CONTRACT BETWEEN THE

DIVISION OF MEDICAID

IN THE OFFICE OF THE GOVERNOR

STATE OF MISSISSIPPI

AND

A COORDINATED CARE ORGANIZATION (CCO)

(UnitedHealthcare of Mississippi, Inc.)

FOR ADMINISTRATION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

Division of Medicaid

Office of the Governor

State of Mississippi

Walter Sillers Building

550 High Street, Suite 1000

Jackson, MS 39201-1399

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CONTRACT BETWEEN
THE DIVISION OF MEDICAID
IN THE OFFICE OF THE GOVERNOR
STATE OF MISSISSIPPI
AND
UNITEDHEALTHCARE OF MISSISSIPPI, INC.

This Contract is made and entered into this 1st day of July, 2015 by and between the Division of Medicaid in the Office of the Governor, an administrative agency of the State of Mississippi, with a principal place of business located at 550 High Street in the City of Jackson, County of Hinds, State of Mississippi (hereinafter "DOM"), and UnitedHealthcare of Mississippi, Inc., a corporation organized and existing pursuant to the laws of the State of Mississippi, which is licensed as defined by the Department of Insurance, with a principal place of business located at 795 Woodlands Parkway, Suite 301, in the City of Ridgeland, County of Madison, State of Mississippi (hereinafter "Contractor").

WHEREAS, DOM is charged with the administration of the **Child Health Plan** for the Children's Health Insurance Program (CHIP) in accordance with the requirements of Title XXI of the Social Security Act of 1935, as amended, (the "Act") and Miss. Code Ann. § 41-86-1, *et. seq.*, and §43-13-101 *et. seq.*;

WHEREAS, Contractor is an entity eligible to enter into a full risk capitated contract in accordance with Section 1903(m) of the Act and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. § 438.2. Contractor is licensed appropriately as defined by the Department of Insurance of the State of Mississippi pursuant to Miss. Code Ann. §83-41-305; and

WHEREAS, DOM desires to contract with a Coordinated Care Organization (CCO) to obtain services for the benefit of a separate child health program in accordance with Section 2101(a)(1) of the Act, and 42 C.F.R. §457.70 and Contractor has provided to DOM continuing proof of Contractor's financial responsibility, including adequate protection against the risk of Insolvency, and its capability to provide quality services efficiently, effectively, and economically during the term of this Contract, upon which DOM relies in entering into this Contract.

NOW THEREFORE, in consideration of the monthly payment of predetermined capitation rates by DOM, the full assumption of risk by Contractor, and the mutual covenants contained herein, and subject to the terms and conditions hereinafter stated, it is hereby understood and agreed by the parties hereto as follows:

SECTION 1 – GENERAL PROVISIONS

A. Term

The term of this Contract shall commence on July 1, 2015, and shall expire on June 30,2017, unless this Contract is terminated pursuant to Section 15, Non-Compliance and Termination. DOM has under the same terms and conditions as the existing Contract, the option for two (2) one-year extensions.

B. Definitions and Construction

References to numbered Sections refer to the designated Sections contained in this Contract. Titles of Sections used herein are for reference only and shall not be deemed a part of this Contract. The headings used throughout the Contract are for convenience only and shall not be resorted to for interpretation of the Contract.

In the event of a conflict between this Contract and the various documents incorporated into this Contract by reference, the terms of this Contract shall govern unless otherwise stated.

This Contract between DOM and Contractor consists of 1) this Contract and any amendments thereto; 2) the Mississippi CHIP RFP and any amendments thereto; 3) Contractor's Proposal submitted in response to the RFP by reference and as an integral part of this Contract; 4) written questions and answers. In the event of a conflict in language among the four (4) documents referenced above, the provisions and requirements set forth and/or referenced in the Contract and its amendments shall govern. After the Contract, the order of priority shall be as follows: Contractor's Proposal and its attachments, the RFP, and written questions and answers. In the event that an issue is addressed in one document that is not addressed in another document, no conflict in language shall be deemed to occur. All the documents shall be read and construed as far as possible to be one harmonious whole; however, in the event of a conflict or dispute, the above list is the list of priority.

However, DOM reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict or ambiguity with the applicable requirements stated in the RFP or Contractor's Proposal. In all other matters not affected by the written clarification, if any, the order of priority outlined above shall govern.

The Contract represents the entire agreement between Contractor and DOM for CHIP and it supersedes all prior negotiations, representations, or agreements, either written or oral between the parties hereto relating to the subject matter hereof.

No modification or change of any provision in the Contract shall be made, or construed to have been made, unless such modification or change is mutually agreed upon in writing by Contractor and DOM. The agreed upon modification or change will be incorporated as a written Contract Amendment and processed through DOM for approval prior to the effective date of such modification or change. In some instances, the Contract must be approved by the Centers for Medicare and Medicaid Services

(CMS) before the change becomes effective.

The only representatives authorized to modify this Contract on behalf of DOM and

Contractor are shown below:

Contractor: Jocelyn Chisolm Carter, J.D., President;

DOM: Executive Director.

C. **State and Federal Law**

Contractor shall comply with all applicable Federal, State, and local laws and regulations and standards, as have been or may hereinafter be established, specifically including without limitation, Title XXI of the Act, 42 C.F.R. § 457 Subpart A, and the policies, rules, and regulations of DOM.

Both parties that enter into this Contract understand that before the Contract can be executed, the Contract must be approved by CMS.

In the event that Contractor requests that the Executive Director of DOM or his/her designee issue policy determinations or operating guidelines required for proper performance of the Contract, DOM shall do so in a timely manner. Contractor shall be entitled to rely upon and act in accordance with such policy determinations and operating guidelines unless Contractor acts negligently, maliciously, fraudulently, or in bad faith.

Contractor expressly agrees to all of the provisions and requirements as set forth in the State Child Health Plan approved by the State of Mississippi and by the Secretary of the United States Department of Health and Human Services, pursuant to the Title XXI of the Act, and understands those provisions and requirements are also incumbent on Contractor.

See also Section 4.3.1, Applicable Law, and Section 4.14.2, Procurement Regulations, of the Mississippi CHIP RFP for additional requirements.

D. **Representatives for DOM and Contractor**

The Executive Administrator of DOM shall serve as the Contract Office, representing the Executive Director of DOM, with full decision-making authority. All statewide policy decisions or Contract interpretation will be made through the Executive Administrator of DOM. The Executive Administrator shall be responsible for the interpretation of all Federal and State laws and regulations governing or in any way affecting this Contract. Contractor shall not interpret general CHIP policy. When interpretations are required, Contractor will submit written requests to DOM.

Contractor's Chief Executive Officer or a comparable representative shall serve as Contract Officer for Contractor, with full decision-making authority for Contractor, and will be required to be physically located in the State of Mississippi.

Each Contract Officer reserves the right to delegate such duties as may be appropriate to others in the Officer's employment or under the Officer's supervision.

E. **Notices**

Whenever, under this Contract or associated RFP, one party is required to give notice to the other, except for purposes of Notice of Termination under Section 15.J, Procedure on Termination, of this Contract, such notice shall be deemed given upon delivery, if delivered by hand, or upon the date of receipt or refusal, if sent by registered or certified mail, return receipt requested, or by other carriers that require signature upon receipt. Notice may be delivered by facsimile transmission, with original to follow by certified mail, return receipt requested, or by other carriers that require signature upon receipt, and shall be deemed given upon transmission and facsimile confirmation that it has been received. Notices shall be addressed as follows:

In case of notice to DOM:

Executive Director
Division of Medicaid
Walter Sillers Building, Suite 1000
550 High Street
Jackson, MS 39201-1399

In case of notice to Contractor:

Jocelyn Chisolm Carter, J.D.
President and Chief Executive Officer
UnitedHealthcare of Mississippi, Inc.
795 Woodlands Parkway, Suite 301
Ridgeland, MS 39157

F. **Contractor Representations**

Contractor hereby represents and warrants to DOM that:

1. Contractor has at least five (5) years of experience with CHIP providing the types of services described in this Contract;

2. Contractor is licensed in the State of Mississippi by the Department of Insurance as a health maintenance organization; or is in the process of obtaining license in Mississippi to be effective prior to the Enrollment of Members;

3. All information and statements contained in the CHIP Contract Proposal and responses to additional letter inquiries submitted by Contractor to DOM are true and correct as of the date of this Contract;

4. A copy of Contractor's Proposal as approved by DOM is on file in Contractor's office in Mississippi and any revisions to the Proposal as approved by DOM are posted in Contractor's copy;

5. There have been no material adverse changes in the financial condition or business operations of Contractor since the date of the Application and the closing date of the most recent financial statements of Contractor submitted to DOM;

6. Contractor has not been sanctioned by a State or Federal government within the last ten (10) years;

7. Contractor shall comply with requirements under 42 C.F.R. § 457.955 as applicable to managed care organizations serving CHIP; and

8. All covered services provided by Contractor will meet the quality management (QM) standards of DOM, and will be furnished to Members as promptly as necessary to meet each individual's needs.

In compliance with Section 2103(f) of the Act, Contractor shall provide assurances, as required by Section 1932(b) of the Act, to State and Federal officials (CMS) 1) that within its service area, it has the capacity to serve its expected enrollment, that it maintains an adequate number, mix, and geographic distribution of providers, that it offers an appropriate range of services and access to preventative and primary care services for the expected enrolled population, and 2) that it will comply with certain maternity and mental health requirements contained in subpart 2 of part A of Title XXVII of the Public Health Service Act.

Contractor shall have, or obtain, any license/permits that are required prior to and during the performance of work under this Contract.

G. **Assignment of the Contract**

Contractor shall not sell, transfer, assign, or otherwise dispose of the Contract or any portion thereof or of any right, title, or interest therein without prior written consent of DOM. Any such purported assignment or transfer shall be void. If approved, any assignee shall be subject to all terms and conditions of this Contract and other supplemental contractual documents. No approval by DOM of any assignment may be deemed to obligate DOM beyond the provisions of this Contract. This provision includes reassignment of the Contract due to change in ownership of Contractor. DOM shall at all times be entitled to assign or transfer its rights, duties, and/or obligations under this Contract to another governmental agency in the State of Mississippi upon giving prior written notice to Contractor.

H. **Notice of Legal Action**

Contractor shall provide written notice to DOM of any legal action or notice listed

below, within ten (10) calendar days following the date Contractor receives notice of the following:

1. Any action, suit, or counterclaim filed against it;

2. Any regulatory action, or proposed action, respecting its business or operations;

3. Any notice received from the Department of Insurance or the State Health Officer;

4. Any claim made against Contractor by any Member, Subcontractor, or supplier having the potential to result in litigation related in any way to this Contract;

5. The filing of a petition in bankruptcy by or against a principal Subcontractor or the Insolvency of a principal Subcontractor;

6. The conviction of any person who has an ownership or control interest in Contractor, any Subcontractor or supplier, or who is an agent or managing employee of Contractor, any Subcontractor or supplier, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Act; and

7. Malpractice action against any provider delivering service under the Contract.

A complete copy of all filings and other documents generated in connection with any such legal action shall be immediately provided to DOM.

I. Ownership and Financial Disclosure

Contractor shall comply with all provisions of 42 C.F.R. § 457.935 and § 1318 of the Health Maintenance Organization Act (42 U.S.C. § 300e, *et seq.)*, which requires the disclosure and justification of certain transactions between Contractor and any related party, referred to as a Party in Interest. Transactions reported under 42 U.S.C. § 300e, *et seq.*, must be justified as to their reasonableness and potential adverse impact on fiscal soundness. Contractor is required to obtain all relevant ownership and financial disclosure information from their own employees, Subcontractors, and network providers.

Contractor shall not knowingly have a person, managing employee, agent, or their affiliate who is debarred, suspended, or otherwise excluded from participating in Federal procurement activities as a director, officer, partner, shareholder, or person with a beneficial ownership interest of more than five percent (5%) of Contractor's equity or have an employment, consulting, or other agreement with a person who has been convicted for the provision of items and services that are significant and material to Contractor's obligations under this Contract, in accordance with 42 C.F.R. §§ 438.610 and 457.935.

1. Disclosures

   In accordance with 42 C.F.R. § 455.104(b) Contractor shall disclose the following:

a. The name and address of any individual or corporation with an ownership or control interest in Contractor. The address for corporate entities must include an applicable primary business address, every business location, and P.O. Box address;

b. Date of birth and Social Security Number (in the case of an individual);

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in Contractor or in any Subcontractor in which Contractor has a five percent (5%) or more interest;

d. Whether the individual or corporation with an ownership or control interest in Contractor is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any Subcontractor in which Contractor has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;

e. The name of any other disclosing entity (or DOM's fiscal agent or other managed care entity) in which an owner of Contractor has an ownership or control interest; and

f. The name, address, date of birth, and Social Security Number of any managing employee of Contractor.

In accordance with 42 C.F.R. § 455.104(c), disclosures from Contractor are due at any of the following times:

a. Upon Contractor submitting a Proposal in accordance with the State's procurement process;

b. Annually, including upon execution, renewal, or extension of the Contract with the State; and

c. Within thirty-five (35) calendar days after any change in ownership of Contractor.

In accordance with 42 C.F.R. § 455.104(d), all disclosures must be provided to DOM, the State agency that administers CHIP.

In accordance with 42 C.F.R. § 455.104(e), Federal financial participation (FFP) is not available in payments made to a Contractor that fails to disclose ownership or control information as required by said section. As described in 42 C.F.R. § 438.808, FFP is also not available for any amounts paid to Contractor that could be excluded from participation in Medicare or Medicaid for any of the following reasons:

a. Contractor is controlled by a sanctioned individual;

b. Contractor has a contractual relationship that provides for the administration, management or provision of medical services, or the establishment of policies, or the provision of operational support for the administration, management or provision of medical services, either directly or indirectly, with an individual convicted of certain crimes as described in section 1128(b)(8)(B) of the Act; or

c. Contractor employs or contracts, directly or indirectly, for the furnishing of health care, utilization review, medical social work, or administrative services, with one of the following: (a) any individual or entity excluded from participation in Federal health care programs. (b) Any entity that would provide those services through an excluded individual or entity.

In accordance with 42 C.F.R. § 455.105, Contractor must fully disclose all information related to business transactions. Contractor must submit, within thirty- five (35) calendar days of the date on a request by the Secretary of the Department of Health and Human Services (HHS) or DOM, full and complete information about:

a. The ownership of any Subcontractor with whom Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request; and

b. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any Subcontractor, during the five (5)-year period ending on the date of the request.

In accordance with 42 C.F.R. § 455.106(b), DOM must notify the Inspector General of the Department of any disclosures under 42 C.F.R. § 455.106(a) within twenty (20) business days from the date it receives the information. DOM must also promptly notify the Inspector General of HHS of any action it takes on Contractor's contractual agreement and participation in the program.

In accordance with 42 C.F.R. § 455.106(c), DOM may refuse to enter into or renew an agreement with Contractor if any person who has an ownership or control interest in Contractor, or who is an agent or managing employee of Contractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XX Services Program since the inception of those programs. Further, DOM may refuse to enter into or may terminate Contractor's agreement if it determines that Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106(a).

At the time of Contract execution, renewal, extension, and as described in Section I.H, Notice of Legal Action, Contractor must submit information for any person who has ownership and control interest of each contracted provider entity or who is an agent or managing employee of the provider (as defined by 42 C.F.R. § 455.101) and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those

programs, as required in 42 C.F.R. § 455.106. Contractor shall also make this information available to DOM upon request within thirty-five (35) calendar days. DOM may refuse to enter into or may terminate this agreement if it determines that Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106.

Contractor shall comply with Federal regulations contained in 42 C.F.R. § 455.104 and § 455.106 which also require disclosure of all entities with which a Medicaid provider has an ownership or control relationship. Contractor shall provide information concerning each Person with Ownership or Control. Contractor shall comply with Federal regulations contained in 42 C.F.R. § 455.436 which require confirmation of the identity and determination of the exclusion status of providers and any person with an ownership or control interest or who is an agent of the managing employee of the provider through routine checks of Federal databases.

Contractor shall advise DOM, in writing, within five (5) business days of any organizational change or major decision affecting its business in Mississippi or other states. This includes, but is not limited to, sale of existing business to other entities or a complete exit from the State of Mississippi to another state or jurisdiction.

2. Change of Ownership

A change of ownership of Contractor includes, but is not limited to inter vivo gifts, purchases, transfers, lease arrangements, case and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest (50.1%) of Contractor. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer-seller relationship.

Contractor must comply with all laws of the State of Mississippi and the Mississippi Department of Insurance requirements regarding change of ownership of Contractor.

Should Contractor undergo a change of direct ownership, Contractor must notify DOM in writing prior to the effective date of the transaction. The new owner must complete a new Contract with DOM and Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract.

If Contractor's parent company is publicly traded, changes in beneficial ownership must be reported to DOM in writing within sixty (60) calendar days of the end of each quarter.

J. **Responsiveness to DOM Requests**

Contractor shall perform all of the services and shall develop, produce and deliver to DOM all of the statements, reports, data, accountings, claims, and documentation described herein, in compliance with all the provisions of this Contract.

Contractor shall acknowledge receipt of DOM's written, electronic, or telephonic non-urgent requests for assistance no later than two (2) business days from receipt of the request from DOM. Executive request, program requests, and DOM Investigated Grievances must be given priority by Contractor and must be completed within the time frame requested by DOM. Such urgent requests include issues involving legislators, legislative committees (e.g., Joint Committee on Performance Evaluation and Expenditure Review), other governmental bodies, and Care Management evaluation requests involving Members or providers requiring an expeditious response based on the Member's health condition.

Contractor's acknowledgement of Division requests for assistance must include a planned date of resolution. Contractor shall submit to DOM, in the format requested, a detailed resolution summary advising DOM of Contractor's Action and resolution.

K. DOM Policies and Procedures

Contractor shall comply with all applicable policies and procedures of DOM, specifically including without limitation all policies and procedures applicable solely to CHIP, which are also covered by the Children's Health Insurance Program Reauthorization Act (CHIPRA), all of which are hereby incorporated into this Contract by reference and form an integral part of this Contract. In no instance may the limitations or exclusions imposed by Contractor with respect to covered services be more stringent than those specified in the applicable laws, policies, and procedures.

If Contractor elects not to reimburse for or provide coverage of counseling or referral service because of an objection on moral or religious grounds, Contractor must furnish information about the services it does not cover:

1. Information must be consistent with the provisions of 42 C.F.R. § 438.10;

2. Information must be provided to potential Members before and during Enrollment; and

3. Information must be provided to Members within ninety (90) calendar days after adopting the policy with respect to any particular service and at least thirty (30) calendar days of the effective date of the policy.

L. Administration, Management, Facilities and Resources

Contractor shall maintain at all times during the term of this Contract adequate staffing, equipment, facilities, and resources sufficient to serve the needs of Members, as specified in this Contract, RFP, Contractor's Proposal, and in accordance with appropriate standards of both specialty and sub-specialty care.

Contractor shall be responsible for the administration and management of all aspects of Contractor and the performance of all of the covenants, conditions, and obligations imposed upon Contractor pursuant to this Contract. No delegation of responsibility, whether by

Subcontract or otherwise, shall terminate or limit in any way the liability of Contractor to DOM for the full performance of this Contract.

Contractor shall have, at a minimum, the following key management personnel or persons with comparable qualifications, as listed below, employed during the term of this Contract. All staff must be qualified by training and experience.

Executive Positions:

1. Chief Executive Officer (CEO): A designated CEO (Contract Officer), with decision-making authority, to oversee the day-to-day business activities conducted pursuant to this Contract located in Mississippi. The Mississippi CEO must be authorized and empowered to make operational and financial decisions, including rate negotiations for Mississippi business, claims payment, and provider relations/contracting. The CEO must be able to make decisions about CHIP activities.

2. Chief Operating Officer: A designated Chief Operating Officer located in Mississippi to administer day-to-day business activities conducted pursuant to this Contract.

3. Chief Financial Officer: A professional designated to oversee financial-related functions of Contractor.

4. Medical Director: A Mississippi licensed physician to serve as the Medical Director, who shall be responsible for all clinical decisions of Contractor, and who shall oversee and be responsible for the proper provision of covered services to Members. The Medical Director must be an actively practicing physician located in Mississippi, unless otherwise authorized by DOM. The Medical Director shall be responsible for overseeing functions of the Credentialing Committee and shall be required to be the Chair of the Credentialing Committee. The Medical Director will also serve as a liaison between Contractor and providers; be available to Contractor's staff for consultation on referrals, denials, Complaints, Grievances, and Appeals; review potential quality of care problems, and participate in the development and implementation of corrective action plans.

5. Chief Information Officer: A professional who will oversee information technology and systems to support Contractor operations, including submission of accurate and timely encounter data.

6. Compliance Officer: A professional located in Mississippi who will be the individual designated by Contractor to act as a primary point of contact for DOM.

Administrative Positions:

1. Provider Services Manager: A professional located in Mississippi to be responsible for oversight of provider Services and network development.

2. Member Services Manager: A professional located in Mississippi to be responsible for oversight of Member services functions.

3. Quality Management Director: A health care practitioner responsible for overseeing QM and improvement activities.

4. Utilization Management (UM) Coordinator: A health care practitioner responsible for UM functions.

5. Grievance and Appeals Coordinator: A professional responsible for the processing and resolution of all Member Grievances and Appeals and Provider Complaints, Grievances, and Appeals.

6. Claims Administrator: A professional responsible for overseeing claims administration.

7. Other key personnel as identified by Contractor.

DOM must approve key personnel required to be located in Mississippi prior to assignment. DOM reserves the right to approve additional key positions as needed. Key management positions cannot be vacant for more than ninety (90) calendar days. Contractor must notify DOM within five (5) business days of learning that any key position is vacant or anticipated to be vacant within the next thirty (30) calendar days.

DOM may impose penalties if any key management personnel positions remain vacant for greater than ninety (90) calendar days in accordance with Section 15.E, Liquidated Damages. Contractor must submit to DOM for prior approval the proposed replacement for key positions at least fifteen (15) calendar days before hire. If the position is filled without DOM approval, DOM may impose penalties in accordance with Section 15.E, Liquidated Damages, of this Contract.

Prior to diverting any of the specified key personnel for any reason, Contractor must notify DOM in writing, and shall submit justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the delivery of covered services. Contractor shall report these changes when individuals either leave or are added to these key positions.

Contractor shall also have the following staff located in Mississippi, at a minimum:

1. A designated person to be responsible for data processing and the provision of accurate and timely reports and encounter data to DOM;

2. Designated staff to be responsible for ensuring that all contracted providers, and all Non-Contracted Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations;

3. Designated staff to be responsible for Marketing or public relations;

4. Sufficient support staff to conduct daily business in an orderly manner;

5. Sufficient medical management staffing to perform all necessary medical assessments

and to meet all CHIP Members' Care Management needs at all times; and

6. Designee(s) who can respond to issues involving systems and reporting, encounter data, Appeals, quality assessment, Member services, provider services, Well-Baby and Well-Child Care assessments and immunization services, pharmacy management, medical management, and Care Management.

M. **Base of Operations**

Contractor shall have an Administrative Office within fifteen (15) miles of DOM's High Street location in Jackson, Mississippi. The office must also have space for Division staff to work and that space must include, at a minimum, the following:

1. A private office with a door that locks;
2. A desk and desk chair;
3. A computer with a printer;
4. A fax machine;
5. A phone;
6. A bookcase;
7. A file cabinet that locks;
8. Internet access; and
9. Standard office supplies.

Contractor shall use its best efforts to ensure that its employees and agents, while on DOM premises, comply with site rules and regulations.

N. **Cultural Competency**

Contractor must demonstrate cultural competency in its communications, both written and verbal, with Members and must ensure that cultural differences between the provider and the Member do not present barriers to access and quality health care. Both Contractor and its providers must demonstrate the ability to provide quality health care across a variety of cultures.

In compliance with Section 2103(f) of the Act, Contractor shall abide by the requirements of Section 1932(a)(5) of the Act by ensuring that all notices and informational materials for Members are in an easily understood language and format.

O. **Representatives for DOM and Contractor**

At its discretion, DOM may rely on contracted Agents to perform selected activities under the direction of DOM. One of these Agents may include but is not limited to the Fiscal Agent that will process encounter data submitted by CCOs to DOM, and provide Enrollment assistance to Members.

P. **Risk Management**

Contractor may insure any portion of the risk under the provision of the Contract based upon Contractor's ability (size and financial reserves included) to survive a series of adverse experiences, including withholding of payment by DOM, or imposition of penalties by DOM.

On or before beginning performance under this Contract, Contractor shall obtain from an insurance company, duly authorized to do business and doing business in Mississippi, insurance as follows:

1. Workers' Compensation

   Contractor shall obtain, purchase, and maintain, during the life of this Contract, workers' compensation insurance for all employees performing work under this Contract. Such insurance shall fully comply with the Mississippi Workers' Compensation Law. In case any class of employees engaged in hazardous work under this Contract at the site of the project is not protected under the Workers' Compensation Statute, Contractor shall provide adequate insurance satisfactory for protection of his or her employees not otherwise protected.

2. Liability

   Contractor shall ensure that professional staff and other decision-making staff shall be required to carry professional liability insurance in an amount commensurate with the professional responsibilities and liabilities under the terms of this Contract and other supplemental contractual documents.

Contractor shall obtain, purchase and maintain, during the contract period general liability insurance against bodily injury or death in an amount commensurate with the responsibilities and liabilities under the terms of this Contractor; and insurance against property damage and fire insurance including contents coverage for all records maintained pursuant to this Contract in an amount commensurate with the responsibilities and liabilities under the terms of this Contract. Contractor shall furnish to DOM certificates evidencing such insurance is in effect after award of contract is accepted, specifically on the first business day following the contract signing, and annually thereafter.

Q. **Readiness Reviews**

Contractor shall comply with all requirements related to the assessment of Contractor's

performance prior to implementation. DOM may, at its discretion, complete readiness reviews of Contractor prior to implementation of CHIP expansions and Contract renewals. This includes evaluation of all program components including information technology, administrative services, Provider Network management, and medical management. The readiness reviews will include desk reviews of materials Contractor must develop and onsite visits at Contractor's administrative offices. DOM may also conduct onsite visits to any Subcontractor's offices.

SECTION 2 – DEFINITIONS

A. **Definitions**

1. **Abuse:** Any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to CHIP, Contractor, a Subcontractor, or provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2. **Action:** Contractor's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or Contractor's failure to provide services in a timely manner; failure to resolve Grievances or Appeals within the time frames specified in this Contract. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

3. **Advance Beneficiary Notification (ABN):** A notice to the Member indicating that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

4. **Agent:** An authorized entity that acts on behalf of DOM.

5. **Allowable Charge:** The lesser of the submitted charge or the amount established by Contractor, as provided through Provider Network contracts or based on analysis of provider charges, as the maximum amount for all such provider services covered under the terms of this Contract.

6. **Appeal:** A request for review by Contractor of a Contractor Action related to a Member or Provider. In the case of a Member, Contractor Action may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member). In the case of a Provider, Contractor Action may include, but is not limited to, delay or non-payment for covered services.

7. **Auto Enrollment:** The process by which Members who have not voluntarily selected a CHIP Contractor are assigned to a CHIP Contractor.

8. **Behavioral Health:** Mental health and/or drug and alcohol abuse treatment services provided by the county mental health/Intellectually Delayed/Developmentally Delayed programs the single county authority administrators, or other appropriately licensed health care practitioners.

