MYERS AND STAUFFER LC

MOLINA HEALTHCARE OF MISSISSIPPI, 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 Molina Healthcare of Mississippi, 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 5, 2026

MISSISSIPPI COORDINATED ACCESS NETWORK (MSCAN) ADJUSTED MEDICAL LOSS RATIO

Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Capitation Revenue and Tax Assessments				
1	Total YTD Capitation Revenue (A)	$ 759,121,709	$ 11,069,633	$ 770,191,342
	Tax Components of Reported Revenue			
2	Less: Health Insurer Fee (Amount Due to IRS)	$ -	$ -	$ -
3	Less: Premium and State Income Taxes	$ 22,773,651	$ 332,089	$ 23,105,740
4	Less: Other taxes and other revenue-based assessments	$ 1,600,916	$ -	$ 1,600,916
5	**NET Current YTD Adjusted Premium Revenue**	$ 734,747,142	$ 10,737,544	$ 745,484,686
MLR Medical and Administrative Expenses				
6a	Net Medical Expenses from Income Statement (A)	$ 394,147,656	$ (108,586)	$ 394,039,070
6b	Mississippi Hospital Access Program (MHAP) Expenses	$ 273,407,896	$ 3,369,933	$ 276,777,829
6c	Medicaid Access to Physician Services (MAPS) Expenses	$ 8,401,385	$ -	$ 8,401,385
6d	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses	$ 5,509,309	$ -	$ 5,509,309
6	**Total Net Medical Expenses**	$ 681,466,245	$ 3,261,347	$ 684,727,593
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claim adjustment additions	$ 565,175	$ 500,169	$ 1,065,344
8	Incurred claim adjustment deductions	$ 11,708,456	$ (11,591,489)	$ 116,967
9	Incurred claim adjustment exclusions	$ 167,836	$ 245,452	$ 413,288
10	**Adjusted Net Medical Expenses**	$ 670,155,128	$ 15,107,553	$ 685,262,682
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 5,491,511	$ (283,204)	$ 5,208,307
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ -	$ -	$ -
13	**Adjusted HCQI/HIT expenses**	$ 5,491,511	$ (283,204)	$ 5,208,307
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 49,715,201	$ (721,053)	$ 48,994,148
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 449,919	$ -	$ 449,919
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 675,646,639	$ 14,824,349	$ 690,470,989
17	Reporting MLR Percentage	92.0%	0.6%	92.6%
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	1,101,358	-	1,101,358
22	MLR Member Months (Annualized)	1,101,358	-	1,101,358
23	Credibility Adjustment	0.0%	0.0%	0.0%
24	Adjusted Reporting MLR Percentage	92.0%	0.6%	92.6%
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 direct claims paid to supporting documentation

The health plan reported direct medical claims paid on the medical loss ratio (MLR) report that did not agree to the health plan's supporting documentation. An adjustment was made to report the direct claims paid per the supporting documentation. The medical expense 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 reported and classified based on supporting documentation.

Line #	Line Description	Amount
6a	Net Medical Expenses from Income Statement (A)	$702,455

Adjustment #2 – To remove reduction reported for recoveries already included within incurred claims

The health plan included a reduction related to recoveries on line 8 of the initial medical loss ratio (MLR) report. However, these recoveries were already included within the net medical expenses amount reported on line 6a resulting in a duplicate reduction of expenses. The health plan self-identified this reporting error after the initial MLR report submission and subsequently notified the Division of Medicaid, which resulted in the submission of a revised MLR template.

Because the health plan subsequently corrected the reporting error after the examination had commenced and the revised template was not used as the basis for this examination, an adjustment was required to revise the reported amounts to reflect the direct claims paid per supporting documentation. The medical expense 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 continue to ensure all reported amounts are appropriately reported and classified based on supporting documentation.

Line #	Line Description	Amount
8	Incurred claims adjustment deductions	($11,606,515)

Adjustment #3 – To adjust incurred claims per third party vendor certification statements

The health plan reported dental, transportation and vision services for third party vendors, Skygen, Medical Transportation Management, Inc., and March Vision Care Group, Incorporated, respectively. Certification statements were 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 amounts. The health plan made an adjustment to remove the administrative components of the capitated amounts from incurred claims; however, the health plan's analysis did not agree with the documentation obtained from the vendors. An adjustment was proposed to reflect incurred claims per each vendor's 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) 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 ensure all reported amounts are appropriately reported and classified based on supporting documentation.

Line #	Line Description	Amount
7	Incurred claims adjustment additions	$560,091
9	Incurred claims adjustment exclusions	$245,452

Adjustment #4 – 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 reported a pharmacy rebate total that was smaller than the amount included on the PBM certification statement. An adjustment was proposed to reduce incurred claims through an increased deduction amount. 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 adjustments to reflect the vendor's actual claim payments and pharmacy rebate amounts are 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 rebate amounts and the actual claims experience reported by the PBM.

