MYERS AND STAUFFER LC

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

Mississippi Children's Health Insurance Program (CHIP)
Mississippi
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

Table of Contents

Independent Accountant's Report

Mississippi Division of Medicaid
Jackson, Mississippi

We have examined the accompanying Adjusted Medical Loss Ratio of UnitedHealthcare 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 reporting 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 Centers for Medicare & Medicaid Services (CMS) and state requirement of 85 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 10, 2026

MISSISSIPPI CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) ADJUSTED MEDICAL LOSS RATIO

Line #	Line Description	Reported Amounts	Adjustment Amounts	Adjusted Amounts
Capitation Revenue and Tax Assessments				
1	Total YTD Capitation Revenue (A)	$ 94,543,000	$ 2,800,476	$ 97,343,476
	Tax Components of Reported Revenue			
2	Less: Health Insurer Fee (Amount Due to IRS)	$ -	$ -	$ -
3	Less: Premium and State Income Taxes	$ 2,836,290	$ 84,014	$ 2,920,304
4	Less: Other taxes and other revenue-based assessments	$ 1,097,668	$ -	$ 1,097,668
5	**NET Current YTD Adjusted Premium Revenue**	$ 90,609,043	$ 2,716,462	$ 93,325,504
MLR Medical and Administrative Expenses				
6	**Total Net Medical Expenses**	$ 84,076,851	$ 33,653	$ 84,110,504
	MLR Expense Adjustments as defined in Exhibit D			
7	Incurred claim adjustment additions	$ -	$ -	$ -
8	Incurred claim adjustment deductions	$ 343,921	$ 14,035	$ 357,956
9	Incurred claim adjustment exclusions	$ -	$ -	$ -
10	**Adjusted Net Medical Expenses**	$ 83,732,930	$ 19,618	$ 83,752,548
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 1,965,209	$ (736,605)	$ 1,228,604
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ (444,904)	$ 889,808	$ 444,904
13	**Adjusted HCQI/HIT expenses**	$ 2,410,113	$ (1,626,413)	$ 783,700
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 5,216,111	$ 501,931	$ 5,718,042
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 190,287	$ -	$ 190,287
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 86,143,043	$ (1,606,795)	$ 84,536,248
17	Reporting MLR Percentage	95.1%	-4.5%	90.6%
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	359,637	-	359,637
22	MLR Member Months (Annualized)	359,637	-	359,637
23	Credibility Adjustment	1.1%	0.0%	1.1%
24	Adjusted Reporting MLR Percentage	96.2%	-4.5%	91.7%
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.*

Schedule of Adjustments

During the course of the engagement, we identified the following adjustments.

Adjustment #1 – To adjust pharmacy claims and rebates 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. Additionally, the health plan reported a pharmacy drug rebate total that was smaller than the amount included on the PBM certification statement. An adjustment was proposed to increase incurred claims per paid claim total from the PBM certification statement and to increase the deduction amount related to rebates 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 repeat finding for the pharmacy claims and a newly identified finding for the pharmacy rebates 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.

Line #	Line Description	Amount
6	Total Net Medical Expenses	$33,653
8	Incurred claim adjustment deductions	$14,035

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 and withhold payments. This adjustment is also inclusive of the anticipated recoupment for premium tax credits taken by the health plan for state income tax.

Additionally, risk corridors were contractually in effect for the MLR reporting period. The final risk corridor calculations occurred subsequent to the filing of the CHIP MLR Rebate Calculation. All applicable MLR examination adjustments are reflected within the final risk corridor calculations. An adjustment was proposed to report revenues based on the final risk corridor calculations 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.

Line #	Line Description	Amount
1	Total YTD Capitation Revenue (A)	$2,800,476

Adjustment #3 – 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 was reported per state data, changes were applied to the premium tax calculation to recalculate based on adjusted premium revenues, including changes to 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 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 the health plan utilize the best information available at the time of filing.

Line #	Line Description	Amount
3	Less: Premium and State Income Taxes	$84,014

Adjustment #4 – To correct indirect margin that was added into HCQI expense.

The indirect margin was added into HCQI expense per the filing as opposed to being removed. Indirect margin is not allowable in HCQI expense. An adjustment was proposed to correct the reduction of indirect margin from HCQI expense. 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 newly identified adjustment for this examination. We recommend that the health plan analyze all reported expenses included in HCQI to identify non-allowable costs that should be excluded.

Line #	Line Description	Amount
12	Adjustments or exclusion to HCQI/HIT meaningful use of expenses	$889,808

Adjustment #5 – 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. An adjustment was proposed to the health plan's supporting

documentation. It was also determined that 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 from HCQI/HIT to non-claims. 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.

Line #	Line Description	Amount
11	HCQI and HIT Administrative Expenses from Income Statement	($736,605)
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	$787,415

Adjustment #6 – To remove unsupported administrative expenses

The health plan included amounts related party intersegment accounts to report administrative cost. An adjustment was proposed to remove the unsupported costs that were identified through the analysis of actual intersegment costs. 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 adjust expenses to the related party's actual costs incurred.

Line #	Line Description	Amount
14	Other Non-Claims Costs	($332,103)

Adjustment #7 – 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 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.

Line #	Line Description	Amount
14	Other Non-Claims Costs	$46,619