9. **Benchmark Plan**: The State and School Employee's Health Insurance Plan.

10. **Benefit Period**: A period of one (1) calendar year commencing each July 1.

11. **Capitation Payments:** Actuarially determined, per Member per month rates paid to Contractor for the provision of all covered services to enrolled Members.

12. **Care Management**: A set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care Management is also referred to as Care Coordination.

13. **Case Identification Number:** With respect to the Member, includes Immediate Family Members and individuals living with the Member.

14. **Child:** For purposes of this Contract, an individual who is under nineteen (19) years of age who is not eligible for Medicaid benefits and is not covered by other health insurance. Also referred to as Member.

15. **CHIP:** The Children's Health Insurance Program as defined in Title XXI of the Social Security Act.

16. **Closed Panel:** Providers who are no longer accepting new Members for Contractor.

17. **Contractor:** An entity eligible to enter a full risk capitated contract in accordance with Section 1903(m) of the Social Security Act and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. § 438.2.

18. **Coordinated Care Organization (CCO):** An organization that meets the requirements for participation as a Contractor in CHIP and manages the purchase and provision of health care services under CHIP.

19. **Co-Payment:** The fixed amount certain CHIP Members pay for a covered health care service. The amount may vary based on the health care service being provided.

20. **Cost Sharing:** In accordance with 42 C.F.R. § 457.10, premium charges, enrollment fees, deductibles, coinsurance, Co-Payments, or other similar fees that the Member has responsibility for paying.

21. **Creditable Coverage:** Prior health insurance coverage as defined under Section 2701(c) of the Public Health Service Act (42 U.S.C. § 300gg(c)). Creditable Coverage includes coverage under group or individual health plans or health insurance, Medicare, Medicaid, other governmental plans and state health benefit risk pools.

22. **Custodial Nursing Home:** Residential designation after a Member has exhausted skilled services. However, the Member continues to have the need for non-skilled, personal care, including assistance with activities of daily living such as bathing,

dressing, eating, toileting, ambulating and transferring in a nursing facility.

23. **Deliverables:** Those documents, records, and reports required to be furnished to DOM for review and/or approval pursuant to the terms of the RFP and this Contract.

24. **Direct Paid Claims:** Claims payments before ceded Reinsurance and excluding assumed Reinsurance except as otherwise provided in Exhibit D, Medical Loss Ratio Requirements, of this Contract.

25. **Disenrollment:** Action taken by DOM, or its Agent, to remove a Member's name from the monthly Member Listing report following DOM's receipt and approval of a request for Disenrollment or a determination that the Member is no longer eligible for Enrollment in Contractor.

26. **Division:** Division of Medicaid (DOM), Office of the Governor, State of Mississippi.

27. **Division of Medicaid (DOM) Investigated Grievance:** A written Member or provider Grievance to the Executive Administrator of DOM (or to another State agency or official and which is directed to DOM) where (a) Division staff are assigned to investigate and address the issues raised by the Complaint, and (b) DOM concludes that the Grievance is valid even if the disposition of the Complaint is not resolved in favor of the complaining party. To be considered valid, these grievances must consist of Complaints or disputes expressing dissatisfaction with any aspect of the operations, activities, or behavior of Contractor, or its providers, that is in violation of the terms of this Contract and/or State or Federal law and that has the potential to cause material harm to the complainant regardless of whether remedial action is requested.

28. **Emergency Medical Condition:** In accordance with Section 1932(b) of the Act, and 42 C.F.R. § 457.10, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

29. **Emergency Services:** Inpatient or outpatient health care services that are (i) furnished by any provider qualified to furnish such services; and (ii) needed to evaluate, treat, or stabilize an Emergency Medical Condition.

30. **Emergency Transportation:** Ambulance services for emergencies.

31. **Enrollment:** Action taken by DOM to add a Member's name to Contractor's monthly Member Listing report following the receipt and approval by DOM of an Enrollment application from an eligible Member who selects a CCO or upon Auto Enrollment of a Member to a CCO.

32. **Expedited Resolution:** An expedited review by Contractor of a Contractor Action within three (3) business days after the Contract receives the request, which may extended by up to fourteen (14) days.

33. **Expedited Authorization Decisions:** Decisions required for authorization requests for which a provider indicates or Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function.

34. **Federally Qualified Health Centers (FQHC):** All organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

35. **Fee-for-Service:** A method of making payment to health care providers enrolled in the Medicaid program for the provision of health care services to Medicaid Beneficiaries based on the payment methods set forth in the Medicaid State Plan and the applicable policies and procedures of DOM.

36. **Fraud:** Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him, or herself, or some other person. The Fraud can be committed by many entities, including the vendor, a Subcontractor, a provider, a State employee, or a Member, among others.

37. **Grievance:** An expression of dissatisfaction about any matter or aspect of Contractor or its operation, other than a Contractor Action as defined in this contract.

38. **Immediate Family Member:** With respect to the Member, may include the following: i) the husband or wife of the Member; ii) the biological or adoptive parent, Child, or sibling of the Member; iii) the stepparent, stepchild, stepbrother, or stepsister of the Member; iv) the father–, mother–, daughter–, son–, brother–, or sister–in–law of the Member; v) the grandparent or grandchild of the Member; and vi) the spouse of a grandparent or grandchild of the Member.

39. **Indian:** An individual, defined at title 25 of the U.S.C. § 1603(c), 1603(f), 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. § 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or through referral under Contract Health Services.

40. **Insolvency:** The inability of Contractor to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of: (i) any capital and surplus required by law for its organization; or (ii) the total par or stated value of its authorized and issued capital stock. "Liabilities" shall include, but not be limited to, reserves required by the Department of Insurance pursuant to Miss. Code Ann. §83-

41-329.

41. **Marketing:** The activities that promote visibility and awareness for CHIP and the CCOs participating in the program. In compliance with Section 1932(d) of the Act, all activities are subject to prior review and approval by DOM and may not contain misleading information.

42. **Medical Home:** A health care setting that facilitates partnerships between individual Members, their Primary Care Providers, and when appropriate, the Member's family to provide comprehensive primary care.

43. **Medical Loss Ratio (MLR):** The proportion of premium revenues spent on clinical services and quality improvement by the CCO.

44. **Medical Loss Ratio Reporting (MLR) Year:** Calendar year (January 1 through December 31) during which benefits and services are provided to Members through contract with DOM.

45. **Medical Record:** A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services, and emergency medical services whether provided by contracted providers or Non-Contracted Providers.

46. **Medically Necessary Services:** Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

    a. Appropriate and consistent with the diagnosis or treatment of the Member's condition, illness, or injury;

    b. In accordance with the standards of good medical practice consistent with the individual Member's condition(s);

    c. Not primarily for the personal comfort or convenience of the Member, family, or provider;

    d. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Member;

    e. Furnished in a setting appropriate to the Member's medical need and condition and, when applied to the care of an inpatient, further mean that the Member's medical symptoms or conditions require that the services cannot be safely provided to the Member as an outpatient;

    f. Not experimental or investigational or for research or education;

    g. Provided by an appropriately licensed practitioner; and

h. Documented in the Member's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically necessary services are also the most appropriate services that help achieve age-appropriate growth and development and will allow a Member to attain, maintain, or regain capacity.

47. **Member:** An individual who meets all of the eligibility requirements for CHIP, enrolls in a CCO under CHIP, and receives health benefits coverage through CHIP.

48. **Non-Contracted Provider:** A health care provider who has not been credentialed by and does not have a signed provider agreement with Contractor.

49. **Ongoing Course of Treatment:** A Member is considered to be receiving an Ongoing Course of Treatment from a provider under the following circumstances: (i) during the previous twelve (12) months the Member was treated by the provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized; or (ii) any Child with a previously scheduled appointment, including an appointment for Well-Baby and Well-Child Care Services.

50. **Open Panel:** Providers who are accepting new CHIP Members as patients from Contractor.

51. **Out-of-Pocket Maximum:** The aggregate amount of Cost Sharing (e.g., deductibles, co-insurance, and Co-Payments) incurred by all enrolled Children in a single family in a Benefit Period. Once the Out-of-Pocket Maximum has been met, covered expenses are paid at one hundred percent (100%) of the Allowable Charge for the remainder of the Benefit Period.

52. **Panel:** Listing and number of Members that contracted providers have agreed to provide services for in accordance with this Contract.

53. **Performance Improvement Project:** A process or project to assess and improve processes, thereby improving outcomes of health care.

54. **Performance Measure:** The specific representation of a process or outcome that is relevant to the assessment of performance; it is quantifiable and can be documented.

55. **Post-Stabilization Care Services:** Post-Stabilization Care Services are covered services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

56. **Preferred Drug List (PDL):** A medication list recommended to DOM by the Pharmacy & Therapeutics Committee and approved by the Executive Director of DOM. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. Contractor is required to

follow the guidance provided in DOM's PDL.

57. **Primary Care Provider (PCP):** Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in CHIP, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician/Gynecologist, Family and General Practitioner, Nurse Practitioners (who meet requirements of Section 4.B, Choice of a Health Care Professional), Physician Assistants, specialists who perform primary care functions upon request, and other providers approved by DOM..

58. **Prior Authorization:** A determination to approve a provider's request, pursuant to services covered in CHIP, to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

59. **Provider Network:** The panel of health service providers with which Contractor contracts for the provision of covered services to Members and Non-Contracted Providers administering services to Members.

60. **Redetermination Date:** The date when CHIP eligibility requirements are reviewed to ensure the Member is eligible to continue receiving benefits.

61. **Reinsurance:** Private insurance purchased by Contractor to protect against individual high cost cases and/or aggregate high cost. Insurance purchased by Contractor from insurance companies to protect against part of the costs of providing covered services to Members.

62. **Reserve Account:** An account established pursuant to Section 12.A, Capitation Payments, of this Contract into which a portion of the payments made by DOM are deposited and held as security for any refund or liquidated damages due DOM.

63. **Rural Health Clinics:** The Rural Health Clinics (RHCs) program is intended to increase primary care services for Medicaid and Medicare Members in rural communities. RHCs can be public, private, or non-profit. RHCs must be located in rural, underserved areas and must use mid-level practitioners.

64. **State Child Health Plan:** State of Mississippi's plan submitted to HHS for the administration of CHIP.

65. **Subcontract:** An agreement between Contractor and an individual, business, university, government entity, affiliate, or nonprofit organization to perform part or all of Contractor's responsibilities under this Contract. DOM must approve Subcontracts in writing prior to the start date of the agreement.

66. **Subcontractor:** An entity with which Contractor enters into an agreement to provide contractually required services.

67. **Third Party Liability/Resource:** Any resource available to a Member for the payment of medical expenses associated with the provision of covered services including but not limited to, insurers and workers' compensation plans.

68. **Transitional Care Management:** A type of Care Management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting.

69. **Unpaid Claim Reserves:** Reserves and liabilities established to account for claims that were incurred during the MLR Reporting Year but had not been paid within three (3) months of the end of the MLR Reporting Year.

70. **Urgent Care:** Services that are urgently needed and the failure to provide them promptly or to continue them may cause deterioration or impair improvement in condition, including but not limited to: inpatient services, home health care, pharmaceuticals, therapy services, or surgery.

71. **Well-Baby and Well-Child Care Services:** Regular or preventive diagnostic and treatment services necessary to ensure the health of babies, children, and adolescents as defined by DOM in the State Child Health Plan. For the purposes of Cost Sharing, the term has the meaning assigned at 42 C.F.R. § 457.520.

B. **Acronyms**

1. ABN – Advance Beneficiary Notification
2. ACIP – Advisory Committee on Immunization Practices
3. CAHPS® – Consumer Assessment of Healthcare Providers and Systems
4. CAP – Corrective Action Plan
5. CCO – Coordinated Care Organization
6. CEO – Chief Executive Officer
7. CHIP – Children's Health Insurance Program
8. CLIA – Clinical Laboratory Improvement Amendments
9. CMS – Centers for Medicare and Medicaid Services
10. COB – Coordination of Benefits

11. CST – Central Standard Time

12. DOM – Division of Medicaid in the Office of the Governor, State of Mississippi

13. DOI – Department of Insurance

14. EDI – Electronic Data Interchange

15. EPA – United States Environmental Protection Agency

16. EQR – External Quality Review

17. EQRO – External Quality Review Organization

18. FFP – Federal Financial Participation

19. FQHC – Federally Qualified Health Center

20. GAAP – Generally Accepted Accounting Principles

21. GAO – General Accounting Office

22. HEDIS® – Healthcare Effectiveness Data and Information Set

23. HHS – United States Department of Health and Human Services

24. HIPAA – Health Insurance Portability and Accountability Act of 1996

25. I/T/U – Indian Tribe, Tribal Organization, or Urban Indian Organization

26. MDFA - Mississippi Department of Finance and Administration

27. MDHS – Mississippi Department of Human Services

28. MES – Medicaid Enterprise System

29. MLR – Medical Loss Ratio

30. MMIS – Medicaid Management Information System

31. MS HIN – Mississippi Health Information Network

32. MSDH – Mississippi State Department of Health

33. NCQA – National Committee for Quality Assurance

34. NPI – National Provider Identifier

35. OIG – Office of Inspector General

36. PCP – Primary Care Provider

37. PDL – Preferred Drug List

38. PHI – Protected Health Information

39. PI – Program Integrity

40. PII – Personal Identification Information

41. PIP – Performance Improvement Project

42. QI – Quality Improvement

43. QM – Quality Management

44. QMC – Quality Management Committee

45. RHC – Rural Health Clinic

46. TPL – Third Party Liability and Recovery

47. TTY/TTD – Text Telephones/Telecommunications Device for the Deaf

48. UM – Utilization Management

SECTION 3 – MEMBER ELIGIBILITY

A. Eligible Populations for CHIP

CHIP eligibility criteria will be based on criteria including citizenship, residency, age, and income requirements. Members must also meet additional requirements for Enrollment as described below and in accordance with 42 C.F.R. § 457.305(a) and § 457.320(a), and the State Child Health Plan.

CHIP will operate on a statewide basis. DOM reserves the right to assign a Member to a specific health plan.

Table 1 specifies populations that must enroll in CHIP. DOM will enroll eligible Members within these categories into one of two CCOs participating in CHIP, and Members will have the option to disenroll once within ninety (90) days of initial Enrollment. Members that disenroll and do not choose another CCO under CHIP may enroll in DOM's Medicaid program if they meet Medicaid eligibility requirements or pursue private insurance independently from DOM.

Table 1. Populations Who Are Eligible for CHIP

Populations	Income Level
Birth to Age One (1) Year	194% FPL to 209% FPL
Ages One (1) to Six (6) Years	133% FPL to 209% FPL
Age Six (6) to Nineteen (19) Years	133% FPL to 209% FPL

B. Coordination with DOM or its Agent

Contractor must develop and maintain written policies and procedures for coordinating Enrollment information with DOM or its contracted Agent. Contractor must receive advance written approval from DOM prior to use of these policies and procedures. DOM will work to review and approve within forty-five (45) calendar days.

SECTION 4 – ENROLLMENT AND DISENROLLMENT

DOM or its Agent shall send written notification to the Member to inform the Member of Enrollment into CHIP and to select a CCO and Primary Care Provider (PCP).

A. Enrollment of Members with a CCO

As part of the application process for coverage under CHIP, a Member shall select a CCO. DOM will send Members identified through the Federal Facilitated Marketplace an Enrollment form. Members will have thirty (30) calendar days to select a CCO.

Members who fail to make a voluntary CCO selection will be subject to Auto Enrollment with a Contractor by DOM. Auto Enrollment rules will include provisions to consider the following in the order listed below:

1. **Family History and Prior Enrollment in CHIP:** DOM will assign the CHIP Member to a CCO if the Member and/or individuals in the Member's Case Identification Number are or were enrolled with a particular CCO as part of CHIP within the past two (2) months. If DOM does not identify that the Member and/or individuals in the Member's Case Identification Number were enrolled in a CCO under CHIP, DOM will check if the Member was enrolled previously in the MississippiCAN Program with a particular CCO.

2. **Prior Enrollment in the MississippiCAN Program:** DOM will assign a Member to a CCO if the Member was enrolled with a particular MississippiCAN CCO within the past two (2) months. If DOM does not identify prior MississippiCAN Enrollment, DOM will review the Member's prior claims history.

3. **Prior Claims History:** DOM will review claims data and encounters from CHIP, MississippiCAN Program, and Medicaid Fee-for-Service Program during the last six (6) months. DOM will assign each Member to the CCO with the highest number of claims for a participating CCO. In cases where the number of highest claims is equal across more than one CCO, DOM will perform a review for the most recent date of service.

    a. **Date of Service:** DOM will assign the Member to the CCO with the most recent date of service for a participating CCO. If there are identical most recent dates of service across more than one CCO, DOM will perform a review for the most recent transaction control number, which uniquely identifies each claim.

    b. **Transaction Control Number:** DOM will assign the Member to the CCO with the most recent transaction control number, which is a unique 17-digit identifier for a claim assigned by the Medicaid Management Information System (MMIS).

4. If multiple contractors meet the requirements above, then assignment will occur using a random assignment.

DOM reserves the right to modify the Enrollment and Auto Enrollment rules at its discretion.

DOM may, at its discretion, set and make subsequent changes to a threshold for the percentage of Members who can be enrolled with a single CCO. Members will not be auto enrolled to a CCO that exceeds this threshold unless a family member is enrolled in the CCO or a historical provider relationship exists with a provider that does not participate in any other CCO. DOM will provide the CCOs with a minimum of fourteen (14) calendar days advance notice in writing when changing the threshold percentage.

DOM will notify Members and Contractor within five (5) business days of the selection or Auto Enrollment. DOM's notice to the Member will be made in writing and sent via surface mail. Notice to Contractor will be made via the Member Listing Report.

B. **Choice of a Health Care Professional**

Contractor shall offer each Member the opportunity to choose from at least two (2) network PCPs. Contractor shall encourage Members to select a PCP to serve as a Medical Home. If the Member does not voluntarily choose a PCP, Contractor may assign the Member a PCP. A Member who has received Prior Authorization from Contractor for referral to a specialist shall be allowed to choose from among all the available specialists and hospitals within Contractor's network to the extent possible, reasonable, and appropriate.

If Contractor elects to assign Members to a PCP, it must have written policies and procedures for assigning Members to PCPs. Contractor must submit PCP assignment policies and procedures to DOM for review and approval thirty (30) calendar days after contract execution and must submit any significant updates. Any changes or modifications to these policies and procedures must be submitted by Contractor to DOM at least thirty (30) calendar days prior to implementation and must be approved by DOM.

These policies and procedures shall include the features listed below:

1. **Providers Qualifying as PCPs:** The following types of specialty providers may perform as Primary Care Providers:

    a. Pediatricians;

    b. Family and General Practitioners;

    c. Internists;

    d. Obstetrician/Gynecologists;

    e. Nurse Practitioners (contracted nurse practitioners acting as PCPs must have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at an inpatient hospital facility or have a written

agreement with a physician who has admitting privileges at a hospital appropriate for the patient needing admission);

f. Physician Assistants;

g. Specialists who perform primary care functions upon request (e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics); or

h. Other providers approved by DOM.

2. **Change of PCP**: Contractor must allow Members to select or be assigned to a new PCP when requested by the Member, when Contractor has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal Grievance proceeding.

   Contractor must notify PCPs via mail, web portal, or by telephone of the Members assigned to them within five (5) business days of the date on which Contractor receives the Member Listing Report from DOM. If Contractor elects to notify PCPs via web portal, Contractor must confirm that the PCP acknowledges receipt of list of Members assigned to them. Contractor will also send written notification to the Member of the PCP assignment.

C. **Enrollment Period**

Each Member shall be enrolled in the CCO subject to meeting applicable CHIP eligibility requirements. Enrollment with Contractor begins at 12:01 a.m. on the first calendar day of the first calendar month for which the Member's name appears on the Member Listing Report, and is automatically renewed for twelve (12) months unless the Member becomes ineligible for the program and is disenrolled.

DOM shall provide Members with continuous open Enrollment periods. The first ninety (90) days following Enrollment will be an open Enrollment period during which they can enroll once with a different Contractor without cause.

Members may change CCOs without cause during this ninety (90) day open Enrollment period. Following the ninety (90) day open Enrollment period, these Members will be locked into that Contractor until the next open Enrollment period that will occur at least once every twelve (12) months.

DOM or its Agent will notify Members at least once every twelve (12) months, and at least sixty (60) calendar days prior to the date upon which the Enrollment period ends that they have the opportunity to switch CCOs. Members who do not make a choice will be deemed to have chosen to remain with their current CCO.

D. **Member Information Packet**

Contractor shall provide each Member, prior to the first day of the month in which their Enrollment starts, an information packet indicating the Member's first effective date of

Enrollment. Contractor must ensure the information is provided no later than fourteen (14) calendar days after Contractor receives notice of the Member's Enrollment. Contractor shall utilize at least standard mail, in envelopes marked with the phrase "Return Services Requested" as the medium for providing the Member identification information packet. DOM must receive a copy of this packet on an annual basis for review and approval thirty (30) calendar days before implementation, or at any point when changes are made to the packet. DOM will work to review and approve within fifteen (15) calendar days any changes to the packet made between annual reviews. At a minimum, the Member information packet shall include:

1. An introduction letter;

2. A CHIP Member identification card;

3. Information about how to obtain a copy of a provider directory in compliance with 42 C.F.R. § 438.10(f)(6) at a minimum;

4. Information regarding the Member's disenrollment rights; and

5. A Member handbook.

If an individual is re-enrolled within sixty (60) days of Disenrollment, Contractor is only required to send the Member a new identification card and the Member's disenrollment rights. However, the complete Member Information Packet must be supplied upon Member request.

E. **Enrollment Verification**

DOM, or its Agent, shall provide Contractor on a monthly basis a listing of all CHIP Members who have selected or been assigned to Contractor.

Contractor must ensure that Non-Contracted Providers can verify Member Enrollment in Contractor's plan prior to treating a Member for non-emergency services. Within five (5) business days of the date on which Contractor receives the Member Listing Report from DOM, Contractor must provide network providers and Non-Contracted Providers the ability to verify Enrollment by telephone or by another timely mechanism.

F. **Disenrollment**

At the time of eligibility redetermination, the Member will be disenrolled from CHIP and Contractor if the Member:

1. No longer qualifies for CHIP under the eligibility categories in the eligible population; or

2. Becomes eligible for Medicaid coverage;

3. Becomes institutionalized in a public institution or enrolled in a waiver program; or

4. Becomes eligible for Medicare coverage.

At any time, the Member must be disenrolled from CHIP and Contractor if the Member:

1. No longer resides in the State of Mississippi;

2. Is identified as pregnant and verified by DOM;

3. Is determined to have Creditable Coverage by DOM;

4. Is deceased; or

5. Becomes a Custodial Nursing Home resident.

Contractor may request Disenrollment of a Member at any time based upon one or more of the reasons listed herein. Contractor must notify DOM within three (3) calendar days of receipt of the Member Listing Report of their request that a Member be disenrolled and provide written documentation of the reason for the Disenrollment request. DOM will make a final determination regarding Disenrollment. Approved Disenrollment shall be effective on the first (1st) day of the calendar month for which the Disenrollment appears on the Member Listing Report.

Contractor must notify DOM of Members identified with a diagnosis related to pregnancy within seven (7) calendar days of identification through a report, in a format and manner to be specified by DOM. If the Member is determined to be eligible for Medicaid, DOM will transmit a termination of eligibility date to Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as Contractor receives a termination code from DOM.

Contractor must file a request to disenroll a Member with DOM in writing stating specifically the reasons for the request if the reasons differ from those specified above.

Additionally, any Member may request Disenrollment from Contractor and Enrollment into another CCO for cause if:

1. Contractor does not, because of moral or religious objections, cover the service the Member seeks;

2. Not all related services are available within the network;

3. The Member's PCP or another provider determines receiving the services separately would subject Member to unnecessary risk; poor quality of care;

4. There is a lack of access to services covered under Contractor; or

5. There is a lack of access to providers experienced in treating the Member's health care needs; or

6. When DOM imposes intermediate sanctions, as defined by 42 U.S.C. § 1396u-2; on the CCO and allows Members to disenroll without cause. In this event, CCO shall be responsible for Member notification of ability to disenroll without cause.

Member requests for Disenrollment must be directed to DOM either orally or in writing.

The effective date of any approved Disenrollment will be no later than the first (1st) day of the second (2nd) month following the month in which the Member or Contractor files the request with DOM. If DOM fails to make a disenrollment determination within the specified time frames, the disenrollment will be considered approved.

G. **Disenrollment of Custodial Nursing Home Residents**

Members who become Custodial Nursing Home Residents must be disenrolled from CHIP. When the Medicaid office has completed the nursing home application process, and the long-term care segment has been entered, the Member will automatically be closed out of CHIP Enrollment, with a closure date of one (1) day prior to the admission date. For Members who become Custodial Nursing Home Residents before the fifteenth (15th) day of a month, Contractor will be required to refund the monthly Capitation Payment for that Member to DOM. For Members who become Custodial Nursing Home Residents on or after the fifteenth (15th) day of a month, Contractor will be allowed to keep the monthly Capitation Payment for that Member.

H. **Disenrollment of Medicare Recipients**

Members who become Medicare Recipients must be disenrolled from CHIP. When DOM receives notice from regulatory source, and the Medicare segment has been entered, the Member will automatically be closed out of CHIP Enrollment, with a closure date at the end of the month of update.

Contractor will be required to render services for the months of Capitation Payment for that Member from DOM.

I. **Re-Enrollment and Retroactive Eligibility**

DOM or its Agent will automatically re-assign a Member into the CCO in which he or she was most recently assigned for CHIP if the Member has a temporary loss of eligibility, defined as less than sixty (60) calendar days.

J. **Member Listing Report**

DOM or its Agent will prepare a Member Listing Report, prior to the first (1st) day of each month, listing all Members enrolled with Contractor for that month. Adjustments will be made to each Member Listing Report to reflect corrections and the Enrollment or Disenrollment of Members reported to DOM or its Agent on or about the twenty-fifth (25th) day of the preceding month. DOM or its Agent will prepare a daily roster listing all new Members and a monthly report listing all disenrolled or closed files. The Member Listing Report will be transmitted to Contractor by electronic media. The Member Listing Report shall serve as the basis for Capitation Payments to Contractor for the ensuing month.

The Member Listing Report shall be provided to Contractor sufficiently in advance of the Member's Enrollment effective date to permit Contractor to fulfill its identification card issuance and PCP notification responsibilities, described in Sections 6.C, Member Identification Card, and 4.B, Choice of a Health Care Professional, of this Contract, respectively. Should the Member Listing Report be delayed in its delivery to Contractor, the applicable time frame s for identification card issuance and PCP notification shall be extended by one (1) business day for each day the Member Listing Report is delayed. DOM and Contractor shall reconcile each Member Listing Report as expeditiously as is feasible but no later than the twentieth (20^{th}) day of each month.

K. **Enrollment Discrimination**

Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services or on the basis of race, color, age, religion, sex, national origin, limited English proficiency, marital status, political affiliation, or level of income and shall not use any policy or practice that has the effect of discrimination on the basis of race, color, national origin, limited English proficiency, marital status, political affiliation, or level of income.

Contractor shall not disenroll a Member because of an adverse change in the Member's health status, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from Member's special needs (except when Member's continued Enrollment in Contractor seriously impairs Contractor's ability to furnish services to either this particular Member or other Members).

DOM may impose penalties in accordance with Section 15, Non-Compliance and

Termination, of this Contract if Contractor is in violation of this section.

