ($6,192) |

**Adjustment #14 – To remove late claims payment interest**

The health plan reported administrative costs from three different entity sources in other non-claims costs consisting of the health plan's direct expenses, their legal entity's expenses, and corporate company allocations. Our review of the supporting documentation submitted for health plan direct expenses identified a reported amount for interest incurred on claims not paid in a timely manner. This expense was deemed as cost in excess of what a reasonable or prudent buyer would pay for goods or services. An adjustment was proposed to remove the amount from 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 the health plan ensure all reported amounts are appropriately reported and classified based on supporting documentation.

| Line # | Line Description | Amount |
|---|---|---|
| 14 | Other Non-Claims Costs | ($138,579) |