MYERS AND STAUFFER LC

UNITEDHEALTHCARE OF MISSISSIPPI, INC.

Mississippi Coordinated Access Network (MSCAN)
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

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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 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 10, 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)	$ 1,576,751,771	$ 2,539,749	$ 1,579,291,520
	Tax Components of Reported Revenue			
2	Less: Health Insurer Fee (Amount Due to IRS)	$ -	$ -	$ -
3	Less: Premium and State Income Taxes	$ 47,302,553	$ 76,192	$ 47,378,745
4	Less: Other taxes and other revenue-based assessments	$ 6,065,067	$ -	$ 6,065,067
5	**NET Current YTD Adjusted Premium Revenue**	$ 1,523,384,151	$ 2,463,557	$ 1,525,847,708
MLR Medical and Administrative Expenses				
6a	Net Medical Expenses from Income Statement (A)	$ 804,389,180	$ 328,237	$ 804,717,417
6b	Mississippi Hospital Access Program (MHAP) Expenses	$ 592,293,557	$ 7,303,227	$ 599,596,784
6c	Medicaid Access to Physician Services (MAPS) Expenses	$ 15,144,714	$ -	$ 15,144,714
6d	Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) Expenses	$ 5,509,309	$ -	$ 5,509,309
6	**Total Net Medical Expenses**	$ 1,417,336,760	$ 7,631,464	$ 1,424,968,224
	MLR Expense Adjustments as defined in Exhibit C			
7	Incurred claim adjustment additions	$ 1,411,637	$ -	$ 1,411,637
8	Incurred claim adjustment deductions	$ 294,929	$ 24,420	$ 319,349
9	Incurred claim adjustment exclusions	$ 2,304,370	$ -	$ 2,304,370
10	**Adjusted Net Medical Expenses**	$ 1,416,149,098	$ 7,607,044	$ 1,423,756,142
	Health Care Quality Improvement (HCQI) and Health Information Technology (HIT) Meaningful Use Expenses			
11	HCQI and HIT Administrative Expenses from Income Statement	$ 18,986,786	$ (8,138,918)	$ 10,847,868
12	Adjustments or exclusions to HCQI/HIT meaningful use expenses	$ 4,218,316	$ -	$ 4,218,316
13	**Adjusted HCQI/HIT expenses**	$ 14,768,470	$ (8,138,918)	$ 6,629,552
14	Other Non-Claims Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 45,631,001	$ 5,868,427	$ 51,499,428
15	Program Integrity Costs (For Reporting Purposes Only. Not Included in Numerator)*	$ 2,525,321	$ -	$ 2,525,321
16	**Total Adjusted Current YTD MLR Medical Expenditures**	$ 1,430,917,568	$ (531,874)	$ 1,430,385,694
17	Reporting MLR Percentage	93.9%	-0.2%	93.7%
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	1,908,928	-	1,908,928
22	MLR Member Months (Annualized)	1,908,928	-	1,908,928
23	Credibility Adjustment	0.0%	0.0%	0.0%
24	Adjusted Reporting MLR Percentage	93.9%	-0.2%	93.7%
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 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 in the PBM certification statement. An adjustment was proposed to increase incurred claims per paid claim total from the PBM certification 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 drug 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
6a	Total Net Medical Expenses from Income Statement (A)	$724,480
8	Incurred claims adjustment deductions	$24,420

Adjustment #2 – 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 non-qualifying 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.

Line #	Line Description	Amount
6a	Net Medical Expenses from Income Statement (A)	($396,243)
14	Other Non-Claims Costs	$275,277

Adjustment #3 – To adjust revenue 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 MSCAN 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)	($4,989,351)

Adjustment #4 – 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 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 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)	$7,529,100
6b	Mississippi Hospital Access Program (MHAP) Expenses	$7,303,227

Adjustment #5 – 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 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 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	$76,192

Adjustment #6 – 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 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.

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	($8,138,918)
14	Other Non-Claims Costs	$7,559,901

Adjustment #7 – 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 reported 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 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 adjust expenses to the related party's actual costs incurred.

Line #	Line Description	Amount
14	Other Non-Claims Costs	($2,397,583)

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 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.

Line #	Line Description	Amount
14	Other Non-Claims Costs	$430,832