L. **Special Rules for American Indians**

If applicable, for Indian managed care entities, Contractor may restrict Enrollment of Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

Indians who are enrolled in a non-Indian MCE and eligible to receive services from a participating I/T/U provider, to elect that I/T/U as his or her Primary Care Provider, if that I/T/U participates in the network as a primary care provider and has capacity to provide the services.

SECTION 5 – COVERED SERVICES AND BENEFITS

Contractor must ensure that all services provided are Medically Necessary. Contractor must submit reports related to covered services and benefits in accordance with Section 10, Reporting Requirements, and Exhibit G, Reporting Requirements, of this Contract.

A. Covered Services

Contractor shall provide all Medically Necessary covered services allowed under CHIP in accordance with the State Child Health Plan. Coverage includes the State and School Employee's Health Insurance Plan, also known as the Benchmark Plan, plus additional coverage and Contractor shall provide Covered services set forth in Exhibit B, Covered Services, of this Contract (for reference only). Contractor shall ensure that all covered services are as accessible to Members (in terms of timeliness, amount, duration, and scope); that no incentive is provided, monetary or otherwise, to providers for withholding from a Member's Medically Necessary Services. Contractor guarantees it will not avoid costs for covered services by referring Members to publicly supported resources, in accordance with 42 C.F.R. § 457.950. Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide covered services consistent with the requirements specified in this Contract.

Contractor will not impose any pre-existing medical condition exclusion for covered services contained in this Contract, in accordance with 42 C.F.R. § 457.480 and Section 2102(b)(1)(B)(ii) of the Act.

B. Emergency Services

Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with Contractor.

Contractor shall not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would have the outcome of placing the health of the individual (or pregnant woman and unborn child) in serious jeopardy, or would result in serious impairment to bodily functions, or would result in serious dysfunction of any bodily part.

2. Contractor instructed the Member to seek Emergency Services.

Contractor shall not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms, or refuse to cover Emergency Services within ten (10) calendar days of presentation for Emergency Services.

Coverage of Emergency Services are not subject to Prior Authorization requirements, but Contractor may include a requirement in its provider agreements that notice be given to

Contractor regarding the use of Non-Contracted Providers for Emergency Services.

Such notice requirements shall provide at least a forty-eight (48) hour time frame after the Emergency Services for notice to be given to Contractor by the Member and/or the emergency provider. Utilization of and payments to Non-Contracted Providers may, at Contractor's option, be limited to the treatment of Emergency Medical Conditions, including Medically Necessary services rendered to the Member until such time as he or she may be safely transported to a network provider service location.

C. **Post-Stabilization Care Services**

Contractor shall cover and pay for Post-Stabilization Care Services in accordance with the provisions of 42 C.F.R. § 422.113(c).

Contractor is financially responsible for Post-Stabilization Care Services obtained within Contractor's Provider Network or from a Non-Contracted Provider that are not pre-approved by a contracted provider or other Contractor representative, but administered to maintain, improve or resolve the Member's stabilized condition if:

1. Contractor does not respond to a request for pre-approval within one (1) hour;

2. Contractor cannot be contacted; or

3. Contractor representative and the treating physician cannot reach an agreement concerning the Member's care and a physician from Contractor's Provider Network is not available for consultation. In this situation, Contractor must give the treating physician the opportunity to consult with a physician from Contractor's Provider Network and the treating physician may continue with care of the Member until a Contractor physician is reached or one of the criteria of 42 C.F.R. § 422.113(c) is met.

Contractor must not charge Members upon the end of Post-Stabilization Care Services that Contractor has not pre-approved. Post-Stabilization Care Services not approved by Contractor end when:

1. A physician from Contractor's Provider Network with privileges at the treating hospital assumes responsibility for the Member's care;

2. A physician from Contractor's Provider Network assumes responsibility for the Member's care through transfer;

3. A Contractor representative and the treating physician reach an agreement concerning the Member's care; or

4. The Member is discharged.

D. **Well-Baby and Well-Child Services and Immunization Services**

Contractor shall provide Well-Baby and Well-Child Care services, including vision screening, laboratory tests and hearing screenings, according to the recommendations of the U.S. Preventive Services Task Force. Vision and hearing screenings shall be included as part of periodic Well-Child assessments.

Contractor must have written policies and procedures related to the provision of the full range of Well-Baby Care, Well-Child Care, and childhood and adolescent immunizations services as defined in, and in accordance with, the State Child Health Plan, 42 C.F.R. § 457.495, and the provisions of this Contract. Services shall include, without limitation, periodic health screenings, and appropriate and up-to-date immunizations using the immunization schedule for all Members recommended by the Advisory Committee on Immunization Practices (ACIP). Contractor shall make all reasonable efforts to identify all Members whose Medical Records do not indicate up-to- date immunizations and shall ensure that these Members receive necessary immunizations. Immunizations are purchased and distributed through the Mississippi State Department of Health. Contractor shall reimburse providers for the administration of the immunizations.

DOM requires that Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi citizens, and to actively work to improve the percentage of Members receiving appropriate screenings, and meet or exceed DOM's targets.

The following minimum elements must be included in the periodic health screening assessment for children:

1. Comprehensive health and development history (including assessment of both physical and mental development);

2. Measurements (e.g., head circumference for infants, height, weight, body mass index);

3. Comprehensive unclothed physical examination;

4. Immunizations appropriate to age and health history;

5. Assessment of nutritional status;

6. Laboratory tests (e.g., tuberculosis screening and federally required blood lead screenings);

7. Vision screening;

8. Hearing screening;

9. Dental and oral health assessment; and

10. Developmental and behavioral assessment.

If a suspected problem is detected by a screening examination, the Child must be evaluated

as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

Contractor must establish a tracking system that provides information on compliance with Well-Baby and Well-Child Care services and immunization services provision requirements in the following areas:

1. Initial visit for newborns;

2. Well-Baby and Well-Child Care services and reporting of all assessment results; and

3. Diagnosis and/or treatment for Children.

Contractor must have an established process for reminders, follow-ups and outreach to Members that includes:

1. Written notification of upcoming or missed appointments within a set time period, taking into consideration language and literacy capabilities of Members;

2. Telephone protocols to remind Members of upcoming visits and follow-up on missed appointments within a set time period;

3. Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate; and
4. A process for outreach and follow-up to Members with special health care needs.

Contractor may develop alternate processes for follow-up and outreach subject to prior written approval from DOM.

E. **Behavioral Health**

Contractor shall provide Behavioral Health services to Members in CHIP. Contractor shall comply with all requirements related to Care Management, access and availability with respect to Behavioral Health services. All Behavioral Health services covered by the State Child Health Plan that are medically necessary must be covered.

All Contract requirements herein shall apply to the provision of Behavioral Health services unless specified.

F. **Prescription Drug Services**

Contractor shall provide pharmacy services to Members enrolled in CHIP. Contractor shall comply with the Mississippi Pharmacy Practice Act (Miss. Code Ann. § 73-21-71, *et. seq.*) and the Mississippi Board of Pharmacy rules and regulations.

Contractor is restricted from requiring Members to utilize a pharmacy that ships, mails, or delivers prescription drugs or devices.

Contractor must use the most current version of the Medicaid Program Preferred Drug List (PDL), which is subject to periodic changes. Contractor must use the Medicaid PDL developed by DOM or its Agent and may not develop and use its own PDL. Contractor will be provided opportunities to offer feedback on the PDL to the Pharmacy and Therapeutics Committee, which is an advisory panel that conducts in- depth clinical evaluations and recommends appropriate drugs for preferred status on the PDL and/or drugs for Prior Authorization. The Executive Director of DOM has final authority on drugs with preferred status on the PDL and/or drugs for Prior Authorization.

Benefits will be provided for select over the counter medications purchased with a prescription, including analgesics, vitamins, nicotine replacement, topical formulations, gastrointestinal agents, and cough/cold medications.

Refer to the Pharmacy Services page on DOM's website for a current listing of prescription drugs on the PDL to ensure continuity of care for Members.

Contractor may approve drugs outside the PDL in accordance with Section 5.H, Prior Authorizations, of this Contract. Contractor must cover and pay for a minimum of a three (3)-day emergency supply of prior authorized drugs until authorization is completed. Contractor shall ensure that prescription drugs are prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment may be made for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature. Contractor may consider exceptions to the criteria if there is sufficient documentation of stable therapy as reflected in ninety (90) calendar days of paid claims.

Contractor shall negotiate rebates with drug companies for preferred pharmaceutical products and submit data to DOM regarding the amount of rebates received for Members specific to CHIP semi-annually, in a format to be specified by DOM.

The dispensing limits for any drug may be restricted to a thirty (30)-day supply at one time. A Member must be allowed to obtain an early refill of a prescription drug under certain circumstances, such as change of dosage during the course of treatment, for lost or destroyed medication, or when the Member is going on vacation. The Member or his/her representative may be required to contact Contractor to obtain authorization for any early refill or advance supply of a medication.

DOM processes Prior Authorization requests for prescription drugs within twenty-four (24) hours of receiving the request. Contractor shall adhere to this time frame.

G. Enhanced Services

Contractor may provide enhanced services that exceed the benefits or services provided under CHIP delivery system, subject to advance written approval by DOM. Enhanced services are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable services include various seminars and educational programs promoting healthy living or illness

prevention, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Members, and may not be tied to specific Member performance without DOM prior approval. DOM may grant exceptions in areas where it believes that such tie-ins shall produce significant health improvements for Members.

Contractor may only include information in Member communications about enhanced services that will apply for a minimum of one full year or until the Member information is revised, whichever is later. Upon sixty (60) calendar days advance notice to DOM, Contractor may modify or eliminate any expanded services. Contractor must send written notice to Members and affected providers at least thirty (30) calendar days prior to the effective date of the change in covered services and must simultaneously amend all written materials describing its covered benefits or Provider Network.

If Contractor elects to provide enhanced services, it shall submit a statement annually as to the value of these services in a format to be specified by DOM.

H. Prior Authorizations

1. General Requirements

   Contractor must have written policies and procedures for the Prior Authorization of services, which must comply with this Contract and 42 C.F.R. § 457.495. DOM must receive Prior Authorization criteria and associated policies and procedures for advanced written approval forty-five (45) calendar days prior to implementation.

   Contractor shall have procedures for processing requests for initial and continuing authorizations of services. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a physician pursuant to 42 C.F.R. § 438.210(b)(3) and Miss. Code Ann. § 41-83-31. The physician shall also have appropriate clinical expertise in treating the Member's condition or disease.

   Contractor shall use a mechanism to ensure consistent application of review criteria for authorization decisions that includes consultation with the requesting provider when appropriate.

   Contractor may not structure compensation to individuals or UM entities so as to provide inappropriate incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Member.

2. Pharmacy

   Contractor must establish policies and procedures to comply with DOM's Prior Authorization criteria in accordance with the PDL guidance for the drugs listed on the PDL. Contractor may approve drugs outside of the PDL when one of the following Prior Authorization criteria is satisfied:

a. Member must have used the preferred agents for at least a thirty (30) calendar day course of treatment per drug and failed trials within six (6) months prior to requesting the Prior Authorization and there is documentation of therapeutic failure of preferred drugs; or

b. Adverse event(s) reaction(s) to preferred medications; or

c. Contraindications to preferred medications (i.e. drug interaction, existing medical condition preventing the use of preferred medications).

Contractor must establish criteria and coverage policies for drugs not listed on the PDL, which must be approved by DOM. DOM must receive this criteria and coverage policies for advanced written approval forty-five (45) calendar days prior to implementation. Contractor must ensure that decisions regarding policies and procedures for administration of prescription drugs are made in a clinically sound manner.

3. Web-based Prior Authorization System

Contractor shall have the capability and established procedures to receive Prior Authorization requests and supporting information via secure web-based submissions and facsimile from providers.

Contractor shall establish a Web-based, electronic review request system accessible to providers and DOM staff, through which providers may submit requests and view determinations. Contractor shall also have the capability to accept supporting documentation for Prior Authorization requests via facsimile transmission, via electronic upload through the Web-based system or via a secure email solution.

Contractor shall have the ability to communicate through the Mississippi Health Information Network (MS HIN) in the future.

Contractor's Web-based, electronic review request system shall include the ability for authorized users to access the Web-based, electronic review request system via a secured logon. Contractor shall establish a protocol to assign user logons and passwords upon receipt of necessary documentation, to verify that the user is authorized to view Member information.

Contractor shall include in the Web-based, electronic review request system the ability for users to view and securely download all data, analytics, or reports that are specific to the user defined by the user's profile and security access.

Contractor's Web-based, electronic review request system shall have the ability to receive Prior Authorization requests from providers using a HIPAA ASC X12 278 Transaction, for the services where electronic submission is required. Contractor shall have the capability to assign a unique tracking number to each review record. Contractor's Web-based, electronic review request system shall have the ability to send and receive HIPAA-compliant Personally Identifiable Information (PII) and

Protected Health Information (PHI) transactions for Prior Authorization requests requiring attachments.

Contractor shall create a "smart" electronic authorization request form, customized for each service that requires certification. The form must be standardized for all CHIP CCOs and must receive prior approval by DOM. The form must be submitted by Contractor to DOM for review and approval fifteen (15) calendar days prior to use. Contractor shall design this form so that it reduces the chances of technical denials due to incorrect or missing information.

Contractor shall provide training in the use of the Web-based system and the equipment required for DOM online access to the Web-based system. DOM staff shall be given access to Contractor's electronic system for the purpose of monitoring Prior Authorizations (at no additional cost to DOM).

4. Time Frames

Contractor must notify the requesting provider and the Member in writing of any decision by Contractor to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested by the treating provider and/or Member. The notice must meet the requirements specified in 42 C.F.R. § 438.404.

Contractor must make standard authorization decisions and provide notice within three (3) calendar days and/or two (2) business days per Minimum Standards for Utilization Review Agents issued by the Mississippi State Department of Health (MSDH) following receipt of the request for services. If Contractor requires additional medical information in order to make a decision, Contractor will notify the requesting provider of additional medical information needed and Contractor must allow three (3) calendar days and/or two (2) business for the requesting provider to submit the medical information. If Contractor does not receive the additional medical information, Contractor shall make a second attempt to notify the requestor of the additional medical information needed and Contractor must allow one (1) business day or three (3) calendar days) for the requestor to submit medical information to Contractor.

Once all information is received from the provider, if Contractor cannot make a decision, the three (3) calendar day and/or two (2) business day period may be extended up to fourteen (14) additional calendar days upon request of the Member or the provider to Contractor, or if Contractor justifies to DOM a need for additional information and how the extension is in the Member's best interest. The extension request to DOM applies only after Contractor has received all necessary medical information to render a decision and Contractor requires additional calendar days to make a decision. Contractor must provide to DOM the reason(s) justifying the additional calendar days needed to render a decision. DOM will evaluate Contractor's extension request and notify Contractor of decision within three (3) calendar days and/or two (2) business days of receiving Contractor's request for extension.

Contractor must expedite authorization for services when the provider indicates or Contractor determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Contractor must provide an Expedited Authorization Decision notice no later than twenty-four (24) hours after receipt of the expedited authorization request. This twenty-four (24) hour period may be extended up to fourteen (14) additional calendar days upon request of the Member, provider, or Contractor. Contractor must justify to DOM a need for additional information and how the extension is in the Member's best interest. The extension request to DOM applies only after Contractor has received all necessary medical information to render a decision and Contractor requires additional calendar days to make a decision. Contractor must provide to DOM the reason(s) justifying the additional calendar days needed to render a decision. DOM will evaluate Contractor's extension request and notify Contractor of decision within three (3) calendar days and/or two (2) business days of receiving Contractor's request for extension.

I. Advance Directives

Contractor shall develop, document, and maintain advance directive policies that comply with 42 C.F.R. § 422.128 and with the State's Uniform Health Care Decisions Act (Miss. Code Ann. § 41-41-201, *et seq.*).

Contractor shall reflect changes in State law in its written advance directives information as soon as possible, but no later than ninety (90) days after the effective date of the change.

J. Member Notification

Contractor shall mail written notice to Members of the opportunity for a Member Appeal in the event of the termination, suspension, or reduction of previously authorized Covered Services within ten (10) calendar days of the date of the Action for previously authorized services as permitted under 42 C.F.R. § 431, Subpart E.

Denials of Claims that may result in Member financial liability require immediate notification. All Member communications shall meet the requirements of Section 6.F, Communication Standards, of this Contract.

Contractor must give notice of adverse action by the date of the action when any of the following occur:

a. The Member has died;

b. The Member submits a signed written statement requesting service termination;

c. The Member submits a signed written statement including information that requires service termination or reduction and indicates that the Member understands that service termination or reduction will result;

d. The Member has been admitted to an institution in which he is ineligible for CHIP services

e. The Member's address is determined unknown based on returned mail with no forwarding address;

f. The Member is accepted for CHIP services by another local jurisdiction, state, territory, or commonwealth;

g. A change in the level of medical care is prescribed by the Member's physician;

h. The notice involves an adverse determination with regard to preadmission screening requirements; and

i. If applicable, the transfer or discharge from a facility will occur in an expedited fashion as described in 42 C.F.R. § 483.12(a)(5)(ii).

K. **Immunization Schedules**

Contractor shall cooperate with the MSDH in matching CHIP Enrollment data with immunization records.

Contractor shall develop and implement procedures to contact Members and their parents/guardians who have not complied with the recommended schedule by the ACIP and to arrange appointments for such Members to receive required immunizations.

L. **Member Financial Liability**

Contractor shall educate network providers to collect Co-Payments from Members in accordance with Table 2.

Table 2. Allowable Cost Sharing by FPL

Requirement	≤150% FPL	151% to 175% FPL	176% to 209% FPL
Per Physician Visit	None	$5.00	$5.00
Per Emergency Room Visit	None	$15.00	$15.00
Out-of-Pocket Maximum	N/A	$800.00	$950.00

Contractor shall track the amount of Co-Payments collected in a given calendar year. When a Member meets his or her Out-of-Pocket Maximum, Contractor shall send a letter to the Member indicating that no further Co-Payments should be paid for the remainder of the State Fiscal Year. Contractor shall include instructions in the letter to

present the letter when future health services are sought, or request the provider to contact Contractor regarding this issue. Contractor must submit the template letter to DOM thirty (30) calendar days prior to use for DOM review. No Cost Sharing may be collected from these CHIP Members for the balance of the State Fiscal Year.

Contractor shall comply with all Cost Sharing restrictions imposed on Members by Federal or State laws and regulations, including the following specific provisions:

1. Contractor shall not apply Cost Sharing to the following services: preventive services, including immunizations, Well-Baby and Well-Child Care Services, routine preventive and diagnostic dental services, routine dental fillings, routine eye examinations, eyeglasses, and hearing aids in accordance with 42 C.F.R. § 457.520.

2. Contractor shall not apply Cost Sharing to the costs of Emergency Services that are provided at a facility that does not participate in Contractor's Provider Network beyond the Cost Sharing amounts specified in Table 2, in accordance with 42 C.F.R.§ 457.515(f).

3. Federal law prohibits charging premiums, deductibles, coinsurance, Co-Payments, or any other Cost Sharing to Native Americans or Alaskan Natives. Contractor shall be responsible for educating network providers regarding the waiver of Cost Sharing requirements for this population.

4. Members shall not be liable for payments to providers for Covered Services provided other than the Co-Payments referenced within this Contract.

5. Providers may not bill a Member for Covered Services in the event the CCO becomes insolvent.

In addition, a Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the Member. The attending emergency physician, or the treating provider, is responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on Contractor for coverage and payment.

SECTION 6 – MEMBER SERVICES

Contractor must submit reports related to Member services in accordance with Section 10, Reporting Requirements, and Exhibit G, Reporting Requirements, of this Contract.

A. Member Services Call Center

Contractor must maintain and staff a toll-free dedicated Member services call center to respond to Members' inquiries, issues, or referrals. Members will be provided with one (1) toll free number, and Contractor's automated system and call center staff will route calls as required to meet Members' needs.

1. Hours of Operation

   Contractor's Member services call center must operate at a minimum during regular business hours (8:00 a.m. to 5:00 p.m. Central Standard Time (CST), Monday through Friday) and one (1) evening per week (5:00 p.m. to 8:00 p.m. CST) and one (1) weekend per month with the exception of Mississippi State holidays to address non-emergency problems encountered by Members. Contractor must also operate a nurse advice line to receive, identify, and resolve in a timely manner emergency Member issues on a twenty-four (24) hour, seven (7) day-a-week basis.

   In the case of Behavioral Health services, Members shall have access twenty-four (24) hours, seven (7) days per week to clinical personnel who act within the scope of their licensure to practice a Behavioral Health-related profession.

2. Functions

   Contractor's Member services functions must include, but are not limited to, the following Member services standards:

   a. Explaining the operation of Contractor and assisting Members in the selection of a PCP;

   b. Assisting Members with making appointments and obtaining services;

   c. Explaining Member rights and responsibilities;

   d. Handling, recording and tracking Member Grievances and Appeals in accordance with this Contract;

   e. Referring Members to the Fraud and Abuse Hotline; and

   f. Receiving, identifying, and making appropriate referrals to assist Members in resolving emergency Member issues.

3. Customer Care

Contractor must develop appropriate, interactive scripts for call center staff to use during initial welcome calls when making outbound calls to new Members and to respond to Member calls, which are subject to DOM approval prior to use. Contractor's call center staff must also use a DOM-approved script to respond to Members who call to request assistance with PCP selection. Contractor must develop special scripts for emergency and unusual situations, as requested by DOM. All scripts must be clear and easily understood. Contractor must review the scripts annually to determine any necessary revisions. DOM reserves the right to request and review call center scripts at any time. All call center scripts must be submitted by Contractor to DOM for review and approval thirty (30) calendar days prior to use.

Under no circumstances will unlicensed Member services staff provide health-related advice to Members requesting clinical information. In such cases, these calls must be immediately transferred to clinical personnel as defined above. Contractor must ensure that all such inquiries are addressed by clinical personnel acting within the scope of their licensure to practice a health-related profession.

Contractor's internal staff is required to ask the callers whether they are satisfied with the response given to their call. All calls must be documented and if the caller is not satisfied, Contractor must ensure that the call is referred to the appropriate individual within Contractor for follow-up and/or resolution. This referral must take place within forty-eight (48) hours of the call.

Contractor is not permitted to utilize electronic call answering methods, as a substitute for staff persons, to perform this service after business hours.

Contractor shall randomly select and record calls received at the call center and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. Contractor will report the findings of these audits to DOM upon request within five (5) business days. Contractor will make recordings and associated transcripts available to DOM upon request within five (5) business days. Contractor shall maintain the recordings and associated transcripts for at least twelve (12) months.

4. Staff Training

Contractor's Member services call center staff must receive trainings at least quarterly. Trainings must include education about CHIP, appropriate instances for transferring a Member to a Care Manager, and customer service. Staff must receive updates about continued CHIP changes and requirements, including "Late Breaking News" articles, provider bulletins, and CHIP updates. Contractor will submit reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

5. Performance

Contractor shall maintain sufficient equipment and call center staff to ensure that the

abandonment rate for any month is not greater than five percent (5%). Contractor will be subject to sanctions if the abandonment rate exceeds this target, in accordance with Section 15.E, Liquidated Damages, of this Contract.

B. **Member Education**

Contractor must implement, monitor, and evaluate a program to promote health education for its new and continuing Members. Contractor shall maintain an annual health education and prevention work plan, based on the needs of its Members, and shall submit this work plan, with quarterly updates, to DOM for approval. DOM will work to review and approve work plan and quarterly updates within thirty (30) calendar days.

At a minimum, the health education and prevention work plan shall describe topics to be addressed, the method of communication with Members, the method of identifying those Members who will be contacted, and the time frames for distributing materials or outreach to Members. Any changes to the health education and prevention work plan, and all materials to be distributed to Members, must be approved by DOM prior to implementation or distribution. The comprehensive health education program shall support and complement Contractor's Care Management programs.

Contractor shall also conduct, in collaboration with DOM, Workshops targeting Members. DOM will notify Contractor of the dates, times, and locations for Workshops. DOM will determine the topics to be covered during each workshop and Contractor shall assist in the presentation of the content. Contractor must submit material used at the Workshops to DOM for approval thirty (30) calendar days prior to the Workshop.

C. **Member Identification Card**

Contractor shall provide each Member an identification card that is recognizable and acceptable to Contractor's network providers. Contractor may only issue one (1) identification card for all covered benefits. Contractor's identification card will include, at a minimum, the name of the Member, the CHIP Member identification number, effective date of coverage, the name and address of Contractor, the name of the Member's PCP (if PCP name is available), a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, the Member services call center phone number, a telephone number for providers to verify eligibility, instruction on obtaining Prior Authorizations including telephone number to call, Cost Sharing amounts and Out-of-Pocket Maximum, and a Contractor identification number, if applicable. Contractor must submit and receive approval of the identification card from DOM fifteen (15) calendar days prior to production of the cards.

Contractor shall provide each Member an identification card, prior to the first day of the month in which their Enrollment starts. Contractor must mail all Member identification cards, utilizing first class presorted mail.

On a monthly basis, Contractor shall provide DOM the date and the number of identification cards mailed to new Members each month.

In cases of returned Member identification cards, Contractor must attempt to contact the Member to verify the Member's address. Contractor shall be innovative and employ creative techniques to contact Members with returned Member identification cards and identify valid addresses for these Members. Contractor shall submit reports on returned Member identification cards in accordance with Section 10.D, Member Identification Card Reports.

D. **Member Handbook**

After Contractor receives notice of the Member's Enrollment and prior to the first day of the month in which their Enrollment starts, Contractor must provide the Member handbook to each Member along with a cover letter providing a summary of the contents of the Member handbook. At least annually, Contractor shall notify all Members of their right to request and obtain the information specified in the Member handbook and in this Contract.

Contractor shall maintain a Member handbook specific to CHIP. The Contractor shall submit a copy of the Member Handbook to DOM for approval sixty (60) calendar days prior to distribution and as part of the readiness review process. Contractor must update the Member handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or an electronic redlined handbook showing before and after language. Upon receipt of any changes to the initial handbook, DOM will work to review and approve any changes within forty- five (45) calendar days. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between Contractor and DOM.

Contractor shall give each of its Members thirty (30) calendar days' written notice of any material change to CHIP before its intended effective date.

When there are changes to covered services, benefits, or the process that the Member should use to access benefits, (i.e., different than as explained in the Member handbook), Contractor shall ensure that affected Members are notified of such changes at least fourteen (14) calendar days prior to their implementation.

The Member handbook must include at a minimum the following information:

1. Table of Contents

2. Terms and conditions under which Member eligibility and coverage for CHIP may be terminated

3. A general description of covered services, including the appropriate utilization of services and eligibility determination process

4. A description of the Members subject to Co-Payments and Out-of-Pocket Maximums, the amount of the Co-Payments and Out-of-Pocket Maximums, the mechanism for Members to make Co-Payments for required charges, and a provider's right to refuse service of

Co-Payments are not paid by the Member

5. Procedures to be followed if Member wishes to change Contractors

6. PCP roles and responsibilities in serving as a Medical Home in directing care

7. Information about choosing and changing PCPs

8. Making appointments and accessing care

   a. Appointment-making procedures and appointment access standards;

   b. A description of how to access all services including specialty care and authorization requirements;

   c. Any restrictions on the Member's freedom of choice among network providers;

   d. The extent to which, and how, Members may obtain benefits, including information about receiving care from Non-Contracted Providers and any referral requirements; and

   e. Information about family planning services.