Line #	Line Description	Amount
6a	Net Medical Expenses from Income Statement (A)	$4,476
8	Incurred claims adjustment deductions	$15,026

Adjustment #5 – 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 PBM, CaremarkPCS Health LLC. It was determined that 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 reduce incurred claims for the calculated Medicaid rate guarantee per PBM supporting documentation 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 repeat 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.

Line #	Line Description	Amount
6a	Net Medical Expenses from Income Statement (A)	($572,619)
14	Other Non-Claims Costs	$572,619

Adjustment #6 – To adjust provider incentives based on supporting documentation

The health plan reported provider incentive payments, inclusive of accrual estimates, for the MLR reporting period. It was determined that the health plan amounts reported were overstated when compared to the final payments made to the providers. 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 repeat finding for this examination; however, it is based on current data that would not be known to the health plan at the time of filing. The health plan completed the MLR based on template instructions.

Line #	Line Description	Amount
7	Incurred claims adjustments additions	($59,922)

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 health 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.

Line #	Line Description	Amount
1	Total YTD Capitation Revenue (A)	$7,595,475

Adjustment #8 – 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). 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)	$3,474,158
6b	Mississippi Hospital Access Program (MHAP) Expenses	$3,369,933

Adjustment #9 – 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 anticipated recoupments related to the premium tax credits taken for investments made, and the 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	$332,089

Adjustment #10 – 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. Additionally, the health plan made an estimated adjustment to their HQCI costs based on the SFY 2023 examination results. Our procedures determined the health plan's adjustment for non-qualifying HCQI expenses based on federal guidance was understated. An adjustment was proposed to reclassify non-qualifying salaries, benefits, and vendor costs from HCQI/HIT to 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 finding 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	($547,957)
14	Other Non-Claims Costs	$547,957

Adjustment #11 – To add expenses to HCQI related to the health plan's member incentives

The health plan reported a reclassification adjustment to reclassify the member incentives total from non-claims costs to HCQI. However, the adjustment amount was related to fraud-related expenses instead of the actual member incentives amount. An adjustment is proposed to reclassify the additional member incentives cost from non-claims costs to HCQI. 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
11	HCQI and HIT Administrative Expenses	$264,753
14	Other Non-Claims Costs	($264,753)

Adjustment #12 – To adjust claims refunds per supporting documentation

The health plan represented that general ledger accounts 56440, Inpatient Refunds – Non-Lag and 56140, Specialty Refunds – Non-Lag are not captured within in 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 repeat finding for this examination. We recommend the health plan thoroughly review the as-filed amounts reported to ensure that all required transactions are reported.

Line #	Line Description	Amount
6a	Net Medical Expenses from Income Statement (A)	($34,232)

Adjustment #13 – To adjust medical rebates per submitted supporting documentation

The health plan reported incurred claims based on the claims lag tables. We noted an account within the general ledger that was identified separately from the submitted incurred claims accounts. The health plan confirmed that the account related to rebate amounts 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 repeat finding for this examination. We recommend the health plan thoroughly review the as-filed amounts reported to ensure that all required transactions are reported.

Line #	Line Description	Amount
6a	Net Medical Expenses from Income Statement (A)	($208,666)

Adjustment #14 – To reverse the health plan's duplicate reduction adjustment of non-claims costs

The health plan understated their non-claims costs by the amount reported in general ledger account 81212 related to their corporate healthcare quality charge allocation. The health plan did not realize that the inclusion of their offsetting general ledger account 81213 had reduced this expense to zero. The health plan then made a duplicate reduction to non-claims costs in their attempt to reclassify the amount reported in account 81212 to their reported HCQI costs. An adjustment was proposed to add back this duplicate reduction to the reported 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 repeat 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.

Line #	Line Description	Amount
14	Other Non-Claims Costs	$3,855,085

Adjustment #15 – To accurately report other non-claims costs

The health plan adjusted non-claims costs by adding expenses reported as supplemental adjustments in Table 5 within the MLR template for incurred claims that exceeded Medicaid Service Limits for Pharmacy, Physicians, and Home Health. Since these supplemental adjustments are informational only and are not intended to be reported as a reclassification adjustment between incurred claims and non-claims costs, the health plan's adjustment to increase non-claims was unnecessary. The health plan also reported program integrity costs that were not separately 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 on 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 C.

This is a repeat finding for this examination. We recommend the health plan ensure all reported amounts are appropriately classified based on supporting documentation.

Line #	Line Description	Amount
14	Other Non-Claims Costs	($3,819,694)

Adjustment #16 – To remove non-allowable expenses within administrative expenses

The health plan reported administrative costs from two different sources in other non-claims costs. During testing, the direct health plan costs and corporate costs were sampled. We noted several accounts that contained non-allowable lobbying and interest expense resulting from non-allowable borrowing activities through our sampling of various accounts. An adjustment was proposed to remove the non-allowable amounts identified. The administrative (non-claims) reporting requirements are addressed within Exhibit C, Section F of the health plan's contract with the Mississippi Division of Medicaid.

This is a newly identified adjustment 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	($1,612,267)