9. Member Services

   a. Instructions on how to contact the Member services call center and a description of the functions of Member services;

   b. A description of availability of and instructions on how to access clinical personnel who act within the scope of their licensure to practice medical and Behavioral Health-related profession twenty-four (24) hours, seven (7) days per week;

   c. A description of availability of and instructions on how to utilize the twenty-four (24) hours, seven (7) days per week nurse advice line;

   d. A description of Well-Baby and Well-Child Care services and instructions advising Members about how to access such services;

   e. A description of all available covered services, including Behavioral Health, dental, maternity, pharmacy, and preventive services, and an explanation of any service limitations, referral, and Prior Authorization requirements. This description should include that the Member may receive a minimum of a three (3)-day emergency supply for prior authorized drugs until authorization is completed;

   f. A description of family planning services and how Members may obtain benefits from Non-Contracted Providers;

g. Information about the features of Care Management, the responsibilities of Contractor for coordination of Member care, and the Member's role in the Care Management process;

h. Procedures for notifying Members of the termination or change in any benefits, services, or locations;

i. A description of the enhanced services Contractor offers, if applicable;

j. A description of Contractor's confidentiality policies;

k. An explanation of any service limitations or exclusions from coverage; including limitations that may apply to services obtained from Non-Contracted Providers;

l. A notice stating that the Member shall be liable only for those services subject to Prior Authorization and not authorized by Contractor and non-covered services;

m. Circumstances under which an eligible Member may be involuntarily disenrolled from Contractor and enrolled into another CCO, and/or from CHIP without any insurance coverage.

10. Instructions on reporting suspected cases of Fraud and Abuse to the Fraud and Abuse Hotline

11. Member Grievances and Appeals

    a. A description of the Member Grievance and Appeals procedures including, but not limited to:

        i. The definition of a Member Grievance and Appeal and who may file each of these;

        ii. Information on filing Member Grievances and Appeal procedures;

        iii. Time frames to register and receive a response regarding a Member Grievance or Appeal with Contractor as described in this Contract;

        iv. The availability of assistance in the filing process, including making available reasonable assistance in completing forms and taking other procedural steps;

        v. The toll-free numbers that the Member can use to file a Member Grievance or an Appeal by telephone;

        vi. A description of the continuation of Enrollment process required by 42 C.F.R. § 457.1170 and information describing how the Member may request continuation of Enrollment;

vii. Information on how the Member may be required to pay the cost of services furnished while the Member Appeal is pending, if the final decision is adverse to the Member; and

viii. Telephone numbers to register Member Grievances regarding providers and Contractor.

12. Emergency Medical Care

a. How to appropriately use Emergency Services and facilities, including a description of the services offered by the Member services call center;

b. Explanation of the definition of an emergency using the "prudent layperson" standard as defined by this Contract and in accordance with 42 C.F.R. § 438.114, a description of what to do in emergency, instructions for obtaining advice on getting care in an emergency, and the fact that Prior Authorization is not required for Emergency Services. Members are to be instructed to use the emergency medical services available or to activate Emergency Services by dialing 911;

c. A description of how to obtain Emergency Transportation and other medically necessary transportation;

d. Availability in the provider directory of locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-Stabilization Care Services covered herein;

e. Information indicating that Emergency Services are available without Prior Authorization and out-of-network Emergency Services are available without any financial penalty to the Member;

f. Information indicating that Members have a right to use any hospital or other setting for emergency care; and

g. Definition of and information regarding coverage of Post-Stabilization Care Services in accordance with 42 C.F.R. § 422.113(c).

13. Member Identification Cards

a. A description of the information printed on the Member Identification Card; and

b. A description of when and how to use the Member Identification Card;

14. Interpretation and Translation Services

a. Information on how to access verbal interpretation services, free of charge, for any non-English language spoken [42 C.F.R. § 438.1 O(c)(5)(i)];

b. A multilingual notice that describes translation services that are available and provides instructions explaining how Members can access those translation services [42 C.F.R. § 438.10(c)(5)(i)]; and

c. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individuals with visual impairments [42 C.F.R. § 438.10(d)(2)].

15. Member Rights

a. A description of Member rights and protections as specified in 42 C.F.R. § 438.100 and Section 6.I, Member Rights and Responsibilities, of this Contract as provided during open Enrollment;

b. Information explaining that each Member is entitled to a copy of his or her Medical Records and instructions on how to request those records from Contractor. [42 C.F.R. § 438.100(b)(2)(vi)]; and

c. Information about Contractor's privacy policies.

16. Member Responsibilities

a. A description of procedures to follow if:

i. The Member's family size changes;

ii. The Member moves out of state or has other address changes; and

iii. The Member obtains or has health coverage under another policy or there are changes to that coverage.

b. Actions the Member can make towards improving his or her own health, Member responsibilities and any other information deemed essential by Contractor;

c. Information about the process that Members and providers must follow when requesting inpatient Prior Authorization and how to notify Contractor of an inpatient admission;

d. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 C.F.R. § 422.128 and the State's Uniform Health Care Decisions Act (Miss. Code Ann. § 41-41-201, et. seq.; and

e. Information regarding the Member's repayment of capitation premium payments if Enrollment is discontinued due to failure to report truthful or accurate information when applying for CHIP;

17. Contractor Responsibilities

a. Additional information that is available upon request, including information about the structure and operation of Contractor;

b. Additional information about physician incentive plans as set forth in 42 C.F.R. § 438.6(h); and

c. Notification to the Member that DOM should be notified if the Member has another health insurance policy or Creditable Coverage.

E. **Provider Directory**

Contractor shall maintain a provider directory specific to CHIP. Contractor shall develop, regularly maintain, and make available provider directories that include information for all types of providers in Contractor's network including, but not limited to PCPs, hospitals, specialists, providers of ancillary services, Behavioral Health facilities, and pharmacies. In accordance with 42 C.F.R. § 438.10(f)(6), the provider directory shall include, but is not limited to:

1. Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Member's area;

2. Identification of PCPs and PCP groups, specialists, and hospitals, facilities, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) by area of the State;

3. Identification of any restrictions on the Member's freedom of choice among network providers;

4. Identification of Closed Panels; and

5. Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. CST or any weekend hours).

Contractor shall make available hard copy provider directories in DOM Regional Offices, the CCOs' offices, WIC offices, upon Member request, and other areas as directed by DOM.

Contractor must also utilize a web-based provider directory, which must be updated within five (5) business days upon changes to the Provider Network. Contractor must establish a process to ensure the accuracy of electronically posted content, including a method to monitor and update changes in provider information. Contractor must perform monthly reviews of the web-based provider directory, subject to random monitoring by DOM to ensure complete and accurate entries.

Contractor must submit its provider directory template to DOM for advance written approval fifteen (15) calendar days prior to use and before distribution to its Members if there are significant format changes to the directory template.

F. **Communication Standards**

All written material provided to Members or potential Members, including all Marketing materials, plan booklets, descriptions and information, instructional materials, policies and procedures disclosures, notices and handbooks must meet requirements specified under 42 C.F.R. § 438.10 and meet the following requirements:

1. Documents are comprehensive yet written to meet a Flesch-Kincaid, or other DOM-approved standard, with a total readability level that does not exceed the sixth (6th) grade level of reading comprehension. Materials must set forth the Flesch-Kincaid, or other approved standard, score and certify compliance with this standard. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.)

2. Documents are available in the prevalent non-English languages in the State of Mississippi, which is defined as five percent (5%) of Contractor's enrolled Members who speak a common, non-English language, in compliance with DOM's Limited English Proficiency Policy.

3. Documents are available, upon request, in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited in accordance with 42 C.F.R. § 438.10(d)(1)(ii).

All Enrollment, Disenrollment and educational documents and materials made available to Members by Contractor must be submitted to DOM for review and approval thirty (30) calendar days prior to release, unless specified elsewhere in this Contract. Contractor must review all materials on an annual basis and provide a list of these materials to DOM annually on October first (1st) indicating the review date. If Contractor revises these materials, Contractor will submit the updated materials to DOM for review and approval highlighting and using a redlined format for changes.

Contractor shall participate in DOM's efforts to promote the delivery of services in a culturally competent manner to all Members including those with limited English proficiency and diverse cultural and ethnic backgrounds.

G. **Internet Presence/Website**

Contractor shall develop, host and maintain a website specific to CHIP. Contractor shall provide general and up-to-date information about Contractor's programs, Provider Network, customer services, and Member and Provider Grievance and Appeals systems on a non-secure section of the website. PHI shall be accessible through a secure section of the website.

The website must comply with the Marketing policies and procedures, requirements for written materials described in this Contract, and must be consistent with applicable State and Federal laws.

Contractor shall submit website screenshots to DOM for review and approval thirty (30) calendar days prior to making the website available and as updated.

1. Member Portal

   Contractor shall maintain a Member portal that allows Members to access a searchable provider directory. Contractor shall also include a copy of the Member handbook, information about Member rights and responsibilities and the Complaints, Grievances, and Appeals process on the Member portal.

   The website must have the capability for Members to submit questions and comments to Contractor and for Members to receive responses.

2. Provider Portal

   Contractor shall dedicate a section of its website to provider services and is encouraged to promote the use of the provider portal among providers. At a minimum, Contractor's provider portal must provide the following capabilities for providers:

   a. Ability to submit inquiries and receive responses;

   b. Access to a copy of the provider manual;

   c. Access to newsletters, updates, and provider notices;

   d. Access to a searchable provider directory;

   e. Ability to link to the State's Medicaid PDL;

   f. Ability to submit Prior Authorization requests and view the status of such requests (e.g., approved, denied, pending);

   g. Information about the process providers must follow when requesting inpatient Prior Authorization; and

   h. Ability to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate claims electronically.

   To the extent a provider has the capability, Contractor shall submit electronic payments and remittance advices to providers. Remittance advices must be provided within one (1) to five (5) business days of when payment is made.

H. **Marketing**

Contractor may not directly market to potential Members and must adhere to the requirements specified by 42 C.F.R. § 438.104. DOM is responsible for creating a process to provide information about choice of Contractors and enrolling the Members into their

chosen Contractor. DOM and/or its Agent will handle all Marketing to potential Members.

Contractor shall develop Marketing materials such as written brochures and fact sheets. Marketing plans and materials shall not mislead, confuse, or defraud the Members or DOM. Specifically, Contractor cannot make any assertion or statement, whether written or verbal, that the Member must enroll in Contractor's CCO in order to obtain benefits or to not lose benefits or that Contractor is endorsed by CMS, the Federal or State government, or similar entity. Contractor shall submit all Marketing materials to DOM thirty (30) business days prior to the planned distribution and DOM must approve these materials before they are released.

Contractor shall maintain procedures to log and resolve Marketing Complaints, including procedures that address the resolution of Complaints against Contractor, its employees, affiliated providers, agents, or Subcontractors. These procedures shall contain a provision that a Contractor employee outside the Marketing department resolve or be involved in the resolution of Marketing/customer service Complaints. Marketing Complaints that cannot be satisfactorily resolved between Contractor and the complainant must be forwarded to DOM for further investigation and resolution.

Marketing and promotional activities (including provider promotional activities) must comply with all relevant Federal and State laws, including, when applicable, the anti-kickback statute, civil monetary penalty prohibiting inducements to Members. An organization may be subject to sanctions if it offers or gives something of value to a Member that the organization knows or should know is likely to influence the Member's selection of a particular provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by CHIP. Additionally, organizations are prohibited from offering rebates or other cash inducements of any sort to Members.

1. Marketing Services

   Contractor shall:

   a. Submit to DOM, for prior written approval a work plan of planned Marketing activities annually. DOM will work to review and approve the work plan within forty-five (45) calendar days;

   b. Submit a log of all completed Marketing activities quarterly;

   c. Submit all new and/or revised Marketing and informational materials or proposed changes to the Marketing work plan to DOM before their planned distribution or implementation (42 C.F.R. § 438.104). Upon receipt, DOM will work to review within fifteen (15) calendar days. Contractor may distribute Marketing materials to CHIP Members where the Member is currently enrolled with Contractor, assuming that DOM has approved the Marketing materials for distribution to Members;

   d. Coordinate and submit to DOM all schedules, plans, and informational materials for

community education, networking and outreach programs. Contractor shall submit the schedule to DOM at least two (2) weeks prior to any event and must be approved by DOM;

e. Assure that all Marketing and informational materials shall set forth the Flesch-Kincaid, or other approved standard, readability scores at or below sixth (6th) grade reading level and certify compliance therewith; and

f. Be subject to a fine or other sanctions if it conducts any Marketing activity that is not approved in writing by DOM (42 C.F.R. § 438.700).

2. Allowable Contractor Marketing Activities

Contractor may engage in the following promotional activities with prior DOM approval:

a. Notification to the public of Contractor in general in an appropriate manner through appropriate media, throughout its Enrollment area;

b. Distribution through DOM or DOM's Agent of promotional materials pre- approved by DOM;

c. Pre-approved informational materials for television, radio, and newspaper dissemination;

d. Marketing and/or networking at community sites or other approved locations for name recognition, which must be prior approved by DOM;

e. Hosting or participating in health awareness events, community events, and health fairs, pre-approved by DOM, in which DOM also participates or provides observation of Contractor participation. Prior approved non-cash promotional items are permitted, but not for solicitation purposes. DOM will be responsible for supplying copies of the benefit charts, if distributed at such events; and

f. Contractor is allowed to offer non-cash incentives to their Members for the purposes of rewarding for compliance in immunizations, prenatal visits, participating in Care Management, or other behaviors as pre-approved by DOM. Contractor shall analyze Member data to identify gaps in care and areas to improve outcomes. Contractor must provide to DOM for approval information about the interventions Contractor will employ to improve upon those gaps, including Member incentives Contractor will provide to Members, and the expected impact of the incentives, along with a plan to evaluate the impact of those incentives. Contractor is encouraged to use items that promote good health behavior (e.g., toothbrushes or immunization schedules). This incentive shall not be extended to any individual not yet enrolled in Contractor. Contractor must submit all incentive award packages to DOM for approval thirty (30) calendar days prior to implementation.

3. Prohibited Marketing and Outreach Activities

The following are prohibited Marketing and outreach activities targeting prospective Members under this Contract:

a. Engaging in any informational or Marketing activities which could mislead, confuse, or defraud Members or misrepresent DOM (42 C.F.R. § 438.104);

b. Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" Marketing of Enrollment at residences and provider sites (42 C.F.R. § 438.104);

c. Sending direct mailing (all Marketing mailings must be processed through DOM or its Agent to Members of Contractor);

d. Making home visits for Marketing or Enrollment;

e. Offering financial incentive, reward, gift, or opportunity to eligible Members as an inducement to enroll with Contractor other than to offer the health care benefits from Contractor pursuant to their contract or as permitted above;

f. Continuous, periodic Marketing activities to the same prospective Member (e.g., monthly or quarterly) giveaways, as an inducement to enroll;

g. Using DOM eligibility database to identify and market itself to prospective Members or any other violation of confidentiality involving sharing or selling Member lists or lists of eligibles with any other person or organization for any purpose other than the performance of Contractor's obligations under this Contract;

h. Engaging in Marketing activities which target prospective Members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services;

i. Contacting Members who disenroll from Contractor by choice after the effective Disenrollment date except as required by this Contract or as part of a DOM approved survey to determine reasons for Disenrollment;

j. Engaging in Marketing activities which seek to influence Enrollment or induce giving Contractor the names of prospective Members in conjunction with the sale or offering of any private insurance (42 C.F.R. § 438.104);

k. No Enrollment related activities may be conducted at any Marketing, community, or other event;

l. No educational or Enrollment related activities may be conducted at Department of Human Services offices unless authorized in advance by DOM;

m. No assertion or statement (whether written or verbal) that Contractor is endorsed by

CMS; Federal or State government; or similar entity (42 C.F.R. § 438.104); and

n. No assertion or statement that the Member must enroll with Contractor in order to obtain or lose benefits (42 C.F.R. § 438.104).

I. Member Rights and Responsibilities

In accordance with 42 C.F.R. § 438.100, Contractor shall have written policies and procedures regarding Member rights and shall ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to Member rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d *et seq.*), as amended and as implemented at 45 C.F.R. Part 80; the Age Discrimination Act of 1975 (42 U.S.C. § 6101 *et seq.*), as amended and as implemented by regulations at 45 C.F.R. Part 91; the Rehabilitation Act of 1973 (29 U.S.C. § 701 *et seq.*), as amended; Titles II and III of the Americans with Disabilities Act (42 U.S.C. § 12101 *et seq.*); 45 C.F.R. Part 84, and other laws regarding privacy and confidentiality.

1. Member Rights

At a minimum, such Member rights include the right to:

a. Receive information in a manner and format that may be easily understood in accordance with 42 C.F.R. § 438.10;

b. Be treated with respect and with due consideration for his or her dignity and privacy;

c. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition and ability to understand;

d. Participate in decisions regarding his or her health care, including the right to refuse treatment;

e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;

f. Request and receive a copy of his or her Medical Records and request that they be amended or corrected, as specified in 45 C.F.R. § 164.524 and § 164.526;

g. Free exercise of rights and the exercise of those rights do not adversely affect the way Contractor and its providers treat the Member; and

h. Be furnished health care services in accordance with 42 C.F.R. §§ 438.206 through 438.210.

The written policies and procedures shall also address the responsibility of Members to pay for unauthorized health care services obtained from non-participating providers

and their right to know the procedures for obtaining authorization for such services. Contractor shall also have policies addressing the responsibility of each Member to cooperate with those providing health care services by supplying information essential to the rendition of optimal care, following instructions and guidelines for care that they have agreed upon with those providing health care services, and showing courtesy and respect to providers and staff. A written description of the rights and responsibilities of Members shall be included in the Member information materials provided to new Members. A copy of Contractor's policies and procedures regarding Member rights and responsibilities shall be provided to all contracted providers and any Non-Contracted Providers to whom Members may be referred.

2. Member Protections

   Contractor agrees to protect Members from certain payment liabilities and not hold Members liable for:

   a. Any and all debts of Contractor if it should become insolvent;

   b. Payment for services provided by Contractor if Contractor has not received payment from the State for the services, or if the provider, under contract or other arrangement with Contractor, fails to receive payment from the State or Contractor;

   c. The payments to providers that furnish covered services under a contract or other arrangement with Contractor that are in excess of the amount that normally would be paid by the Member if the services had been received directly from Contractor; and

   d. Contractor agrees to honor and be bound by Section 1128B(d)(1) of the Balanced Budget Act of 1997 (Pub.L. 105–33) which protects Members against balance billing by Subcontractors.

J. Member Grievance and Appeal Process

Contractor must establish procedures for receiving and responding to Member Grievances and Appeals, which has the prior written approval of DOM for the receipt and adjudication of Grievances and Appeals by Members. Contractor must submit the Member Grievance and Appeal policies and procedures to DOM for review and approval forty-five (45) calendar days before implementation.

The Member Grievance and Appeal policies and procedures shall be in accordance with 42 C.F.R. § 457.1120 *et seq.*, 42 C.F.R. Part 438, Subpart F, and the State's Managed Care Quality Strategy, with the modifications that are incorporated in the Contract and Exhibit E, Member Grievance and Appeal Process, of this Contract. Contractor shall not modify the Member Grievance and Appeal procedure without the prior approval of DOM, and shall provide DOM with a copy of the modification at least fifteen (15) calendar days prior to implementation.

Contractor shall review the Member Grievance and Appeal procedure at reasonable intervals, but no less than annually, for amending as needed, with the prior written approval of DOM, in order to improve said system and procedure.

Contractor's Grievance procedures shall provide for a three-step Appeal process. Step one (1) in the process is considered a Grievance Review. Step two (2) is considered a Grievance Reconsideration. Step three (3) is a Grievance Review by an independent external review organization. Contractor must also utilize the expertise of its designated independent external review organization for any expedited review where a denial has been proposed by Contractor staff.

Contractor standard Member Grievance procedures must provide for completion of the entire three-step process within ninety (90) calendar days and completion of expedited review within seventy-two (72) hours. Upon Member request and Contractor agreement, these time frames may be extended.

If a Member Grievance is filed orally, Contractor Member services staff must obtain and document all pertinent information and promptly send documentation in writing to Contractor's designated Grievance and Appeals Coordinator. If a Member Grievance is filed in writing, it must be referred upon receipt to Contractor's Grievance and Appeals Coordinator.

If the Member Grievance involves an urgent or emergency medical situation such that an expedited review is appropriate, it must be immediately referred to a designated Contractor representative. The process explained in Exhibit E, Member Grievance and Appeal Process, of this Contract must be followed.

Contractor's Grievance and Appeals Coordinator must thoroughly investigate each Member Grievance using applicable statutory, regulatory, and contractual provisions, as well as Contractor's written policies and procedures. All pertinent facts must be collected during the investigation through telephone or face-to-face contact.

Nothing in this Contract shall be construed as removing any legal rights of Members under State or Federal law, including the right to file judicial actions to enforce rights.

Contractor must publish its Member Grievance and Appeal Procedures, including time frames for each step of the review process, in its Member handbooks and in informational material shared with its network providers.

SECTION 7 – PROVIDER NETWORK

Contractor must submit reports related to Provider Networks in accordance with Section 10, Reporting Requirements, and Exhibit G, Reporting Requirements, of this Contract.

A. General Requirements

Contractor shall recruit and maintain a Provider Network, using provider contracts as

approved by DOM. Contractor is solely responsible for providing a network of physicians, pharmacies, facilities, and other health care providers through whom it provides the items and services included in covered services. In establishing its Provider Network, Contractor shall contract with FQHCs and RHCs and shall provide payment that is not less than the level and amount of payment for which Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC. Contractor must contract with as many FQHCs and RHCs as necessary to permit Member access to participating FQHCs and RHCs without having to travel a significantly greater distance than the location of a non-participating FQHC or RHC. If Contractor cannot satisfy this standard for FQHC and RHC access at any time, Contractor must allow its Members to seek care from non-contracting FQHCs and RHCs and must reimburse these providers at Medicaid fees.

In the case of specialty pharmacies, Contractor may not deny a pharmacy or pharmacist the right to participate as a contract provider if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs, that meets the terms and requirements set forth by Contractor and agrees to the terms of reimbursement set forth by Contractor in accordance with Miss. Code Ann. § 83-9-6.

If a female Member's designated primary care physician is not a women's health specialist, Contractor shall provide Members with direct access to women's health specialist within the network for covered routine and preventive women's health care services.

Contractor shall ensure that its network of providers is adequate to assure access to all covered services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services. Contractor may not close their Provider Network for any provider type without prior approval from DOM. Contractor must ensure that provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

B. Provider Network Requirements

1. Geographic Access Standards

   In addition to maintaining in its network a sufficient number of providers to provide all services to its Members, Contractor shall meet the geographic access standards for all Members set forth in Table 4.

Table 4. Geographic Access Standards

Provider Type	Urban	Rural
PCPs	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles

Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles
Dialysis Providers	One (1) within sixty (60) minutes or sixty (60) miles	One within ninety (90) minutes or ninety (90) miles

DOM shall specify the urban and rural designation of counties within Mississippi. All travel times are maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the provider.

When necessary, Contractor shall extend its Provider Network into border state areas or Subcontract for an out-of-state network to provide a comprehensive range of specialty care (e.g., for specialists not available or fully accessible within the State of Mississippi) and to serve those Members who reside within a closer proximity to health care services in border states than within Mississippi.

If Contractor is unable to identify a sufficient number of providers located within an area to meet the geographic access standards, or is unable to identify a sufficient number of providers within a provider type or specialty, Contractor will submit documentation to DOM verifying the lack of providers. DOM may approve exceptions to the geographic access standards in such cases. DOM may impose penalties under Section 15, Non-Compliance and Termination, of this Contract if Contractor fails to meet Provider Network access standards.

Contractor shall pay for services covered under the contract on an out-of-network basis for the Member if Contractor's Provider Network is unable to provide such services within the geographic access standards. Contractor shall ensure that the cost to the Member is no greater than it would be if the services were furnished within the network. The Member's financial liability for such services shall be limited to the Co-Payments amount the Member would have paid, if any, had a network provider rendered the services. The cost of services rendered beyond the Member's financial liability shall be Contractor's financial responsibility. Balance billing is prohibited. Services must be provided and paid for in an adequate and timely manner, as defined by DOM, and for as long as Contractor is unable to provide them. When necessary, Contractor may negotiate discounts with approved out-of-network providers.

Contractor shall submit a Network Geographic Access Assessment (GeoAccess) Report on a quarterly basis to DOM demonstrating compliance with these requirements.

2. Accessibility

Contractor shall have in its network the capacity to ensure that the appointment scheduling does not exceed those set forth in Table 5.

Table 5. Appointment Scheduling Time Frames

Type	Appointment Scheduling Time Frames
PCPs (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (Urgent Care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar

Type	Appointment Scheduling Time Frames
	days

Dental Providers (Urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed twenty-one (21) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health Providers (post-discharge from an acute psychiatric hospital when Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

Each network physician shall maintain hospital admitting privileges with a network hospital as required for the performance of his or her practice or have a written agreement with a network physician who has hospital admitting privileges.

All network providers must be accessible to Members and must maintain a reasonable schedule of operating hours. At least annually, Contractor must conduct a review of the accessibility and availability of PCPs and must follow-up with those providers who do not meet the accessibility and availability standards set forth by DOM in this contract. Contractor will submit the findings from this review in writing to DOM.

DOM shall have the right to periodically review the adequacy of service locations and hours of operation, and will require corrective action to improve Member access to services.

Contractor shall also demonstrate that there are sufficient Indian Tribe, Tribal Organization, or Urban Indian Organization (I/TIU) providers in the network to ensure timely access to services under the contract for Indian members who are eligible to receive services from such providers.

3. Direct Contracting with School Clinics and School-Based Providers

Contractor shall contract with school-based providers and clinics unless good faith negotiations fail, and mutually agreeable contract terms cannot be reached. Any qualified school-based provider or clinic willing to accept Contractor's operating terms including, but not limited to, its schedule of fees, covered expenses, and UM requirements shall be allowed to participate as a network provider.

4. Second Opinions

Contractor shall have policies and procedures for rendering second opinions by providers within the network, or by non-participating providers. Upon request, Contractor must provide for a second opinion from a qualified health care professional

within the network, or arrange for the Member to obtain one outside the network from a Non-Contracted Provider, at no cost to the Member.

5. Non-Contracted Providers

   Contractor must notify and advise all Members in writing of the provisions governing the use of Non-Contracted Providers.

   If a Member receives medically necessary non-emergency services from a Non-Contracted Provider and Contractor has not authorized such services in advance, Contractor is not financially liable for these services. Contractor will not be financially responsible to Non-Contracted Provider for services that are not covered under CHIP.

6. Additional Requirements

   Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency as well as expected utilization of services, given the characteristics and health care needs of the population enrolled in the CCO.

   Contractor shall also not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of the Member for the following:

   a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

   b. Any information the Member needs in order to decide among all relevant treatment options;

   c. The risks, benefits, and consequences of treatment or non-treatment;

   d. The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

   e. The Member may be responsible for non-covered item(s) and/or service(s) only if the provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is sent to the Member that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

C. **PCP Responsibilities**

Contractor shall require PCPs to meet the following requirements:

1. PCPs who serve Members under the age of nineteen (19) are responsible for

conducting all Well-Baby and Well-Child Care services. Should the PCP be unable to conduct the necessary Well-Baby and Well-Child Care services screens, the PCP is responsible for arranging to have the necessary Well-Baby and Well-Child Care services screens conducted by another network provider and ensure that all relevant medical information, including the results of the Well-Baby and Well-Child Care services screens, are incorporated into the Member's PCP Medical Record

2. PCPs who serve Members under the age of nineteen (19) report encounter data associated with Well-Baby and Well-Child Care services, using a format approved by DOM, to Contractor within one hundred eighty (180) calendar days from the date of service.

3. PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. Contractor must require the PCP to:

   a. Contact Members identified in the quarterly Encounter lists as not complying with Well-Baby, Well-Child Care, and immunization schedules for Children;

   b. Identify to Contractor any such Members who have not come into compliance with Well-Baby, Well-Child Care, and immunization schedules within one (1) month of such notification to the site by Contractor; and

   c. Document the reasons for noncompliance, where possible, and to document its efforts to bring the Member's care into compliance with the standards.

4. Specialists as PCPs

   Members with disabling conditions, chronic conditions, or with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Contractor; in consultation with the PCP to which the Member is currently assigned, the Member and, as appropriate, the specialist. When possible, the specialist must be a provider participating in Contractor's network.

   The specialist as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special health care need in accordance with Contractor's standards and within the scope of the specialty training and clinical expertise. To accommodate the full spectrum of care, the specialist as a PCP must also have admitting privileges at a hospital in Contractor's network.

   Contractor shall have in place procedures for ensuring access to needed services for these Members or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

D. **Provider Terminations**

If a provider is no longer available to the Member through Contractor's network, Contractor shall have a plan to ensure continuity and coordination of care and to assist the Member in selecting a network provider.

1. Termination by Contractor

   Contractor must notify DOM in writing of its intent to terminate a contracted provider and services provided by a contracted provider (which includes a specialty unit within a facility and/or a large provider group). This notification shall occur sixty (60) calendar days prior to the effective date of the termination, if Contractor is aware of the termination prior to this time frame.

   For PCPs and hospital terminations, Contractor must submit a provider termination work plan and supporting documentation within ten (10) business days of Contractor's notification to DOM of the termination and must provide weekly updates to this information. DOM may also request provider termination work plans and supporting documentation for other provider types. This work plan shall document work steps and due dates and shall include, but is not limited to the submission of:

   a. Provider impact and analysis;

   b. Updated Provider Network and/or provider affiliation file;

   c. Provider notification of the termination;

   d. Member impact and analysis;

   e. Member notification of the termination;

   f. Member transition and continuity of care;

   g. Systems changes;

   h. Provider directory updates for DOM's Agent (include date when all updates will appear on provider files);

   i. Contractor online directory updates;

   j. Submission of required documents to DOM (Member notices for prior approval);

   k. Submission of final Member notices to DOM;

   l. Communication with the public related to the termination; and

   m. Termination retraction plan, if necessary.

DOM may also request additional background information regarding the provider termination, including but not limited to a summary of the issues, reasons for the termination, and information on negotiations or outreach between Contractor and provider.

Contractor must deny or revoke a provider agreement for cause for any reasons set forth in 42 C.F.R. §§ 455.416 and 457.935, and Miss. Code Ann. § 43-13-121(7).

Unless the provider is being terminated for cause, Contractor must allow a Member to continue an Ongoing Course of Treatment from the provider for up to sixty (60) calendar days from the date the Member is notified by Contractor of the termination or pending termination of the provider, or for up to sixty (60) calendar days from the date of provider termination, whichever is greater.

The transitional period may be extended by Contractor if the extension is determined to be clinically appropriate. Contractor shall consult with the Member and the health care provider in making the determination. Contractor must review each request to continue an Ongoing Course of Treatment and notify the Member of the decision as expeditiously as the Member's health condition requires, but no later than two (2) business days. If Contractor determines that what the Member is requesting is not an Ongoing Course of Treatment, Contractor must issue the Member a denial notice.

Contractor must also inform the provider that to be eligible for payment for services provided to a Member after the provider is terminated from the network, the provider must agree to meet the same terms and conditions as participating providers.

2. Termination by the Provider

If Contractor is informed by a provider that the provider intends to no longer participate in Contractor's Network, Contractor must notify DOM in writing sixty (60) calendar days prior to the date the provider will no longer participate in Contractor's network. If Contractor receives less than sixty (60) calendar days' notice that a provider will no longer participate in Contractor's Network, Contractor must notify DOM within two (2) business days after receiving notice from the provider.

Contractor must submit a provider termination work plan that includes the elements listed in Section 7.D.1, Termination by Contractor, above within ten (10) business days of Contractor notifying DOM of the termination and must provide weekly status updates to the work plan.

3. Member Notification

Contractor shall send a written notice within fifteen (15) calendar days of notice or issuance of termination of a provider to Members who receive primary care from the provider, who are treated on a regular basis from the provider, or who are affected by the loss of the provider for other reasons. The written notice shall include information about selecting a new provider, and a date after which Members that are undergoing an active course of treatment cannot use the terminated provider. Contractor shall receive

DOM prior approval for Member notices.

E. Provider Credentialing and Qualifications

Contractor must follow a documented process for credentialing and recredentialing of providers who have signed contracts with Contractor, in accordance with 42 C.F.R. § 438.214 and Mississippi Department of Insurance Regulation 98-1. Contractor shall maintain a Credentialing Committee and Contractor's Medical Director shall have overall responsibility for the committee's activities.

Contractor shall use credentialing and recredentialing standards set forth by NCQA and External Quality Review Organization (EQRO) recommendations. Contractor must follow the most current version of the credentialing organization's credentialing requirements from year to year.

Contractor shall verify and certify to DOM that all contracted providers and any Non-Contracted Providers to whom Members may be referred are properly licensed in accordance with all applicable State law and regulations, are eligible to participate in CHIP, and have in effect appropriate policies of malpractice insurance as may be required by Contractor and DOM. Contracted nurse practitioners acting at PCPs shall be held to the same requirements and standards as physicians acting at PCPs.

In contracting with providers, Contractor will be responsible for obtaining all disclosure information from all contracted providers and Non-Contracted Providers and abide by all applicable Federal regulations, including 42 C.F.R. § Part 455, Subpart B. Contractor shall maintain a file for each provider containing a copy of the provider's current license issued by the State, cover page of malpractice insurance, and such additional information as may be specified by DOM.

In contracting with laboratory providers and or any provider who bills for laboratory services, Contractor must ensure that all laboratory testing sites providing services under the contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. Provider attestation of CLIA certificate is not acceptable. Contractor shall maintain copies of the CLIA certificate or waiver of the certificate of registration in the provider's credentialing and recredentialing files.

The process for verification of provider credentials and insurance and periodic review of provider performance shall be embodied in written policies and procedures, approved in writing by DOM as part of the readiness review prior to implementation. Credentialing policies and procedures must meet Federal, State, and DOM requirements and shall include:

1. The verification of the existence and maintenance of credentials, licenses, malpractice claims history, certificates, and insurance coverage of each provider from a primary source, site assessment;

2. A methodology and process for recredentialing providers;

3. A description of the initial quality assessment of private practitioner offices and other Member care settings conducted in-person during the provider office visit;

4. Procedures for disciplinary action, such as reducing, suspending, or terminating provider privileges;

5. Procedures for practitioners to correct erroneous information;

6. Process for making available to practitioners Contractor's confidentiality requirements to ensure that all information obtained in the credentialing process is confidential except as otherwise provided by law;

7. Procedures for verifying that contracted nurse practitioners acting as PCPs have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at a contracted inpatient hospital facility; and

8. Procedures for verifying the exclusion of providers by searching at a minimum the following databases: United State Department of Health and Human Services - Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) System for Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded providers. Copies or prints of all queries shall be included in provider credentialing files.

Contractor shall allow practitioners to review the information submitted in support of the practitioner's credentialing application.

Contractor shall notify a practitioner of any information obtained during the credentialing process that varies substantially from the information provided to Contractor by the practitioner.

Contractor shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, Contractor shall credential all completed application packets within forty-five (45) calendar days of receipt. Contractor shall notify DOM of any provider applications requiring longer than ninety (90) calendar days via quarterly report.

Contractor shall notify DOM within ten (10) calendar days of Contractor's denial of a provider credentialing application either for program integrity-related reasons or due to limitations placed on the provider's ability to participate for program integrity-related reasons.

Contractor must submit reports in accordance with Section 10.E, Provider Services Reports, of this Contract.

F. **Provider Agreements**

Contractor must have written agreements with a sufficient number of providers to ensure Member access to all Medically Necessary Services covered by CHIP.

Contracts with all Behavioral Health providers must have provisions that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital.

Contractor's provider agreements must include at least the following provisions:

1. A requirement that Contractor must not exclude or terminate a provider from participation in Contractor's Provider Network due to the fact that the provider has a practice that includes a substantial number of Members with expensive medical conditions.

2. A requirement to ensure that Members are entitled to the full range of their health care providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of this Contract. Any contractual provisions, including gag clauses or rules, that restricts a health care provider's ability to advise Members about medically necessary treatment options violate Federal law and regulations.

3. A requirement that Contractor cannot prohibit or restrict a provider acting within the lawful scope of practice from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member including; information regarding the nature of treatment options; risks of treatment; alternative treatments; or the availability of alternative therapies, consultation or tests that may be self-administered.

4. A requirement that Contractor cannot prohibit or restrict a provider acting within the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

5. A requirement that Contractor cannot terminate a contract or employment with a provider for filing a Grievance or Appeal on a Member's behalf.

6. A requirement securing cooperation with the QM and UM program standards outlined in Section 9, Quality Management, of this Contract.

7. A requirement that PCPs comply with requirements of Section 7.C, PCP Responsibilities, of this Contract.

8. A requirement that Contractor include in all capitated provider agreements a clause which requires that should the provider terminate its agreement with Contractor, for any reason, the provider will provide services to the Members assigned to the provider under the contract up to the end of the month in which the effective date of termination falls pertaining to the confidentiality of Member Medical Records, including obtaining

any required written Member consents to disclose confidential Medical Records.

9. A requirement that the provider must make referrals for social, vocational, education or human services when a need for such service is identified.

10. In the event Contractor becomes insolvent or unable to pay the participating provider, a requirement that the provider shall not seek compensation for services rendered from the State, its officers, Agents, or employees, or the Members or their eligible dependents.

11. A requirement that the provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to Contractor within ninety (90) calendar days from the date of denial.

Contractor may not enter into a provider agreement that prohibits the provider from contracting with another CCO or that prohibits or penalizes Contractor for contracting with other providers. Contractor may not require providers who agree to participate in CHIP to contract with Contractor's other lines of business.

G. Mainstreaming

Contractor shall make all reasonable efforts to ensure that network providers do not intentionally segregate their Members in any way from other persons receiving services.

Contractor must investigate Complaints regarding providers and take affirmative action so that Members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

1. Denying or not providing a Member any CHIP covered service or availability of a facility within Contractor's network. Health care and treatment necessary to preserve life must be provided to all Members who are not terminally ill or permanently unconscious, except where a competent Member objects to such care on his/her own behalf.

2. Subjecting a Member to segregated, separate, or different treatment, including a different place or time from that provided to other Members, public or private Members, in any manner related to the receipt of any CHIP covered service, except where medically necessary.

3. The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program Membership, language, health status, disease or disability of the Members to be served.

If Contractor knowingly executes an agreement with a provider with the intent of allowing or permitting the provider to implement barriers to care (e.g., the terms of the provider agreement are more restrictive than this Contract), Contractor shall be in breach of this Contract.

H. Provider Services

Contractor must submit reports in accordance with Section 10.E, Provider Services Reports, of this Contract.

1. Provider Services Call Center

   Contractor must operate provider services call center functions at a minimum during regular business hours (8:00 a.m. to 5:00 p.m. CST, Monday through Friday). Arrangements must be made to deal with emergency provider issues on a twenty-four (24) hours per day, seven (7) days a week basis. Provider services functions include, but are not limited to, the following:

   a. Assisting providers with questions concerning Member eligibility status;

   b. Assisting providers with Contractor Prior Authorization and referral procedures, including the use of Non-Contracted Providers;

   c. Assisting providers with claims payment procedures, the coverage provided through Contractor including supplemental coverage, and electronic submission of claims in accordance with HIPAA Electronic Data Interchange (EDI) standards.

   d. Handling Provider Complaints and Grievances;

   e. Facilitating transfer of Member Medical Records among medical providers, as necessary;

   f. Educating providers as to covered medical services, excluded medical services and benefit limitations; and

   g. Providing to PCPs a monthly list of Members who are under their care, including identification of new and deleted Members; An explanation guide detailing use of the list must also be provided to PCPs.;

   h. Referring providers to the Fraud and Abuse Hotline;

   i. Developing a process to respond to provider inquiries regarding current Enrollment; and

   j. Coordinating the administration of out-of-network services.

   Contractor must develop appropriate, interactive scripts for call center staff to use when

making outbound calls to providers and to respond to providers calls. Contractor must develop special scripts for emergency and unusual situations, as requested by DOM. All scripts must be clear and easily understood. All scripts shall promote the use of Contractor's web-based provider portal. Contractor must review the scripts annually to determine any necessary revisions. DOM reserves the right to request and review call center scripts at any time. All call center scripts must be submitted by Contractor to DOM for review and approval thirty (30) calendar days prior to use.

Contractor shall randomly select and record calls received at the call center and monitor no less than three percent (3%) of calls for compliance with customer care guidelines. Contractor will report the findings of these audits to DOM upon request within five (5) business days. Contractor will make recordings and associated transcripts available to DOM upon request within five (5) business days. Contractor shall maintain the recordings and associated transcripts for at least twelve (12) months.

Contractor shall maintain sufficient equipment and call center staff for provider services call center to ensure that the average abandonment rate for any month is not greater than five percent (5%). Contractor will be subject to sanctions if the abandonment rate exceeds this target, in accordance with Section 15.E, Liquidated Damages, of this Contract.

2. Provider Manual

Contractor shall develop and maintain a provider manual for network providers. Copies of the provider manual must be distributed in a manner that makes them easily accessible to all participating providers, including provision of an electronic version through the web portal. DOM must receive a copy of the provider manual for review and approval sixty (60) calendar days before implementation and/or prior to use.

The provider manual must be updated annually and approved by DOM prior to use. DOM may grant an exception to this annual requirement upon written request from Contractor provided there are no major changes to the manual. Contractor shall be expected to notify network providers of subsequent contract clarifications and procedural changes.

The provider manual must include, at a minimum, the following information:

a. Introduction to CHIP, which explains Contractor's organization and administrative structure;

b. Description of the Care Management system and protocols, including Transitional Care Management;

c. Description of the role of a PCP and Covered Services, including excluded services, Co-Payments, and benefit limitations;

d. Emergency room utilization (appropriate and non-appropriate use of the emergency

room);

e. Listing of key contacts and telephone numbers at Contractor;

f. Information about how Members may access specialists, including standing referrals and specialists as PCPs;

g. Contact follow-up responsibilities for missed appointments;

h. Information about filing provider disputes;

i. Provider Complaint, Grievance, and Appeal information;

j. Member Grievance and Appeal information;

k. Billing instructions, including claims submission procedures and time frame requirements;

l. Provider performance expectations, including disclosure of QM and UM criteria and processes;

m. Provider responsibility to follow up with Members who are not in compliance with the Well-Baby and Well-Child Care services in accordance with the ACIP Recommended Immunization Schedule;

n. A definition of "Medically Necessary" consistent with the language in this Contract;

o. Prior Authorization requirements, including the requirement that a Member may receive a minimum of a three (3) day emergency supply for prior authorized drugs until authorization is completed;

p. Information about Member confidentiality requirements;

q. Information about the process for communicating with Contractor on limitations on accepting new Members;

r. Information about the process for contacting Contractor regarding assignment of a Member to an alternate PCP;

s. Explanation of DOM's requirements that Contractor may not require the provider to agree to non-exclusivity requirements nor to participate in Contractor's other lines of business to participate in CHIP; and

t. Description of the web portal information available through the portal and the process for accessing it.

3. Provider Education and Training

Contractor shall provide training to all providers and their staff regarding the

requirements of the contract and special needs of Members, including Well-Baby and Well-Child Care services. Contractor shall conduct initial training within thirty (30) calendar days of placing a newly contracted provider on active status. Contractor shall also conduct ongoing training as deemed necessary by Contractor or DOM or as requested by the provider to ensure compliance with program standards and the Contract.

Contractor shall develop and submit a provider training manual and prospective training plan to DOM for review and approval initially and as updated prior to use. DOM will work to review and approve the initial manual within forty-five (45) calendar days and any subsequent changes within fifteen (15) calendar days. Contractor will submit reports on the trainings conducted, topics covered, the number and positions of staff completing the trainings.

Contractor shall also conduct, in collaboration with DOM, a minimum of ten (10) CHIP Workshops annually targeting providers. DOM will notify Contractor of the dates, times, and locations for workshops.

I. Provider Complaint, Grievance, and Appeal Process

Contractor shall establish procedures for the resolution of administrative, payment or other disputes between providers and Contractor.

1. General Requirements

Contractor shall draft and disseminate to providers and Subcontractors, a system and procedure, which has the prior written approval of DOM for the receipt and adjudication of Provider Complaints, Grievances, and Appeals by providers. Contractor must submit the Provider Complaint, Grievance, and Appeal policies and procedures to the DOM for review and approval forty-five (45) calendar days before implementation. The Provider Complaint, Grievance, and Appeal policies and procedures shall be in accordance with the State's Managed Care Quality Strategy, with the modifications that are incorporated in the Contract. Contractor shall not modify the Provider Complaint, Grievance, and Appeal procedure without the prior approval of DOM, and shall provide DOM with a copy of the modification at least fifteen (15) calendar days prior to implementation.

Contractor shall review the Provider Complaint, Grievance, and Appeal procedure at reasonable intervals, but no less than annually, for amending as needed, with the prior written approval of DOM, in order to improve said system and procedure.

DOM shall have the right to intercede on a provider's behalf at any time during Contractor's Provider Complaint, Grievance, and/or Appeal process whenever there is an indication from the provider, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately.

2. Provider Complaints, Grievances, and Appeals

Contractor shall provide providers as a part of the provider manual, information on how they or their representative(s) can file a Provider Grievance or an Appeal, and the resolution process.

Contractor shall use the definitions for Provider Complaints, Grievances, and Appeals as set forth in this section and adhere to time frames required by this Contract. Table 6 below outlines additional specific requirements pertaining to Complaints, Grievances, and Appeals.

Table 6. Summary of Provider Complaints, Grievances, and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Provider Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Provider Complaint not resolved within one (1) business day shall be treated as a Grievance. A Provider Complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.			
Provider	Submit a Provider Complaint	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Respond to a Provider Complaint	Within one (1) business day	
Provider Grievance: An expression of dissatisfaction received orally or in writing about any matter or aspect of Contractor or its operation, other than a Contractor Action as defined in this contract. A Provider Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or an employee.			
Provider	File a Provider Grievance	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Confirm receipt of the Provider Grievance and expected date of resolution	Within ten (10) calendar days of receipt of the Provider Grievance	
Party	**Action**	**Time Frame**	**Extensions Available**

Party	Action	Time Frame	Extensions Available
Contractor	Resolve a Provider Grievance	Within thirty (30) calendar days of the date Contractor receives the Provider Grievance	Contractor may extend time frames up to fourteen (14) calendar days
Provider Appeal: A request for review by Contractor of a Contractor Action.			
Provider	File a Provider Appeal	Within thirty (30) calendar days of receiving Contractor's notice of action	
Contractor	Confirm receipt of the Provider Appeal and expected date of resolution	Within ten (10) calendar days of receipt of the Provider Appeal	
Contractor	Resolve a Provider Appeal	Within forty-five (45) calendar days of the date Contractor receives the Provider Appeal or as expeditiously as the Member's health condition requires Within three (3) business days after Contractor receives the request for an Expedited Resolution of a Provider Appeal	Contractor may extend time frames by up to fourteen (14) calendar days

Nothing in this Contract shall be construed as removing any legal rights of providers under State or Federal law, including the right to file judicial actions to enforce rights.

J. **Reimbursement**

Contractor shall reimburse Non-Contracted Providers for which Contractor has referred the Member to a Non-Contracted Provider and out-of-area services provided to a Member in accordance with Contractor's approved plan for out-of-network services.

Contractor shall also pay I/T/U providers, whether participating in the network or not, for covered managed care services provided to Indian Members who are eligible to receive services from the I/T/U either at a negotiated rate between the CCO and the I/T/U provider, if there is no negotiated rate, at a rate no less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

Contractor shall be responsible for full payment for services received by Members from Non-Contracted Providers because Contractor's services were not available as required pursuant to the terms of this Contract.

Contractor shall generate Explanations of Benefits, in a format approved by DOM and submit the policy and procedures for sampling for Explanation of Benefits for DOM approval forty-five (45) calendar days prior to use. Contractor must send the Explanation of Benefits to Members within thirty (30) calendar days of adjudication.

Contractor is prohibited from paying for an item or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. § 14401 *et seq.*), for roads, bridges, stadiums, or any other item or service not covered under the Child Health Plan, and for home health care services provided by an agency or organization, unless the agency provides Contractor with a surety bond as specified in Section 1861(0)(7) of the Act.

1. Claims Payment, Denial, and Appeals

   Contractor will be responsible for processing claims. Contractor must pay at least ninety percent (90%) of all clean claims (as defined by Miss. Code Ann. § 83-9-5) for covered services, including services provided by I/T/U providers in the network, within thirty (30) calendar days of receipt and pay at least ninety-nine percent (99%) of all clean claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the contract. For other claims, Contractor shall notify the provider of the status (e.g., pend, deny, or other reason) of the claim and if applicable, the reason the claim cannot be paid within thirty (30) calendar days of the adjudication of the claim. Contractor must pay all other claims (e.g., adjusted, corrected), except those from providers under investigation for Fraud and Abuse, within twelve (12) months of the date of receipt.

   Claims pending or suspended for additional information must be closed (paid or denied) by the sixtieth (60^{th}) calendar day following the date the claim is suspended if all requested information is not received prior to the expiration of the sixty (60) calendar day period. Contractor shall send providers written notice (notification via e-mail or by mail satisfies this requirement) for each claim that is denied, including the reason(s) for the denial.

   Contractor shall have written policies and procedures, in form and content acceptable to DOM, providing a mechanism for providers to Appeal the denial of claims by Contractor. Contractor must submit written policies and procedures to DOM for review and approval forty-five (45) calendar days prior to implementation. If a claim is denied following completion of Contractor's internal Appeals procedure, Contractor shall provide written notice of the denial to the provider and DOM.

2. Payments from Members

Members utilizing medical services which are not medically necessary or who obtain covered services from Non-Contracted Providers without Prior Authorization and referral by Contractor shall be responsible for payment in full of all costs associated with such services.

The Member may be responsible for non-covered item(s) and/or service(s), only if, the provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is sent to the Member that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Member will be financially responsible for the item(s) and/or service(s).

K. **Provider Discrimination**

Neither Contractor, Subcontractor, nor representatives of Contractor shall provide false or misleading information to providers in an attempt to recruit providers for Contractor's network. Contractor shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable State law or regulation solely on the basis of the provider's license or certification.

Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely based on the license or certification. Contractor shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If Contractor declines to include individual or groups of providers in its network, it must provide the affected providers written notice of the reason for its decision. Denials of provider enrollment due to excess network capacity must receive DOM approval prior to provider notification. Nothing in this provision, however, shall preclude Contractor from using a fee schedule for different specialties or for different practitioners in the same specialty, or preclude Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members. Contractor shall not employ or contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Act. Contractor is prohibited from employing or contracting a provider that has been excluded by DOM, other state Medicaid agencies, or other state CHIP.

SECTION 8 – CARE MANAGEMENT

A. Care Management Responsibilities

Contractor is responsible for Care Management – a set of Member-centered, goal- oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care Management includes but is not limited to continuity of care, transition of care, and discharge planning.

Contractor shall develop and implement a Care Management system to ensure and promote timely access and delivery of health care and services required by Members, continuity of Members' care, and coordination and integration of Members' care, including physical and Behavioral Health services.

Within thirty (30) calendar days of contract execution, Contractor shall provide its overall approach to Care Management specific to CHIP to DOM for review and approval. Contractor shall revise its approach as requested by DOM, and will submit any subsequent updates to DOM for approval thirty (30) calendar days prior to implementation.

1. Assignment of Risk Levels

Contractor shall develop a Care Management program that addresses the varying and differing levels of Care Management needs for Members. Contractor's Care Management program must provide for the completion of a detailed health risk assessment for Members, which includes an assessment of and assignment to risk stratification levels (e.g., low, medium, high) which determine the intensity of interventions and follow-up care required for each Member. Contractor shall prioritize and assign Members to low, medium, or high levels based on the identified risk and level of need. Members who have high costs or potentially high costs or otherwise qualify, including but not limited to Members with persistent and/or preventable inpatient readmissions, serious and persistent Behavioral Health conditions, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level and receive Care Management services. Members with less intensive needs will be assigned to the low risk level and shall have access to Care Management teams.

Contractor shall conduct predictive modeling upon initial Enrollment and at least monthly to identify and evaluate Member risk levels, which must incorporate the use of pharmacy utilization data. Contractor shall also consider Members for receiving Care Management through provider referral, State Agency referral, and Member self- referral.

In addition, in consideration of the potential lack of complete claims or encounter data for the CHIP population prior to Enrollment with Contractor, particularly for Members new to CHIP, Contractor may use other analyses used to identify and stratify Members who may be in need of Care Management services.

The Care Manager may contact potentially medium- and high-risk Members and/or the Member's guardian via telephone or face-to-face interview to administer the detailed

health risk assessment. This detailed health risk assessment must evaluate the Member's medical condition(s), including physical, behavioral, social, and psychological needs. The goal of this assessment is to confirm the Member's need for Care Management, identify the Member's existing and /or potential health care needs, determine the types of services needed by the Member, and begin the development of the Member's treatment plan. Contractor will determine the need for an onsite visit at the Member's residence to complete this assessment. This detailed health risk assessment must occur within thirty (30) calendar days for Members newly identified as potentially high- or medium-risk levels as a result of referral and/or predictive modeling.

The detailed health risk assessment must be reviewed by a qualified health professional appropriate for the Member's health condition. The detailed health risk assessment shall address the following, at a minimum:

a. Identification of the severity of the Member's conditions/disease state (e.g., medical, Behavioral Health, social), documentation of recent treatment history and current medications;

b. Evaluation of co-morbidities, or multiple complex health care conditions;

c. Demographic information (including ethnicity, education, living situation/housing, legal status, employment status); and

d. The Member's current treatment providers and treatment plan, if available.

The treatment plan for the Member must be completed within thirty (30) days of the completion of the detailed health risk assessment.

At a minimum, Contractor shall provide Care Management services to all Members identified with the following chronic conditions: diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants.

Following the detailed health risk assessment, Contractor shall update the risk level assignment at least annually and when there has been a change in the health status, needs, or a significant health care event relevant to the Member's risk level assignment.

Contractor must receive DOM approval for other analysis or methods used to identify or re-assess Member's risk level thirty (30) calendar days prior to use by Contractor. Contractor shall modify its approach upon DOM request. Additionally, Contractor shall provide alternate solutions if the implemented approach does not achieve the targeted outcomes and savings over time.

All Members shall have access to the Care Management team and Contractor must provide all Members with information on how to contact the Care Management team through Contractor Member Information Packet.

2. Care Management Services

Member information shall be maintained by Contractor and accessible twenty-four (24) hours per day seven (7) days per week by Members of the Care Management team.

Contractor must develop and adopt policies and procedures to ensure all Members have access to required services. At a minimum, Members shall have available the following services:

a. Assignment to a Care Management team: Contractor must assign a point of contact for each Member. Contractor shall assign Members in the high risk and medium risk categories to a specific Care Management team member;

b. Access to a Member services call center;

c. Assistance with care coordination and access to primary care, inpatient services, Urgent Care, Behavioral Health, preventive and specialty care, as needed;

d. Assistance in developing treatment plan, conducting comprehensive needs assessment, and implementing treatment plan;

e. Coordination of discharge planning and follow-up to care post inpatient discharge;

f. Assistance with and coordination of re-admissions to ensure timely follow-up and documentation;

g. Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1400 *et seq.*),the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for Children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services;

h. Coordination with other CCOs;

i. Developing, planning and assisting Members with information about community-based, free care initiatives and support groups;

j. Responding to Member clinical care decision inquiries in a manner that promotes Member self-direction and involvement;

k. When requested by individuals, identifying participating providers, facilitating access and assisting with appointment scheduling when necessary;

l. Providing information about the availability of services and access to those services;

m. Working with Members and providers to ensure continuity of care and care

coordination; and

n. Monitoring and following up with Members and providers, which may include regular mailings, newsletters, or face-to-face meetings, as appropriate.

In addition, Contractor must develop and adopt policies and procedures to address the following:

a. A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning, as appropriate;

b. A method for actively engaging Members in need of Care Management who are unresponsive to contact attempts or disengaged from Care Management;

c. An approach that uses pharmacy utilization data to tailor Care Management services;

d. Systems for assuring that Members with serious, chronic, and rare disorders receive appropriate diagnostic, testing and maintenance work-ups on a timely basis;

e. Procedures and criteria for making referrals to specialists and sub-specialists and assisting with care coordination between primary care, Behavioral Health and specialty providers;

f. Acceptance and transmittal of results of the identification and assessment of any Member with special health care needs (as defined by DOM) to or from another entity upon transition of the Member, so that those activities will not be duplicated;

g. Procedures and criteria for maintaining treatment plans and referral services when the Member changes PCPs;

h. Documentation of referral services and medically indicated follow-up care in each Member's Medical Record;

i. Documentation in each Medical Record of all Urgent Care, emergency encounters and any medically indicated follow-up care; and

j. Ensuring that when a provider is no longer available through Contractor, Contractor allows Members who are undergoing an active course of treatment to access services from Non-Contracted Providers for sixty (60) calendar days.

Members identified as medium risk or high risk will be assigned a Care Manager.

Contractor shall provide Members assigned to the medium risk level all services included in the low risk level and the following services, at a minimum:

a. Facilitate relapse prevention plans for Members with depression and other high- risk

Behavioral Health conditions and their PCPs/Community Mental Health Centers (e.g., Member education, extra clinic visits, and follow-up phone calls);

b. Partner with provider practices having higher medication adherence rates to identify and transfer best practices and leverage tools and education to support practices with lower rates of adherence;

c. Educate provider office staff about symptoms of exacerbations and how to communicate with Member;

d. Develop speaking points and triggers for making primary care, urgent and emergency appointments; and

e. Develop specific forms and monitoring tools to support monitoring of conditions, behaviors, risk factors or unmet needs.

Contractor shall provide Members assigned to the high-risk level all the services included in the low risk and medium risk levels and the following services, at a minimum:

a. As appropriate, form inter-disciplinary treatment teams to assist with development and implementation of individual medical and Behavioral Health treatment plans;

b. Provide list of community resources (for referral) including PCPs, Certified Diabetic Educators, free exercise classes, nutritional support, etc.;

c. Identify providers with special accommodations (e.g., sedation dentistry);

d. Educate staff about barriers Members experience in making and keeping appointments and methods or practices to minimize such barriers;

e. Facilitate group visits to encourage self-management of various physical and Behavioral Health conditions/diagnoses such as pregnancy, diabetes and tobacco use; and

f. Communicate on a Member-by-Member basis on gaps/needs to assure Member has baseline and periodic medical evaluations from the PCP.

3. Continuity of Care

When Members disenroll from Contractor, Contractor is responsible for transferring to DOM and/or the accepting CCO the Member's Care Management history, six (6) months of claims and encounter history, and pertinent information related to any special needs of transitioning Members. Contractor, when receiving a transitioning Member is responsible for coordinating care with Contractor from which the Member is disenrolling so that services are not interrupted, and for providing the new Member with service information, emergency numbers, and instructions on how to obtain services.

Contractor shall provide Members transitioning to a new CCO on July 1, 2015, a sixty (60) day exemption to complete an Ongoing Course of Treatment with his or her provider, if the provider is not in Contractor's Provider Network. Contractor shall work with the Member and the Non-Contracted Provider to identify a new provider for ongoing treatment and ensure than an appropriate continuity of care plan is developed.

4. Reporting

Contractor will submit monthly and quarterly reports to DOM that include specified Care Management program data as described in Section 10, Reporting Requirements, and Exhibit G, Reporting Requirements, of this Contract. DOM will request cases to review for appropriateness in terms of assignments to risk levels, treatment plans, and discharge planning, at its discretion.

B. Transitional Care Management

1. General Requirements

Contractor shall maintain and operate a formalized Transitional Care Management program to support Members' transition of care when discharged from an institutional clinic or inpatient setting to include, but not limited to:

a. Collaborating with hospital discharge planners, primary care and Behavioral Health staff;

b. Ensuring appropriate home-based support and services are available and delivered in a timely manner;

c. Implementing medication reconciliation in concert with the PCP, Behavioral Health provider and network pharmacist to assure continuation of needed therapy following inpatient discharge;

d. Ensuring appropriate follow-up appointments are made with the PCP and/or Behavioral Health or other specialists, as appropriate;

e. Ensuring that the Member receives the necessary supportive equipment and supplies without undue delay;

f. Limiting future institutional and/or inpatient setting re-admissions;

g. Promoting the ability, confidence and change in self-management of chronic conditions; and

h. Providing Care Management until all goals are met or Members elect not to receive services.

2. Transitional Care Management Policies and Procedures

   Contractor shall, initially, and as revised, submit to DOM for review and prior approval, Transitional Care Management policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to Member's care. DOM will work to complete the initial review within forty-five (45) calendar days and any subsequent updates within fifteen (15) calendar days prior to implementation.

3. Transition of Care Team

   Contractor shall have an interdisciplinary transition of care team to design and implement the transition of care plan and provide oversight and management of all transition of care processes. The transition of care team will consist of transitional care nurses in addition to any staff necessary to enhance services for Members and provide support for their return to the home or other community setting.

4. Transition of Care Process

   Contractor will manage transition of care and continuity of care for new Members and for Members moving from an institutional clinical or inpatient setting back to the Member's home or other community setting. Contractor's process for facilitating continuity of care will include:

   a. Identification of Members needing transition of care;

   b. Communication with entities involved in Member's transition;

   c. Making accommodations such that all community supports, including housing and other support services, are in place prior to the Member's transition and that treating providers are fully knowledgeable and prepared to support the Member, including interface and coordination with and among social supports and medical and/or Behavioral Health services;

   d. Environmental adaptations, equipment and other technology the Member's needs for a successful care setting transition;

   e. Stabilization and provision of uninterrupted access to Covered Services for the Member;

   f. Summary of Member's history and current medical, Behavioral Health, and social needs and concerns;

   g. Assessment of Member's short-term, and long-term goals, including progress and revision of goals where appropriate; and

   h. Monitoring of continuity and quality of care, and services provided.

SECTION 9 – QUALITY MANAGEMENT

Contractor must submit reports related to QM in accordance with Section 10, Reporting Requirements, Exhibit F, CHIP Quality Management, and Exhibit G, Reporting Requirements, of this Contract.

A. General Requirements

Contractor shall support and comply with the State's Managed Care Quality Strategy. Contractor shall also comply with all reporting requirements in formats to be determined by DOM.

Contractor shall comply with the Mississippi CHIP QM requirements to improve the health outcomes for all Members. Improved health outcomes will be documented using established Performance Measures.

Contractor shall implement and maintain a QM program as described below. DOM retains the right of advance written approval and to review on an ongoing basis all aspects of Contractor's QM program, including subsequent changes.

DOM, in collaboration with Contractor, retains the right to determine and prioritize QM activities and initiatives based on areas of importance to DOM and/or CMS.

Contractor shall participate and shall recruit network providers to participate in the Managed Care Quality Leadership Team as defined in Table 7 below.

Table 7. Managed Care Program Quality Committees

Quality Committee	Committee Membership
Managed Care Quality Leadership Team	• Medical Directors of each CCOs • Other CCO Executives, as designated by DOM • Other representatives, as determined by DOM • At least two (2) network providers from each CCO who are actively involved in providing services to CHIP Members • Members receiving CHIP services, to be determined by Contractor • DOM Staff
Managed Care Quality Task Force	• CCOs, including the Quality Managers and Health Services Managers • Quality Managers and Health Services Managers from the Behavioral Health subsidiary • DOM Staff

B. **Accreditation**

DOM encourages Contractor to obtain accreditation by the NCQA for MCOs. If Contractor selects this option, it shall provide to DOM upon request any and all documents related to achieving such accreditation and DOM shall monitor Contractor's progress towards accreditation.

C. **External Quality Review**

On at least an annual basis, Contractor will cooperate fully with any external evaluations and assessments of its performance authorized by DOM under this Agreement and conducted by DOM's contracted EQRO or other designee. Independent assessments will include, but not be limited to, any independent evaluation required or allowed by Federal or State statute or regulation. See Exhibit C, External Quality Review, of this Contract for additional requirements of Contractor.

Contractor shall address any deficiencies or contract variances identified by the EQRO expediently, on a schedule to be determined by DOM. DOM may issue sanctions for deficiencies or contract variances, which are not addressed to the satisfaction of DOM.

D. **Quality Management System and Quality Improvement Program**

Contractor shall implement and operate an internal QM system and quality improvement (QI) program in compliance with 42 C.F.R. § 438.240 which:

1. Provides for review by appropriate health professionals of the process followed in providing covered services to Members;

2. Provides for systematic data collection of performance and Member outcomes;

3. Provides for interpretation and dissemination of performance and outcome data to contracted providers and Non-Contracted Providers approved for referrals for primary and specialty;

4. Provides for the prompt implementation of modifications to Contractor's policies, procedures and/or processes for the delivery of covered services as may be indicated by the foregoing;

5. Provides for the maintenance of sufficient encounter data to identify each practitioner providing services to Members, specifically including the unique physician identifier for each physician; and

6. Complies with Miss. Code Ann. § 83-41-313 *et. seq.*, of the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plan Protection Act and Miss. Code Ann. § 83-41-409 of the Patient Protection Act of 1995, as amended.

Contractor will have a written description of the QM program specific to CHIP that

focuses on health outcomes and that includes the following:

1. A written program description including an Annual QM Program Work Plan; detailed objectives, accountabilities and time frames; definition of the scope of the QM program, and an Annual Program Evaluation. Detailed requirements are included in Exhibit F, CHIP Quality Management, of this Contract.

2. A work plan and timetable for the coming year which clearly identifies target dates for implementation and completion of all phases of all QM activities, consistent with the clinical Performance Measures and targets put forth by DOM, including, but not limited to:

    a. Data collection and analysis;

    b. Evaluation and reporting of findings;

    c. Implementation of improvement actions where applicable; and

    d. Individual accountability for each activity.

3. Composition of the QM committee including, at a minimum, a physical and Behavioral Health provider.

4. Procedures for remedial action when deficiencies are identified.

5. Specific types of problems requiring corrective action.

6. Provisions for monitoring and evaluating corrective action to ensure that actions for improvement have been effective.

7. Procedures for provider review and feedback on results.

8. Annual performance evaluation of the QM program that includes:

    a. Description of completed and ongoing QM activities including Care Management effectiveness evaluation;

    b. Identified issues, including tracking of issues over time;

    c. Trending of measures to assess performance in quality of clinical care and quality of service to Members; and

    d. An analysis of whether there have been demonstrated improvements in Members' health outcomes, the quality of clinical care, and quality of service to Members; and overall effectiveness of the QM program (e.g., improved Healthcare Effectiveness Data and Information Set (HEDIS®) scores).

9. Contractor must have in effect mechanisms to assess the quality and appropriateness of

care furnished to Members with special health care needs. The assessment mechanisms must be used by appropriate health care professionals.

10. Contractor must address health care disparities.

    Contractor will submit a copy of Annual Program Description, Annual Program Evaluation, and Annual Work Plan to DOM annually for review and approval. The QM program description, including the Annual Work Plan, will be submitted to DOM for written approval annually. Contractor will also submit regular quarterly work plan updates to DOM. DOM reserves the right to expand the QM program as needed to assure quality Member care.

    Contractor will make available to its Members and providers information about the QM program and a report on Contractor's progress in meeting its goal annually. This information must be reviewed and approved by DOM prior to distribution.

E. **Performance Measures**

Contractor shall comply with DOM's QM and performance measurement requirements to improve the health outcomes for all Members. DOM will adopt the CHIPRA Quality Measures as its Performance Measures for CHIP. Contractor shall meet specific performance targets, as outlined by DOM annually for each of the Performance Measures identified by DOM.

DOM may update performance targets, include additional Performance Measures, or remove Performance Measures from the list of required Performance Measures and required targets at any time during the Contract period. DOM and Contractor(s) shall have an ongoing collaborative process on the development, addition, and modification of Performance Measures and setting of performance targets to identify opportunities for improving health outcomes. Contractor will be required to report performance on all Performance Measures annually and quarterly in accordance with Exhibit G, Reporting Requirements.

Contractor shall contract with a Certified HEDIS® Audit Firm to conduct a certified audit of its HEDIS® rates, and shall report the findings of that audit, including the actual report submitted by the auditor to NCQA, to DOM. Contractor shall also arrange for the audit of Performance Measures not included as part of HEDIS®. Contractor shall report rates for all Performance Measures to DOM, regardless of whether they are based on HEDIS® technical specifications.

While Contractor must meet DOM Performance Measure Targets for each measure, it is equally important that Contractor continually improve health outcomes from year to year. Contractor shall strive to meet the Performance Measure targets established by DOM.

DOM reserves the right to make any HEDIS® and Performance Measures results public.

F. **CAHPS® Member Satisfaction Survey**

Contractor shall contract with an NCQA certified survey vendor to administer an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Survey. The results of the survey and action plans derived from these results must be filed with DOM at least ninety (90) calendar days following Contractor's receipt of the survey findings from its certified survey vendor.

DOM reserves the right to make any CAHPS® Member Survey and results public.

G. **Provider Satisfaction Survey**

Contractor shall conduct annual provider satisfaction surveys. Contractor must submit the survey questions and methodology to DOM for review and approval by March 1 for the current calendar year. The results of the survey and action plans derived from these results must be filed with DOM at least ninety (90) calendar days following the completion of the survey and no later than December 1 for the current calendar year.

H. **Value-Based Purchasing**

At its option, DOM may implement a value-based purchasing within CHIP. DOM reserves the right to phase in implementation of a value-based purchasing model beginning with a performance incentive program. Should DOM move forward with such an effort, DOM will provide operational protocols describing the process for selecting priority areas, measures, and targets, Contractor expectations, and DOM responsibilities prior to implementation. If implemented, the value-based purchasing model will require the participation of key Contractor staff, including the Medical Director, in regular meetings with DOM staff. The value-based purchasing model may lead to the creation of subcommittees to current Managed Care Program Quality Committees, referenced in Section 9.A, General Requirements, of this Contract.

Contractor will have an opportunity to provide recommendations on selections for priority areas, measures, and targets based on the results of gaps analysis and root cause analyses performed by Contractor. DOM will have final authority on the selection of priority areas, measures, and targets, which Contractor will be required to comply.

I. **Performance Improvement Projects**

Contractor shall also perform a minimum of four (4), either clinical or non-clinical Performance Improvement Projects (PIP) each year on topics prevalent and significant to the population served. PIPs shall meet all relevant CMS requirements. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Contractor shall:

1. Show that the selected area evaluation is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);

2. Establish clear, defined and measurable goals and objectives that Contractor shall achieve in each year of the project;

3. Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;

4. Implement interventions designed to achieve Quality improvements;

5. Evaluate the effectiveness of the interventions;

6. Establish standardized Performance Measures (such as HEDIS® or another similarly standardized product);

7. Plan and initiate activities for increasing or sustaining improvement; and

8. Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

Due to the critical importance of the area of obesity to the CHIP population, this area should be selected annually for study providing continuous evaluation. At least three (3) other clinical or health service delivery areas completing the required total of four (4) should be selected annually for quality improvement activities. DOM will pre-approve all PIPs. DOM may require Contractor to implement PIPs focusing on specified conditions. Contractor will include study question and study indicators agreed upon by DOM and Contractor.

Contractor shall include information on PIPs in the QM program description and work plan submitted to DOM.

In addition to those set forth herein, CMS, in consultation with the State, and other stakeholders, may specify additional Performance Measures and topics for PIPs to be undertaken by Contractor.

J. **Quality Management Committee**

Contractor must operate under a formal organizational structure for the implementation and oversight of the internal QM program. The formal organizational structure must include at a minimum, the following:

1. Established parameters of operation including specifics regarding role, function and structure;

2. A designated health care practitioner, qualified by training and experience, to serve as

the QM Director;

3. A committee which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization;

4. A senior executive who is responsible for program implementation;

5. Substantial involvement in QM activities by Contractor's Medical Director;

6. QM activities must be distinctly separate from the Utilization Management (UM) activities and the distinction must be well defined;

7. The QM committee must meet regularly with specified frequency to oversee QM activities. This frequency will be sufficient to demonstrate that the committee is following up on all findings and required actions, but in no case are such meetings to be less frequent than quarterly;

8. Records that document the committee's activities, findings, recommendations, actions, and results; and

9. Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

K. **Standards**

The QM program shall provide continuous performance of quality of care studies, health service delivery studies, and other monitoring activities using objective, measurable, and current standards for service delivery, quality indicators, or pre-established practice guidelines.

L. **Clinical Practice Guidelines**

Contractor shall develop and make clinical practice guidelines consistent with national standards for disease and chronic illness management of Members available to providers. These clinical practice guidelines shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by contracted providers who can recommend adoption of clinical practice guidelines to Contractor, and communicated to those whose performance will be measured against them. Clinical guidelines are provided by Contractor to physicians and other contracted providers as appropriate. Contractor reviews the guidelines at least every two (2) years and updates them as appropriate.

Contractor, on an annual basis, shall measure provider performance against at least two (2) of the clinical guidelines and provide DOM the results of the study and a summary of any corrective actions taken to ensure compliance with the guidelines.

M. **Utilization Management**

Contractor will provide for a system of UM or utilization review consistent with the

requirements of 42 C.F.R. Part 456 and in accordance with Miss. Code Ann. § 41-83-1 *et. seq.* and other applicable sections.

Contractor shall have a written UM program description specific to CHIP which outlines the program structure and accountability and includes, at a minimum:

1. Criteria and procedures for the evaluation of medical necessity of medical services for Members;

2. Criteria and procedures for pre-authorization or pre-certification for inpatient hospital stays and certain surgical and diagnostic procedures, and referral that include Appeal mechanisms for providers and Members to preclude denial of care that is appropriate and Medically Necessary;

3. Mechanisms to detect and document under-utilization as well as over utilization of all Covered Services;

4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs;

5. Availability of UM criteria to providers;

6. Involvement of actively practicing, board certified physicians in the program to supervise all review decisions and to review denials for medical appropriateness;

7. Availability of physician reviewer to discuss determinations by telephone with providers who request such;

8. Evaluation of new medical technologies and new application of existing technologies and criteria for use by contracted providers;

9. Annual UM program review to determine effectiveness and need for changes;

10. Process for measuring provider performance against at least two (2) of the clinical guidelines on an annual basis;

11. Process and procedure to address disparities in health care, which shall be included in the Quality Improvement Work Plan;

12. A process for identifying clinical issues and analyzing the issues by appropriate clinicians and, when appropriate, developing corrective action taken to improve services;

13. Development of disease management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, obesity, attention deficit hyperactivity disorder, and organ transplants; and

14. A comprehensive health education program that will support the Care Management programs.

At its discretion, Contractor may elect to (but is not required to) extend Covered Services beyond the benefit limitations and/or cover alternative benefits for cost-effective health care services and supplies which are not otherwise covered. The decision to provide extended or alternative benefits shall be made on a case-by-case basis to Members who meet the UM Program's criteria. Any decision regarding the provision of extended or alternative benefits shall be made as part of the UM Program. Contractor shall be responsible for the payment of any such benefits and shall not authorize any services specifically excluded from the State Child Health Plan.

Contractor shall annually evaluate its UM program and submit a copy of this evaluation to DOM annually. The UM program description will be submitted to DOM for written approval annually.

Contractor shall provide UM criteria to providers upon request.

N. **Medical Audit**

DOM may conduct annual medical audits of Contractor during which DOM will identify and collect management data including information on the use of services and Enrollment and Disenrollment policies to ensure that Contractor furnishes quality and accessible health care to enrolled Members. DOM will review any of Contractor's policies and procedures for compliance with the terms of this Contract and any policies and procedures for services.

O. **Well-Care Child Assessments and Immunizations Audit**

In conjunction with the medical audit, complete well-care assessments and immunizations claims data for Contractor and a sample of Medical Records will be evaluated by DOM annually to determine compliance by Contractor with the requirements of this Contract for provision of these services to Members will be based on the CMS 416 report.

Contractor must achieve the screening rates in Table 8 to comply with this Contract. The identified targets are in effect for the first year of operations, and DOM will update these targets annually.

Table 8. Well-Care Child Assessments and Immunizations Screening Rates

Measure	Screening Rate Targets
Screenings	Eighty-five percent (85%) of Children enrolled had required screenings
Immunizations	Ninety percent (90%) of Children enrolled had required immunizations

The screening rate will be calculated using the reportable number for Line 7-Screening Ratio of the CMS 416 report. To calculate the screening rate, DOM shall divide the

actual number of initial and periodic screening services received (line 6 of 416 report) by the expected number of initial and periodic screening services (line 5 of 416 report).

This ratio indicates the extent to which eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule prorated by the portion of the year for which they are eligible for CHIP. For a Child who has been enrolled from birth through twelve (12) months, compliance with the DOM's periodicity schedule is six (6) screens. Immunization compliance means that the Child is up-to-date with his/her immunizations based on the ACIP immunization schedule.

Contractor shall publish screening rates in required educational and Marketing presentations to potential Members.

Contractor may be subject to sanctions if it does not achieve the targets specified in Table 8, and provide satisfactory explanation for noncompliance to DOM,in accordance with Section 15.E, Liquidated Damages, of this Contract.

SECTION 10 – REPORTING REQUIREMENTS

DOM reserves the right to make operational reports, data, and information submitted by Contractor public. DOM also reserves the right to perform audits, as appropriate, to verify and validate operational reports, data, and information submitted by Contractor.

A. Record System Requirements

Contractor shall maintain detailed records evidencing all expenses incurred pursuant to this Contract; Member Enrollment status; provision of covered services; Complaints; and all relevant medical information relating to individual Members, for the purpose of audit and evaluation by DOM and other Federal or State agencies. All records, including training records, pertaining to the Contract, shall be maintained and available for review by authorized Federal and State agencies during the entire term of this Contract and for a period of five (5) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit is in progress, audit findings are unresolved, or there is pending litigation that has not been completed, records shall be kept for a period of five (5) years or until all issues are finally resolved, whichever is later. All records shall be maintained at one central office in Mississippi designated by Contractor and approved by DOM.

All records, including training records, pertaining to the Contract must be readily retrievable within three (3) business days for review at the request of DOM and its authorized representatives at no cost to DOM or its authorized representatives.

Related to QM activities, Contractor shall maintain and make available to DOM, CMS, Office of Inspector General (OIG), and State and Federal Auditors, all studies, reports, protocols, standards, work plans, work sheets, committee minutes, committee reports to the Board of Directors, Medical Records, and such further documentation as may be required by DOM, concerning QM activities and corrective actions.

B. Reporting Requirements

Contractor is responsible for complying with the reporting requirements set forth in this Section, and for assuring the accuracy, completeness, and timely submission of each report. Contractor shall provide such additional data and reports as may be requested by DOM. DOM will furnish Contractor with the appropriate reporting formats, instructions, and timetables for submission.

DOM will also provide technical assistance in filing reports and data as may be permitted by DOM's available resources. DOM reserves the right to modify from time to time the form, content, instructions, and timetables for the collection and reporting of data. DOM will provide Contractor with written notice of such modifications. Modifications will be effective no earlier than sixty (60) days from the date on the written notice provided to Contractor.

Contractor shall transmit and receive all transactions and code sets required by the HIPAA

regulations, as required by Section 16.A, Privacy/Security Compliance, of this Contract.

Contractor shall submit to DOM copies of all reports, in full, submitted to the Mississippi Department of Insurance.

Contractor agrees to furnish to DOM, at no cost to DOM, any records, documents, reports, or data generated or required in the performance of this Contract including, but not limited to, the reports specified in Exhibit G, Reporting Requirements, of this Contract.

C. **Enrollment Reports**

Contractor shall submit to DOM information about all new Enrollments, Disenrollments, reinstatements, and circumstances affecting the Enrollment status of Members, as received by Contractor, in a submission format approved by DOM. Contractor shall review each Member Listing Report upon receipt and shall submit all corrections to DOM on or before the thirtieth (30^{th}) day of the month for which the Member Listing Report is issued. Adjustments will be made to the next Member Listing Report to reflect corrections, and the Enrollment or Disenrollment of Members reported to DOM (and approved by DOM in the case of voluntary or involuntary Disenrollment for cause) on or before the fifteenth (15^{th}) calendar day of each month.

D. **Member Identification Card Reports**

Contractor shall submit a monthly report of returned identification cards. The report must identify all returned cards, with the Member's Mississippi CHIP Member identification number, first/last name, incorrect address, and correct address, if available. In cases where a returned card may be a HIPAA violation, Contractor must notify DOM of the potential violation within seventy-two (72) hours of discovery, in accordance with the Business Associate Agreement.

E. **Provider Services Reports**

Contractor shall submit a quarterly report providing information on general provider services operations, including but not limited to provider credentialing and recredentialing, provider enrollment, provider services call center, staff training, and Complaints, Grievances, and Appeals.

F. **CMS 416 Reports**

Contractor shall comply with all requirements related to the submission of a CMS 416 report as required by the Federal government. This report must be submitted annually and quarterly to DOM.

G. **Medical Records**

Contractor shall make all reasonable efforts to ensure the maintenance of current, detailed, organized Medical Records by health care providers for each Member sufficient to disclose

the quality, quantity, appropriateness, and timeliness of services performed pursuant to this Contract. Medical Records shall be accessible and made available to providers providing services to Members enrolled with Contractor, and to DOM for purposes of Medical Record review. Contractor shall follow applicable DOM policies and procedures.

As described in 42 C.F.R. Part 456, Subparts C and D, Medical Record content must include, at a minimum for hospitals and mental hospitals:

a. Identification of the Member;

b. Physician name;

c. Date of admission and dates of application for and authorization of CHIP benefits if application is made after admission; the plan of care;

d. Initial and subsequent continued stay review dates;

e. Reasons and plan for continued stay if applicable;

f. Other supporting material the committee believes appropriate to include. For non-mental hospitals only;

g. Date of operating room reservation; and

h. Justification of emergency admission if applicable.

H. **Financial Reports**

Contractor shall file with DOM, within seven (7) calendar days after issuance, a true, correct, and complete copy of any report or notice issued in connection with a financial examination conducted by or on behalf of the Department of Insurance, State of Mississippi.

Contractor shall submit to DOM a copy of all quarterly and annual filings submitted to the Department of Insurance. A copy of such filing shall be submitted to DOM on the same day on which it is submitted to the Department of Insurance. Any revisions to a quarterly and/or annual Department of Insurance financial statement shall be submitted to DOM on the same day on which it is submitted to the Department of Insurance (DOI).

Throughout the duration of the Contract term, Contractor shall operate and maintain an accounting system that either (1) meets Generally Accepted Accounting Principles (GAAP) as established by the Financial Accounting Standards Board or (2) can be reconciled to meet GAAP. This accounting system shall have the capability to produce standard financial reports and ad hoc financial reports related to financial transactions and ongoing business activities, and Contractor shall enhance or update it upon request. Throughout the term of the Contract, Contractor must notify DOM prior to making any changes to its basis of accounting.

The Department of Insurance regulates the financial stability of all appropriately licensed

Contractors in Mississippi. Contractor agrees to comply with all Department of Insurance standards.

Contractor shall file with DOM, within seven (7) calendar days of request, other financial reporting as required for the Capitation Payment development process.

I. **Third Party Liability Audit**

DOM or its designated Agent may conduct a Third Party Liability audit of Contractor. Contractor shall make available specific data as requested to complete the audit.

J. **Third Party Liability Reporting**

Contractor shall provide a monthly report to DOM in a format specified by DOM by the thirtieth (30^{th}) of each month. In cases where DOM has a claim, Contractor will work closely with DOM to coordinate efforts and will provide documents containing related information for DOM's review within three (3) business days of the request.

K. **Member Grievances and Appeal Reporting**

Contractor shall maintain a health information system to track the receipt and resolution of verbal, in-person, and written Member Grievances and Appeals. Contractor shall submit to DOM by the thirtieth (30th) calendar day of the month after the end of each month, a mutually agreed upon summary report of all Member Grievances, and Appeals as illustrated in this Contract. The system and the tracking logs shall be made accessible to DOM for review.

Contractor shall also submit to DOM upon request within five (5) business days a detailed log of all Member Grievances and Appeals and made under this Contract.

1. Member Grievance and Appeal categories identified shall be organized or grouped by the following general guidelines:

    a. Access to services/providers;

    b. Provider care and treatment;

    c. Contractor customer service;

    d. UM;

    e. Marketing;

    f. Payment and reimbursement issues; and

    g. Administrative issues.

2. Member Appeal categories identified shall be organized or grouped by the following

general guidelines:

a. Contractor administrative issues; and

b. Benefit denial or limitation.

3. The log shall contain the following information for each Member Grievance or Appeal:

a. The date of the communication;

b. The Member's Mississippi CHIP identification number;

c. Whether the Grievance or Appeal was written or verbal;

d. Indication of whether the dissatisfaction was Member Grievance or an Appeal;

e. The category, specified in Subsection 1, of each inquiry;

f. A description of subcategories or specific reason codes for each Member Grievance and Appeal;

g. The resolution (detailed information about how the Member Grievance or Appeal was resolved); and

h. The resolution date.

Contractor shall submit to DOM within thirty (30) calendar days of filing a copy of any report regarding specific Member Grievances, or Appeals or its system for tracking Member Grievances and Appeals required to be filed with the Mississippi Department of Insurance. Contractor shall document Member Grievances and Appeals that proceed through multiple review steps in its tracking systems such that the entire Member Grievance and Appeal process is easily identified. Contractor must maintain Member Grievance and Appeal records in a manner that is reasonably clear and accessible to DOM for review and shall be provided to DOM for inspection upon request. Contractor shall maintain records for the length of the Contract and transferred to DOM upon termination of the Contract.

L. Provider Complaints, Grievances, and Appeal Reporting

Contractor shall maintain a health information system to track the receipt and resolution of verbal, in-person, and written Provider Complaints, Grievances, and Appeals. Contractor shall submit to DOM by the thirtieth (30th) calendar day of the month after the end of each month, a mutually agreed upon summary report of all Provider Complaints, Grievances, and Appeals as illustrated in this Contract. The system and the tracking logs shall be made accessible to DOM for review.

Contractor shall also submit to DOM upon request within five (5) business days a detailed log of all Provider Grievances and Appeals and all Provider Complaints, Grievances

and Appeals made under this Contract.

1. Provider Grievance and Complaint categories identified shall be organized or grouped by the following general guidelines:

   a. Access to services/providers;

   b. Provider care and treatment;

   c. Contractor customer service;

   d. Payment and reimbursement issues; and

   e. Administrative issues.

2. Provider Appeal categories identified shall be organized or grouped by the following general guidelines:

   a. Contractor administrative issues; and

   b. Benefit denial or limitation.

3. The log shall contain the following information for each Provider Complaint, Grievance, or Appeal:

   a. The date of the communication;

   b. The provider's Mississippi CHIP identification number and/or NPI number;

   c. Whether the Provider Complaint, Grievance or Appeal was written or verbal;

   d. Indication of whether the dissatisfaction was a Provider Complaint, Grievance or Appeal;

   e. The category, specified in Subsection 1, of each inquiry;

   f. A description of subcategories or specific reason codes for each Provider Complaint, Grievance and Appeal;

   g. The resolution (detailed information about how the Provider Complaint, Grievance or Appeal was resolved); and

   h. The resolution date.

Contractor shall submit to DOM within thirty (30) calendar days of filing a copy of any report regarding specific Provider Complaints, Grievances, or Appeals or its system for tracking Provider Complaints, Grievances, and Appeals required to be filed with the Mississippi Department of Insurance. Contractor shall document Provider Complaints, Grievances, and Appeals that proceed through multiple review steps in its tracking systems

such that the entire Provider Complaints, Grievance, and Appeal process is easily identified. Contractor must maintain Provider Complaints, Grievance, and Appeal records in a manner that is reasonably clear and accessible to DOM for review and shall be provided to DOM for inspection upon request. Contractor shall maintain records for the length of the Contract and transferred to DOM upon termination of the Contract.

M. **Confidentiality of Information**

Contractor shall treat all information, including that relating to Members and providers, which is obtained by Contractor through its performance under this Contract as confidential information and shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights hereunder.

All information as to personal facts and circumstances concerning Members obtained by Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of DOM and the written consent of the Member, his/her attorney, or his/her responsible parent or guardian, except as may be required by DOM. The use or disclosure of information concerning Members shall be limited to purposes directly connected with the administration of the Contract. All of Contractor officers and employees performing any work for or on the Contract shall be instructed in writing of this confidentiality requirement and required to sign such a document upon employment and annually thereafter.

Contractor shall immediately notify DOM of any unauthorized possession, use, knowledge, or attempt thereof, of DOM's data files or other confidential information. Contractor shall immediately furnish DOM full details of the attempted unauthorized possession, use, or knowledge, and assist in investigating or preventing the recurrence thereof.

DOM, the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties, including, without limitation, any employee, Agent, or Contractor of DOM, CMS, and DOM's Agent, shall have access to all confidential information in accordance with the requirements of this Contract and State and Federal law and regulations pertaining to such access. DOM shall have authority to determine if and when any other party has properly obtained the right to have access to such information in accordance with applicable State and Federal laws and regulations. Contractor shall adhere to 42 C.F.R. Part 2, 42 C.F.R. Part 431, Subpart F and 45 C.F.R. Parts 160 and 164, Subparts A and E to the extent these requirements are applicable to the obligations under this Contract.

This requirement of confidentiality survives the term of the Contract between DOM and Contractor.

See also Section 4.14.3, Release of Public Information, and Section 4.14.4, Transparency, of the Mississippi CHIP RFP for additional requirements.

N. **Access to Records**

Pursuant to the requirements of Title XXI, Section 2107(b)(3) of the Act,42 C.F.R. § 434.6(a)(5), § 457.720, and § 457.950, Contractor and each of its providers shall make all of its books, documents, papers, provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records) available for examination and audit by DOM, the State Attorney General, authorized Federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, Agent, or Contractor of DOM, CMS, and DOM's Agent. Access will be at the discretion of the requesting authority and will be either through on-site review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) calendar days following a request, for desk audits. Requests may be written or verbal. All records shall be provided at the sole cost and expense of Contractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping, and/or mailing of records. DOM shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by Contractor and in any way relating to this Contract in accordance with applicable State and Federal laws and regulations.

In accordance with 45 C.F.R. § 74.48, the Contract awarded to Contractor and their Contractors shall make available to the HHS awarding agency, the U. S. Comptroller General, or any representatives, access to any books, documents, papers, and records of Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

There will be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness, or timeliness of services and reasonableness of their costs.

Any person (including an organization, agency or other entity, but excluding a Member) that fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of HHS, for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of HHS, DOM, or any other duly authorized representative, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of fifteen thousand dollars and zero cents ($15,000.00) for each day of the failure to make accessible all books, documents, papers, provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records). In addition, DOM may make a determination to terminate the Contract.

O. **Health Information System**

Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, Grievances and Appeals, and Disenrollment for other than loss of CHIP eligibility. Contractor must collect data on Member and provider characteristics (i.e., tracking of appointments kept and not kept, place of service, provider type), and make all collected data available to DOM, to CMS, to the Mississippi Department of Insurance, and to any other oversight agency of DOM.

P. **Encounter Data**

Contractor must submit complete, accurate, and timely encounter data to DOM that meets Federal requirements and allows DOM to monitor the program. Encounter Data consists of a separate record each time a Member has an Encounter with a health care provider. A service rendered under this Agreement is considered an Encounter regardless of whether or not it has an associated Claim. Contractor shall only submit Encounter Data for Members enrolled with Contractor on date of service and not submit any duplicate records. The provider's National Provider Identifier (NPI) shall be used when submitting required Encounter Data.

Contractor is required to submit encounter data directly to DOM's Agent.

Contractor must maintain appropriate systems and mechanisms to obtain all necessary data from its providers to ensure its ability to comply with the Encounter Data reporting requirements. The failure of a provider or Subcontractor to provide Contractor with necessary encounter data shall not excuse Contractor's non-compliance with this requirement.

Contractor will be given a minimum of sixty (60) calendar day notification of any new edits or changes that DOM intends to implement regarding encounter data.

1. Data Format

   Contractor must submit Encounter Data to DOM's Agent using established protocols.

   Encounter Data files must be provided in the following HIPAA transactions:

   a. 837 Professional;

   b. 837P Drug;

   c. 837 Institutional;

   d. 837 Dental; and

   e. NCPDP batch files.

2. Provider Claims

Contractor shall encourage providers to submit claims as soon as possible after the dates of service. Providers shall be provided and a maximum of six (6) months to submit claims from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to Contractor within ninety (90) calendar days from the date of denial.

Claims adjudicated by a third party vendor must be provided to Contractor by the end of the month following the month of adjudication.

DOM may impose penalties under Section 15.E, Liquidated Damages, of this Contract for non-compliance with these requirements.

3. Encounter Submissions

All Encounter records must be submitted by Contractor and determined acceptable by DOM's Agent on or before the last calendar day of the third month after the payment/adjudication calendar month in which Contractor paid/adjudicated the Claim. Contractor shall submit the encounter data to DOM on a weekly basis.

Encounter records sent to DOM's Agent by Contractor are considered acceptable when they pass all DOM's Agent's edits.

Encounter records that deny or suspend due to DOM's Agent's edits are returned to Contractor and Contractor must make the requested corrections. Contractor shall resubmit denied Encounter records as a "new" Encounter record if appropriate and within the time frame referenced above.

Contractor shall correct and resubmit suspended Encounter records as an adjustment within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted by DOM's Agent.

Failure of Subcontractors to submit Encounter Data timely shall not excuse Contractor noncompliance with this requirement, and DOM may impose penalties under Section 15.E, Liquidated Damages, of this Contract for non-compliance.

4. Encounter File Specifications

Contractor must adhere to the file size and format specifications provided by DOM. Contractor must also adhere to the Encounter file submission schedule provided by DOM.

5. Data Completeness

Contractor shall submit records each time a Member has an Encounter with a health care provider. Contractor must have a data completeness monitoring program in place that:

a. Demonstrates that all Claims and Encounters submitted to Contractor by providers and Subcontractors are submitted accurately and timely as Encounters to DOM's Agent. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;

b. Evaluates provider and Subcontractor compliance with contractual reporting requirements; and

c. Demonstrates Contractor has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Encounter Data reporting to DOM.

Contractor must submit an annual Data Completeness Plan for review and approval. DOM will work to review and approve the Data Completeness Plan within thirty (30) calendar days. This Data Completeness Plan must include the three (3) elements listed above. Contractor must report findings from its annual Data Completeness internal audits on at least an annual basis, or at the request of DOM.

6. Data Validation

Contractor agrees to assist DOM in its validation of Encounter Data by making available Medical Records and claims data as requested. The validation may be completed by DOM staff and/or independent, external review organizations.

In addition, Contractor will validate files sent to them when requested.

7. Secondary Release of Encounter Data

All Encounter Data recorded to document services rendered to Members under this Agreement are the property of DOM. Access to this data is provided to Contractor and its agents for the sole purpose of operating CHIP under this Contract. Contractor and its agents are prohibited from releasing any data resulting from this Agreement to any third party without the advance written approval of DOM.

DOM will impose penalties and/or sanctions under Section 15.E, Liquidated Damages, of this Contract for any encounter data not received monthly or in cases that the data does not meet DOM's requirements.

Q. **Data Certifications**

All data, reports, documents, records, encounter data, and any other information required to be submitted to DOM by Contractor shall be certified by one of the following: Contractor's Chief Executive Officer, Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports to, Contractor's Chief Executive Officer or Chief Financial Officer. The certification must attest, under penalty of perjury, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of the data and to the accuracy completeness and truthfulness of the documents. Contractor

must submit the certification in writing with the signature of the appropriate certifier, at the time the certified data, documents, reports, records, encounter data, or other information is submitted to DOM.

R. **Claims Processing and Information Retrieval Systems**

Contractor's claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Contract. Contractor's claims processing and information retrieval systems must have the capability to accept claims history data from DOM or its Agent.

S. **Fraud and Abuse Reporting**

Contractor shall report Member or provider Fraud or Abuse which it had reasonable cause to suspect, or should have had reasonable cause to suspect, immediately to DOM, and shall cooperate with DOM regarding the investigation. Failure to do so could result in criminal and/or civil penalties. Contractor must report Member or provider Fraud or Abuse in a format, to be specified by DOM. Contractor must use the most current version of DOM's Standard Operating Procedure for Managed Care Fraud and Abuse for Referrals and Reporting to Program Integrity (PI).

Quarterly, Contractor must report the number of investigations and/or cases of Fraud and Abuse made to DOM that warrant preliminary investigation. Contractor will immediately notify DOM in the following instances:

1. If Contractor's preliminary investigation reveals a credible allegation of Fraud; and

2. If Contractor takes any adverse Action against a network provider for program integrity-related reasons.

DOM will notify the Office of Program Integrity of any probable Fraud or Abuse that is obtained from, or developed by, Contractor's system.

T. **Subcontractor Disclosures**

Contractor must disclose all information in accordance with 42 C.F.R. § 455.104(b) regarding Subcontractors. Contractor is responsible for obtaining all disclosure information from all Subcontractors, managing employees, and agent's employees, and submitting to DOM.

Contractor must disclose all information from their Subcontractors as related to persons convicted of crimes in accordance with 42 C.F.R. § 455.106.

U. **Deliverables**

Contractor must obtain DOM's prior written approval of all Deliverables prior to the operational date of the Initial Term and throughout the duration of the Contract unless otherwise specified by DOM. Deliverables include, but are not limited to operational

policies and procedures, required materials, letters of agreement, provider Agreements, provider reimbursement methodology, reports, tracking systems, required files, and QM program documents. Failure by DOM to respond to approval requests shall not be interpreted as approval of Deliverables.

Contractor must meet DOM's required time frames for the submission of Deliverables in the event that requested Deliverables do not have a submission time frame specified. In such cases, DOM will specify the time frame for submission of Deliverables. In the absence of a specific time frame listed for a Deliverable within the Contract, DOM will work to review and approve a Deliverable within forty-five (45) calendar days from the date of submission.

DOM may impose penalties under Section 15.E, Liquidated Damages, of this Contract if Contractor fails to submit Deliverables for approval based on the requirements set forth in this Contract.

V. **Small and Minority Business Reporting**

DOM encourages the employment of small business and minority business enterprises. Therefore, Contractor shall report, separately, the involvement in this Contract of small businesses and businesses owned by minorities and women. Such information shall be reported on an invoice annually on the Contract anniversary and shall specify the actual dollars contracted to-date with such businesses, actual dollars expended to date with such businesses, and the total dollars planned to be contracted for with such businesses on this Contract.

W. **Cost or Pricing Data**

If DOM determines that any price, including profit or fee, negotiated in connection with this Contract was increased because Contractor furnished incomplete or inaccurate cost or pricing data not current as certified in Contractor's certification of current cost or pricing data, then such price or cost shall be reduced accordingly and this Contract shall be modified in writing and acknowledged by Contractor to reflect such reduction.

X. **Drug Rebate Data**

Contractor must report to DOM, on a timely and periodic basis specified by the Secretary of HHS, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Members for which the entity is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary.

SECTION 11 – FRAUD AND ABUSE

A. General Requirements

Contractor shall have internal controls, policies and procedures, and a compliance plan to guard against Fraud and Abuse in accordance with 42 C.F.R. Part 457, Subpart I and 42 C.F.R. Part 455. Specifically, Contractor shall have written policies, procedures, and standards of conduct that articulate Contractor's commitment to comply with all applicable Federal and State standards subject to approval by DOM. DOM will work to review initial policies and procedures within forty-five (45) calendar days and subsequent changes within fifteen (15) calendar. Contractor shall annually review and submit an updated Fraud and Abuse compliance plan to DOM for approval. DOM will work to review and approve the Fraud and Abuse Compliance Plan with forty-five (45) calendar days.

B. Fraud and Abuse Compliance Plan

At a minimum, the Fraud and Abuse compliance plan shall comply with DOM's policies and procedures for Fraud and Abuse and include the following:

1. The designation of a Fraud and Abuse Compliance Officer and a compliance committee that is accountable to senior management;

2. Effective training and education for the Fraud and Abuse Compliance Officer and Contractor's employees;

2. Operation of a Fraud and Abuse Hotline during which all calls are recorded. DOM may request to review call recordings and associated transcripts at its discretion;

3. Effective lines of communication between the Fraud and Abuse Compliance Officer and Contractor's employees;

4. Enforcement of standards through well publicized disciplinary guidelines (e.g., provision for internal monitoring and auditing);

5. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Contract;

6. Procedures for:

    a. Conducting regular reviews and audits of operations to guard against Fraud and Abuse;

    b. Verifying whether services reimbursed were actually furnished to Members, as required in 42 C.F.R. § 455.1, § 455.20, and § 457.980;

    c. Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly;

d. Responding to cases of potential provider and Member Abuse referred by DOM;

e. Reporting information to DOM; and

f. Developing procedures to monitor service patterns of providers, Subcontractors, and Members.

7. Assistance to DOM in any investigation or prosecution of Fraud by providing the following:

   a. Access to and free copies of computerized data stored by Contractor;

   b. Direct computer access to computerized data stored by Contractor that is supplied without charge and in the form requested by DOM; and

   c. Access to any information possessed or maintained by any provider of service(s) under CHIP to which DOM and Contractor are authorized to access.

If Contractor identifies that a Member or provider is committing Fraud and Abuse, Contractor may disenroll the provider and request to DOM that the Member be disenrolled. However, Contractor shall not indicate to the provider or Member that they will be disenrolled from CHIP.

Contractor shall not pay for an item or services (other than an emergency item or services, not including items or services furnished in an emergency room of a hospital), furnished by an individual or entity to whom DOM has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless DOM determines there is good cause not to suspend such payments.

DOM, designated parties and Contractor shall meet quarterly to collaborate on Complaints of Fraud and Abuse.

SECTION 12 – FINANCIAL REQUIREMENTS

A. Capitation Payments

Exhibit A, Capitation Rates, of this Contract includes the capitation rates per Member per month.

1. Monthly Payments

   On or before the fifteenth (15th) day of each month during the term of this Contract, DOM shall remit to Contractor the capitation fee specified for each Member listed on the Member Listing Report issued for that month. Payment is contingent upon satisfactory performance by Contractor of its duties and responsibilities as set forth in this Contract. All payments shall be made by electronic funds transfers, the cost of which shall be borne by Contractor. Contractor shall set up the necessary bank accounts and provide written authorization to DOM's Agent to generate and process monthly payments through DOM's internal billing procedures.

   DOM will pay Contractor monthly Capitation Payments based on the number of eligible and enrolled Members. DOM will calculate the monthly Capitation Payments by multiplying the number of Members times the applicable monthly capitation rate. Contractor must provide the Services and Deliverables, including covered services to Members, described in the Contract for monthly Capitation Payments to be paid by DOM. Contractor must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to DOM, delays or denials of required approvals, cost of claims incorrectly paid by the funding to DOM, and cost overruns not reasonably attributable to DOM. Contractor must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from DOM or any other State agency, nor will the failure of DOM or any other party to pay for such incidental or ancillary services entitle Contractor to withhold services or Deliverables due under the Contract.

2. Payment in Full

   Contractor shall accept the capitation rate paid each month by DOM as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith. At time of capitation rate acceptance, Contractor shall provide an actuarial certification that states the capitation rates are adequate in light of Contractor's specific circumstances. Members shall be entitled to receive all covered services for the entire period for which payment has been made by DOM. Any and all costs incurred by Contractor in excess of the Capitation Payment will be borne in full by Contractor. Interest generated through investment of funds paid to Contractor pursuant to this Contract shall be the property of Contractor.

3. Rate Adjustments

Contractor and DOM acknowledge that the capitation rates are subject to approval by the Federal government. Adjustments to the rates may be required to reflect legislatively or congressionally mandated changes in CHIP services, program changes, in the scope of mandatory services, or when capitation rate calculations are determined to have been in error. In such events, funds previously paid may be adjusted as well. Contractor agrees to refund any overpayment to DOM, and DOM agrees to pay any underpayment to Contractor, within thirty (30) calendar days following written notice by DOM. In addition, DOM will review rates annually and adjust rates as deemed necessary subject to approval from the Federal government.

4. Refund and Recoupment

DOM may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to Contractor for a Member who is determined to have been ineligible for Enrollment for any month. Upon notice by DOM of a Member who is ineligible, Contractor may recoup from the provider the amounts paid for any provided covered services.

5. Reserve Account

Contractor shall establish and maintain an insured bank account or a secured investment which is in compliance with the Department of Insurance regulations referenced in Miss. Code Ann. § 83-41-325.

6. Reinsurance

Contractor must supply a guarantee of coverage letter, with annual updates, for any outstanding claims.

Contractor may insure any portion of the risk under the provision of the Contract based upon Contractor's ability (size and financial reserves included) to survive a series of adverse experiences, including withholding of payment by DOM, or imposition of penalties by DOM. These arrangements must be approved by DOM.

7. Third Party Resources

If Contractor identifies that a Member has third party coverage, it shall notify DOM within five (5) business days in the specified format and procedure as directed by DOM. DOM will review the Member's third party coverage. If the Member is determined to have Creditable Coverage by DOM, DOM will transmit a termination of eligibility date to Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as Contractor receives a termination code from DOM.

Contractor may delay payment of a provider for up to sixty (60) calendar days following the date of receipt of the claims by Contractor in the event that a Third Party Resource is

identified from which the provider is obligated to collect payment.

If payment is made by the third party directly to a provider within sixty (60) calendar days following the date of service, Contractor may pay the provider only the amount, if any, by which the allowable claim exceeds the amount of the Third Party Liability. If payment is not made by the third party within such sixty (60) calendar day period, Contractor must pay the provider and obtain a refund of any subsequent payments made by the third party. Contractor may not withhold payment from a provider for services provided to a Member due to the existence of Third Party Resources, because the liability of a Third Party Resource cannot be determined, or because payment will not be available within sixty (60) calendar days.

B. **Indemnification and Insurance**

To the fullest extent allowed by law, Contractor shall indemnify, defend, save, and hold harmless, protect, and exonerate DOM, the State of Mississippi, their commissioners, board members, officers, Agents, employees, representatives, assignees, Members and eligible dependents, and contractors from and against all claims, demands, liabilities, suits, actions, damages, losses, and costs of every kind and nature whatsoever including, without limitation, court costs, investigative fees and expenses, and attorney's fees, arising out of or caused by Contractor and/or its partners, principals, agents, employees, laborers, and/or subcontractors in the performance of or failure to perform this Contract, including:

1. To indemnify and hold harmless the State, its officers, Agents and employees, and the Members and their eligible dependents from any and all claims or losses accruing or resulting from Contractor's negligence to any participating provider or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.

2. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from liability deriving or resulting from Contractor's Insolvency or inability or failure to pay or reimburse participating providers or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.

3. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from any and all claims for services for which Contractor receives monthly Capitation Payments, and shall not seek payments other than the Capitation Payments from the State, its officers, Agents, and/or employees, and/or the Members and/or their eligible dependents for such services, either during or subsequent to Contract termination.

4. Any and all liability, loss, damages, costs or expenses which DOM or the State may incur, sustain or be required to pay by reason of Contractor, its employees, agents or assigns: 1)failing to honor copyright, patent or licensing rights to software, programs or technology of any kind in providing services to DOM, or 2) breaching in any manner the confidentiality required pursuant to Federal and State law(s) and regulations.

5. Any and all liability, loss, damage, costs or expenses which DOM may sustain, incur, or be required to pay: 1) by reason of any person suffering personal injury, death or property loss or damage of any kind either while participating with or receiving services from Contractor under this Contract, or while on premises owned, leased, or operated by Contractor or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of Contractor or any officer, agent, or employee thereof; or 2) by reason of Contractor or its employee, agent, or person within its scope of authority of this Contract causing injury to, or damage to the person or property of a person including but not limited to DOM or Contractor, their employees or agents, during any time when Contractor or any officer, agent, employee thereof has undertaken or is furnishing the services called for under this Contract.

6. All claims, demands, liabilities, and suits of any nature whatsoever arising out of the Contract because of any breach of the Contract by Contractor, its agents or employees, including but not limited to any occurrence of omission or commission or negligence of Contractor, its agents or employees.

7. All claims and losses accruing or resulting to any and all Contractor employees, agents, Subcontractors, laborers, and any other person, association, partnership, entity, or corporation furnishing or supplying work, services, materials, or supplies in connection with performance of this Contract, and from any and all claims and losses accruing or resulting to any such person, association, partnership, entity, or corporation who may be injured, damaged, or suffer any loss by Contractor in the performance of the Contract.

Contractor, providers and other Contractor vendors do not hold Members liable for payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if Contractor authorized the services directly.

If in the reasonable judgment of DOM a default by Contractor is not so substantial as to require termination and reasonable efforts to induce Contractor to cure the default are unsuccessful and the default is capable of being cured by DOM or by another resource without unduly interfering with the continued performance of Contractor, DOM may provide or procure such services as are reasonably necessary to correct the default. In such event, Contractor shall reimburse DOM for the cost of those services in accordance with Section 15.F, Retainage, of this Contract.

In the DOM's sole discretion, Contractor may be allowed to control the defense of any such claim, suit, etc. In the event Contractor defends said claim, suit, etc., Contractor shall use legal counsel acceptable to DOM. Contractor shall be solely responsible for all costs and/or expenses associated with such defense, and DOM shall be entitled to participate in said defense. Contractor shall not settle any claim, suit, etc. without DOM's concurrence, which DOM shall not unreasonably withhold.

C. **No Limitation of Liability**

Nothing in this Contract shall be interpreted as excluding or limiting any liability of Contractor for harm caused by the intentional or reckless conduct of Contractor, or for damages incurred through the negligent performance of duties by Contractor, or for the delivery by Contractor of products that are defective, or for breach of contract or any other duty by Contractor. Nothing in the Contract shall be interpreted as waiving the liability of Contractor for consequential, special, indirect, incidental, punitive or exemplary loss, damage, or expense related to Contractor's conduct or performance under this Contract.

D. **Federal, State, and Local Taxes**

Contractor understands and agrees that the State is exempt from the payment of taxes. Contractor shall pay all taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. DOM makes no representation whatsoever as to exemption from liability to any tax imposed by any governmental entity on Contractor. In no event will DOM be responsible for the payment of taxes Contractor may be liable as a result of this Contract.

E. **Medical Loss Ratio**

Contractor shall provide an annual Medical Loss Ratio (MLR) report by April 1 following the end of the MLR Reporting Year, which shall be the calendar year. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), Contractor shall refund DOM the difference by June 1 following the end of the Reporting Year. Any unpaid balances after June 1 shall be subject to interest of ten percent (10%) per annum.

Contractor must report to DOM, on a quarterly basis, the MLR for the reporting period. The format will be specified by DOM.

See Exhibit D, Medical Loss Ratio Requirements, of this Contract for MLR calculation methodology and classification of costs, and further reporting requirements.

F. **Responsibility for Inpatient and Maternity Services**

1. Inpatient Services

Contractor shall be responsible for any charges for services rendered on or after the date of eligibility. Any charges incurred prior to the date of eligibility will be the responsibility of the prior entity or individual. Contractor's responsibility ends on the date of Disenrollment from the CCO.

2. Maternity Services

Contractor shall be responsible for payment of all maternity services related to a

pregnancy for Members enrolled in CHIP and with Contractor at the time of delivery. If the Member is determined to be eligible for Medicaid, DOM will transmit a termination of eligibility date to Contractor, along with the code indicating the reason for termination, via the eligibility/enrollment update. Coverage will continue until such time as Contractor receives a termination code from DOM.

G. **Physician Incentive Plan**

Contractor may only operate a Physician Incentive Plan (PIP) if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an incentive to reduce or limit Medically Necessary services to a Member.

If Contractor puts a physician/physician group at substantial financial risk for services not provided by the physician/physician group, Contractor must ensure that the physician/physician group has adequate stop-loss protection.

H. **Health Insurer Fee Under Section 9010 of the Patient Protection and Affordable Care Act of 2010**

DOM will annually reimburse CCO the full cost of the Health Insurer Fee (HIF) that CCO incurs and becomes obligated to pay pursuant to Section 9010 of the Patient Protection and Affordable Care Act of 2010, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, hereafter collectively referred to as "PPACA", due to its receipt of CHIP premiums pursuant to the Contract. The full cost of the Health Insurer Fee will include both the health insurer fee and the allowance to reflect the Federal income tax liability related to the health insurer fee incurred. Payment to the CCO shall be made following the submission of sufficient documentation detailing liability for such fee.

After CCO financial statements are finalized for the calendar year, DOM, or its Agent, will estimate the Federal income, state income, and premium tax impact of the HIF, as it is not tax-deductible. DOM will then reimburse CCO in one (1) payment representative of a rate adjustment for all applicable taxes.

SECTION 13 – THIRD PARTY LIABILITY (TPL)

Contractor will have the option of pursuing payments from liable third parties. If Contractor selects to Subcontract with any individual, firm, corporation, or any other entity, Contractor shall notify DOM not less than forty-five (45) calendar days in advance of its desire to Subcontract and include a copy of the proposed Subcontract with notification of and information about the proposed Subcontractor. The Subcontract must receive written approval from DOM prior to the effective date of the Subcontract.

Contractor shall obtain written approval from DOM for all form letter templates and form document templates prior to use. Contractor shall submit a copy of all form letter templates and form document templates to DOM for written approval and as part of the readiness review process. DOM will impose liquidated damages in accordance with Section 15.E, Liquidated Damages, of this Contract in the event of non-compliance.

Contractor and its Subcontractor(s) will be prohibited from stating or implying that it is DOM; however, it is appropriate to state that Contractor provides services for DOM.

For guidance with respect to Third Party Resources, please refer to Section 12.A, Capitation Payments, of this Contract.

SECTION 14 – SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

A. Right to Enter Into Other Contracts

DOM and Contractor agree that each may contract for the provision or purchase of services for and from third parties not related to this contract arrangement, subject to DOM approval.

DOM may undertake or award other contracts for services related to the services described in this Contract or any portion herein. Such other contracts include, but are not limited to consultants retained by DOM to perform functions related in whole or in part to Contractor services. Contractor shall fully cooperate with such other Contractors and DOM in all such cases.

B. Requirements

Contractor has the right to Subcontract to provide services specified under this Contract. Any Subcontract into which Contractor enters with respect to performance under the Contract shall in no way relieve Contractor of the legal responsibility to carry out the terms of this Contract. DOM will consider Contractor to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract. Nothing contained in the Subcontract shall be construed as creating any contractual responsibility between the Subcontractor(s) and DOM. Contractor is solely responsible for fulfillment of the Contract terms with DOM and for the performance of any Subcontractor under such Subcontract approved by DOM. DOM will make Contract payments only to Contractor.

Contractor shall not Subcontract any portion of the services to be performed under this Contract without the prior written approval of DOM. All Subcontracts may be subject to review and approval by DOM and must include all DOM required terms and conditions. At contract execution, DOM will provide a checklist of specific requirements that Contractor must include in every Subcontract supporting CHIP. When submitting the Subcontract to DOM for approval, Contractor must provide the completed checklist to indicate where within the Subcontract the requirement is addressed.

A Subcontract that must be submitted to DOM for advance written approval is any Subcontract between Contractor and any individual, firm, corporation, or any other entity to perform part or all of the selected Contractor's responsibilities under this Contract. This provision includes, but is not limited to, contracts for Behavioral Health services, vision services, dental services, claims processing, pharmacy services, third party services and Member services. This provision does not include, for example, purchase orders. The contract language for Subcontractors must be standardized, as approved by DOM. Contractor must submit the Subcontract and supporting documentation to DOM for advance written approval not less than forty-five (45) calendar days in advance of its desire to Subcontract.

Contractor must oversee and will be held accountable for any functions and responsibilities

that it delegates to any Subcontractor or subsidiary. All Subcontracts and agreements must be in writing, must specify the activities and report responsibilities delegated to the Subcontractor and provide for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate, and shall contain provisions such that it is consistent with Contractor's obligations pursuant to this Contract.

Approval of any Subcontract shall neither obligate DOM nor the State of Mississippi as a party to that Subcontract nor create any right, claim, or interest for the Subcontractor against the State of Mississippi or DOM, their Agents, their employees, their representatives, or successors.

Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in CHIP Annual Quality Management Program Evaluation. If Contractor identifies deficiencies or areas for improvement in the performance of any of its Subcontractors that is providing services under this Contract, Contractor must take corrective action. The Subcontract must comply with the provisions of this Contract, and must include any general requirements of this Contract that are appropriate to the service or activity identified. It is not required that Subcontractors be enrolled as a CHIP provider.

Subcontracts and revisions to Subcontracts must be maintained and available for review at one (1) central office in Mississippi designated by Contractor and approved by DOM.

DOM may refuse to enter into or renew an agreement with a Contractor if any Subcontractor entity has any person who has an ownership or control interest in the Subcontract entity, or who is an agent or managing employee of the Subcontractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XXI Services Program.

DOM may refuse to enter into or may terminate this agreement if it determines that Contractor did not fully and accurately make any disclosure of any Subcontractor entity required under 42 C.F.R. § 455.106.

DOM may refuse to enter into or renew this Contract if any person who has ownership or control interest in any Subcontractor entity, or who is an agent or managing employee of the Subcontractor entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XXI Services Program.

Contractor shall give DOM immediate written notice by certified mail, facsimile, or any other carrier that requires signature upon receipt of any action or suit filed and prompt notice of any claim made against Contractor or Subcontractor which in the opinion of Contractor may result in litigation related in any way to the Contract with DOM.

C. **Remedies**

DOM shall have the right to invoke against any Subcontractor any remedy set forth in this

Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against Contractor or require the termination of this Contract. Suspected Fraud and Abuse by any Subcontractor will be investigated by DOM.

SECTION 15 – NON-COMPLIANCE AND TERMINATION

A. Sanctions

In the event DOM finds Contractor to be non-compliant with program standards, performance standards, provisions of this Contract, or the applicable statutes or rules governing CHIP managed care entities, DOM shall issue a written notice of deficiency, request a corrective action plan (CAP), and/or specify the manner and time frame in which the deficiency is to be cured. If Contractor fails to cure the deficiency as ordered, DOM shall have the right to exercise any of the administrative sanction options described below, in addition to any other rights and remedies that may be available to DOM. The type of action taken shall be in relation to the nature and severity of the deficiency.

DOM shall provide Contractor fifteen (15) calendar days written notice before sanctions as specified above are imposed, and such notice will include the basis and nature of the sanction.

B. Disputes of Sanctions or Damages

In order to Appeal DOM's imposition of any sanctions or damages, Contractor shall request review by and submit supporting documentation first to the Executive Administrator of DOM within thirty (30) calendar days of receipt of notice.

The Executive Administrator shall issue a decision within thirty (30) calendar days after receipt of the final written submission by either Contractor or DOM.

Thereafter, Contractor may obtain a second review by the Executive Director by filing the request for review with supporting documentation and copy of the Executive Administrator's decision within thirty (30) calendar days of Contractor's receipt of the decision.

The imposition of sanctions and liquidated damages is not automatically stayed pending Appeal. Pending final determination of any dispute hereunder, Contractor shall proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's direction.

C. Inspection and Monitoring

DOM, the Mississippi Department of Audit, HHS, CMS, OIG, the General Accounting Office (GAO), and any other auditing agency prior-approved by DOM, or authorized representatives of these parties including, without limitation, any employee, Agent, or Contractor of DOM, CMS, DOM's Agent, and DOM's Program Integrity Bureau shall, at reasonable times, have the right to enter onto Contractor's premises, or such other places where duties under this Contract are being performed, with or without notice, to inspect, monitor, or otherwise evaluate (including periodic systems testing) the work being performed by Contractor, Subcontractor, or supplier, in accordance with 42 C.F.R.

§ 457.950. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. Refusal by Contractor to allow access to all documents, papers, letters, or other materials, shall constitute a breach of contract. All audits performed by persons other than DOM staff will be coordinated through DOM and its staff.

Such monitoring activities shall include, but are not limited to, on-site inspections of all service locations and health care facilities; auditing and/or review of all records developed under this Contract including periodic medical audits, Grievances, Enrollments, Disenrollments, termination, utilization and financial records; reviewing management systems and procedures developed under this Contract; and review of any other areas of materials relevant to or pertaining to this Contract. Because of the importance of having accurate service utilization data for program management, UM, and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. DOM shall prepare a report of its findings and recommendations and require Contractor to develop a CAP to address any deficiencies.

D. **Corrective Action**

DOM may require corrective action in the event that any report, filing, examination, audit, survey, inspection, investigation, or the like should indicate that Contractor, any Subcontractor, or supplier is not in compliance with any provision of this Contract, or in the event that DOM receives a Complaint concerning the standard of care rendered by Contractor, any Subcontractor, or supplier. DOM may also require the modification of any policies or procedures of Contractor relating to the fulfillment of its obligations pursuant to this Contract. DOM may issue a deficiency notice and may require a CAP be filed within fifteen (15) calendar days following the date of the notice. A CAP shall delineate the time and manner in which each deficiency is to be corrected. The CAP shall be subject to approval by DOM, which may accept it as submitted, accept it with specified modifications, or reject it. DOM may extend or reduce the time frame for corrective action depending upon the nature of the deficiency, and shall be entitled to exercise any other right or remedy available to it, whether or not it issues a deficiency notice or provides Contractor with the opportunity to take corrective action.

E. **Liquidated Damages**

1. Failure to Meet Contract Requirements

DOM reserves the right to assess actual or liquidated damages, upon Contractor's failure to provide timely services required pursuant to this Contract. It is agreed by DOM and Contractor that in the event of Contractor's failure to meet the requirements provided in this Contract and/or all documents incorporated herein, damage will be sustained by DOM and the actual damages which will be sustained by event of and by reason of such failure are uncertain, and extremely difficult and impractical to ascertain and determine. The parties therefore agree that Contractor will pay DOM liquidated damages in the fixed amounts as stated in Table 9; provided however, that if it is finally determined that Contractor would have been able to meet the Contract requirements listed below but for DOM's failure to perform as provided in this

Contract, Contractor shall not be liable for damages resulting directly therefrom. DOM may impose liquidated damages upon Contractor when it fails to timely and accurately submit any reports under this Contract.

The purpose of establishing and imposing monetary penalties is to provide a means for DOM to obtain the services and level of performance required for successful operation of the Contract. DOM's failure to assess monetary penalties in one or more of the particular instances described herein will in no event waive the right for DOM to assess additional monetary penalties or actual damages. Continued violations of the Deliverable requirements set forth in Table 9 may result in termination of the Contract by DOM.

The assessment of any actual or liquidated damages will be offset against the subsequent monthly payments to Contractor. Assessment of any actual or liquidated damages does not waive any other remedies available to DOM pursuant to this Contract or State or Federal law. If liquidated damages are known to be insufficient then DOM has the right to pursue actual damages.

Table 9. Monetary Penalties

Failed Deliverable	Damages
Call Center Performance	If Contractor's average abandonment rate for any period exceeds five percent (5%) for the Member services and/or provider services call centers, Contractor will be penalized up to ten thousand dollars and zero cents
Claims Payment	If Contractor fails to meet the targets outlined in Section 7.J.1, Claims Payment, Denial and Appeal, of this Contract, DOM shall deem this to be an instance of unsatisfactory claims performance and Contractor will pay a fine of fifteen thousand dollars and zero cents ($15,000.00) for each month that such determination is made. Should Contractor have two (2) consecutive months of unsatisfactory claims performance, DOM shall immediately suspend Enrollment of CHIP Members with Contractor, until such time as Contractor successfully demonstrates that all past due clean claims have been paid or denied.
Corrective Action	Failure to complete corrective action as described in Section 15.D, corrective action, of this Contract, Contractor shall pay liquidated damages in the amount of three thousand dollars and zero cents ($3,000.00) per calendar day for each day the corrective action is not completed in accordance with the timeline established in the CAP.
DOM Investigated Grievances	If Contractor is subject to more than three (3) valid DOM Investigated Grievances in any one (1) month, DOM may assess civil monetary penalties of up to ten thousand dollars and zero cents ($10,000.00) for each such valid DOM Investigated Grievance above three (3) per month.

Failed Deliverable	Damages
Encounter Data	Contractor will be responsible for processing claims within ninety (90) calendar days of receipt unless pended for additional information or to determine medical necessity. Contractor shall submit complete encounter data to DOM that meets Federal requirements and allows DOM to monitor the program. DOM will establish minimum standards for financial and administrative accuracy and for timeliness of processing; these standards will be no less than the standards currently in place for the MississippiCAN Program. If Contractor does not meet these standards, Contractor may be penalized each month encounter data is not submitted or not submitted in compliance with DOM's requirements for timeliness, completeness, and accuracy. Contractor will be penalized up to the following amounts: a. Ten thousand dollars and zero cents ($10,000.00) per calendar day for each day encounter data is received after the due date, b. Ten thousand dollars and zero cents ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the Contract, and c. Ten thousand dollars and zero cents ($10,000.00) per calendar day for each day Contractor fails to correct and resubmit encounter data that was originally returned to Contractor for correction because the error rate for the submission data was in excess of the five percent (5%), until acceptance.

<table>
<tr><th>Failed Deliverable</th><th>Damages</th></tr>
<tr><td>General Deliverables and Reports</td><td>For each day that a Deliverable or required report is late, incorrect, or deficient, Contractor may be liable to DOM for monetary penalties in an amount per calendar day per Deliverable as specified in the table below for reports and Deliverables not otherwise specified in this table. Monetary penalties have been designed to escalate by duration and by occurrence over the term of this Contract.
<table>
<tr><th>Occurrence</th><th>Daily Amount for Days 1-14</th><th>Daily Amount for Days 15-30</th><th>Daily Amount for Days 31-60</th><th>Daily Amount for Days 61 and Beyond</th></tr>
<tr><td>1-3</td><td>$750.00</td><td>$1,200.00</td><td>$2,000.00</td><td>$3,000.00</td></tr>
<tr><td>4-6</td><td>$1,000.00</td><td>$1,500.00</td><td>$3,000.00</td><td>$5,000.00</td></tr>
<tr><td>7-9</td><td>$1,500.00</td><td>$2,000.00</td><td>$4,000.00</td><td>$6,000.00</td></tr>
<tr><td>10-12</td><td>$2,000.00</td><td>$3,000.00</td><td>$5,000.00</td><td>$8,000.00</td></tr>
<tr><td>13 and Beyond</td><td>$4,000.00</td><td>$7,000.00</td><td>$9,500.00</td><td>$12,000.00</td></tr>
</table></td></tr>
<tr><td>Key Personnel</td><td>If key management personnel positions remain vacant for greater than ninety (90) calendar days, Contractor shall pay a fine in the amount of one hundred and seventy-five dollars ($175.00) per day the key management personnel position remains vacant.
If Contractor fills a position without DOM approval, Contractor will pay a fine in the amount of ten thousand dollars and zero cents ($10,000.00) per violation.</td></tr>
<tr><td>Marketing</td><td>If DOM determines that Contractor has violated the requirements of Contractor's obligations with respect to Marketing and Marketing materials, Contractor will pay a fine in the amount of twenty-five thousand dollars and zero cents ($25,000.00) for each violation, in connection with an audit or investigation.</td></tr>
</table>

Network Access Report and Provider Network Reports	If DOM determines that Contractor has not met the established Provider Network access standards, DOM shall impose sanctions on Contractor and require submission of a corrective action plan to DOM within fifteen (15) business days following imposition of sanctions. Determination of failure to meet network access standards shall be made following a review of Contractor's Network Geographic Access Assessment (GeoAccess) Report. Contractor will pay a fine in the amount of fifteen thousand dollars and zero cents ($15,000.00) for each month that Contractor fails to meet the Provider Network access standards. Further, should Contractor fail to meet the Provider Network access standards for two (2) consecutive reporting quarters, DOM shall immediately suspend Enrollment of CHIP Members with Contractor until Contractor successfully demonstrates compliance with the Provider Network access standards. Continued failure to meet Provider Network access standards may result in termination of the Contract by DOM.
Physician Incentive Plan	If Contractor fails to comply with the Section 12.G, Physician Incentive Plan, DOM may impose a civil monetary penalty of up to twenty-five thousand dollars and zero cents ($25,000.00) for each failure to comply.
Provider Credentialing	If DOM determines that Contractor has not completed credentialing of providers within ninety (90) calendar days, DOM may impose penalties of up to five thousand dollars and zero cents ($5,000.00) per violation.
Premiums	If Contractor imposes premiums or charges on Members that are in excess of those permitted in CHIP, DOM may impose a civil monetary penalty of up to twenty-five thousand dollars and zero cents ($25,000.00) or double the amount of the excess charges (whichever is greater). DOM will also deduct the amount of the overcharge from the
Subcontractor Prior Approval	Contractor's failure to obtain advance written approval of a Subcontract will result in the application of a penalty of one (1) month's Capitation Payment rates for each day that the Subcontractor was in effect without DOM's approval.
Third Party Liability Form Letters and Form Documents	If Contractor fails to submit form letter templates and form document templates to DOM for advance written approval or fails to use the approved letter templates and form document templates, DOM may impose penalties of up to five thousand dollars and zero cents ($5,000.00) per violation.

Timely Access	If Contractor fails to grant timely access, upon reasonable request to the Inspector General of HHS, for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of HHS, DOM, or any other duly authorized representative, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of fifteen thousand dollars and zero cents ($15,000.00) for each day of the failure to make accessible all books, documents, papers, provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records).
Well-Baby and Well-Child Care Assessments and Immunizations	Achievement of less than eighty-five percent (85%) screening and less than ninety percent (90%) immunization rate (the lowest rate shall be considered to be the rate for both screenings and immunizations) will, at the discretion of DOM, require a refund of one hundred dollars and zero cents ($100.00) per Member for all enrolled Members. DOM will re-evaluate this level in subsequent years of the Contract and notify Contractor in writing of changes.

With the exception of encounter data submissions, DOM will utilize the following guidelines to determine whether a report is correct and complete for the purposes of liquidated damages: (a) The report must contain one hundred percent (100%) of Contractor's data; (b) one hundred percent (100%) of the required items for the report must be completed; and (c) ninety-nine point five percent (99.5%) of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by DOM.

Liquidated damages for late reports or Deliverables shall begin on the first day the report is late. Liquidated damages for incorrect reports or deficient Deliverables shall begin on the sixteenth (16th) calendar day after the date on the written notice provided by DOM to Contractor that the report remains incorrect or the Deliverables remain deficient.

Any liquidated damages assessed by DOM shall be due and payable to DOM within thirty (30) calendar days after Contractor's receipt of their notice of assessment. If payment is not made by the due date, said liquidated damages shall be withheld from future Capitation Payments by DOM without further notice. The collection of liquidated damages by DOM shall be made without regard to any Appeal rights Contractor may have pursuant to this Contract. However, in the event an Appeal by Contractor results in a decision in favor of Contractor, any such funds withheld by DOM will be returned to Contractor.

Whenever liquidated damages for a single occurrence exceed two thousand five hundred dollars and zero cents ($2,500.00), Contractor staff will meet with DOM staff to discuss the causes of the occurrence and to negotiate a reasonable plan for corrective action. Once a CAP is agreed upon by both parties, collection of liquidated damages during the agreed upon corrective action period will be suspended. The CAP must include a date certain for correction of the problems that led to the occurrence. Should that date be missed by Contractor, the original schedule of damages will be reinstated, including collection of damages for the corrective action period, and liquidated damages will continue until satisfactory correction of the occurrence, as determined by DOM, has been made.

If Contractor fails to fulfill its duties and obligations pursuant to this Contract, DOM may issue a written notice to Contractor indicating the violation(s) and advising Contractor that failure to cure the violation(s) within a defined time span, to the satisfaction of DOM, may lead to the imposition of all or some of the sanctions listed below:

a. Suspension of further Enrollment after notification by DOM of a determination of a Contract violation. Whenever DOM determines that Contractor is out of compliance with this Contract, DOM may suspend Enrollment of new Members into Contractor. DOM, when exercising this option, must notify the Contractor in writing of its intent to suspend new Enrollment at least seven (7) business days prior to the

beginning of the suspension period. The suspension period may be for any length of time specified by DOM, or may be indefinite. DOM may also notify existing Members of Contractor non-compliance and provide an opportunity to disenroll from Contractor and/or to re-enroll with another Contractor;

b. Suspension or recoupment of the capitation rate paid for any month for any Member denied the full extent of covered services meeting the standards set by this Contract or who received or is receiving substandard services after notification by DOM of a determination of a Contract violation. Whenever DOM determines that Contractor has failed to provide to a Member any medically necessary items and/or covered services required under this Contract, DOM may impose a fine of up to twenty five thousand dollars and zero cents ($25,000.00). Contractor shall be given at least fifteen (15) calendar days written notice prior to the withholding of any Capitation Payment;

c. Notwithstanding the provisions contained in this Contract, DOM may withhold portions of Capitation Payments from Contractor as provided herein;

d. Civil money penalties of no more than one hundred thousand dollars and zero cents ($100,000.00) for acts of discrimination against individuals or providers or misrepresentation of information to CMS or DOM;

e. Temporary management upon a finding by DOM that there is continued egregious behavior or substantial risk to the health of Members in accordance with § 1932(e)(2) of the Act;

f. Reduce or eliminate Marketing and/or community event participation;

g. Refuse to allow participation in Contractor pay for performance programs;

h. Refuse to renew the Contract;

i. In the case of inappropriate Marketing activities, referral may also be made to the Department of Insurance for review and appropriate enforcement action;

j. Require special training or retraining of Marketing representatives including, but not limited to, business ethics, Marketing policies, effective sales practices, and State Marketing policies and regulations, at Contractor's expense;

k. In the event Contractor becomes financially impaired to the point of threatening the ability of the State to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Contract effective the close of business on the date specified;

l. Refuse to consider for future contracting a Contractor that fails to submit encounter data on a timely and accurate basis;

m. Refer any matter to the applicable Federal agencies for civil money penalties;

n. Refer any matter to the Deputy Administrator for the DOM Office of External Affairs, the United States Department of Justice Civil Rights Division, the HHS Office for Civil Rights, or other similar Federal or State agency where applicable;

o. Exclude Contractor from participation in CHIP;

p. Denial of payments for new Members when, and for so long as, payment for those Members is denied by CMS based on DOM's recommendation under 42 C.F.R § 438.730; and

q. Refer any matter to the Consumer Protection Division, Office of the Attorney General, State of Mississippi.

2. Termination of the Contract

Contractor acknowledges and agrees that DOM has incurred substantial expense in connection with the preparation and entry into this Contract, including expenses related to training of staff, data collection and processing, actuarial determination of capitation rates for the initial term and each renewal term, and ongoing changes to the MMIS/Medicaid Enterprise System (MES) operated by DOM. Contractor further acknowledges and agrees that in the event this Contract is terminated prior to the end of the initial term or any renewal term, due to the Actions of Contractor or due to Contractor's failure to fully comply with the terms and conditions of this Contract, DOM will incur substantial additional expense in processing the Disenrollment of all Members and MMIS/MES changes, in effecting additional staffing changes, in procuring alternate health care arrangements for Members, and in modifying any Member service materials identifying Contractor; and that such expense is difficult or impossible to accurately estimate.

Based upon the foregoing, Contractor and DOM have agreed to provide for the payment by Contractor to DOM of liquidated damages equal to ten thousand dollars and zero cents ($10,000.00) plus, for each month of the Contract term remaining after the effective date of termination, five percent (5%) of the maximum monthly Capitation Payment, such payment to be made no later than thirty (30) calendar days following the date of the notice of termination. DOM and Contractor agree that the sum set forth herein as liquidated damages is a reasonable estimate of the probable loss which will be incurred by DOM in the event this Contract is terminated prior to the end of the Contract term or any renewal term due to the Actions of Contractor or due to Contractor's failure to comply fully with the terms and conditions of this Contract. In addition, Contractor will reimburse DOM for any Federal disallowances or sanctions imposed on DOM as a result of Contractor's failure to abide by the terms of this Contract.

DOM and Contractor agree that this Section 15.E.2., Termination of the Contract, relating to liquidated damages does not apply if the Contract is terminated without cause in accordance with Section 15.H, Option to Terminate.

F. **Retainage**

If Contractor's failure to perform satisfactorily exposes DOM to the likelihood of contracting with another person or entity to perform services required of Contractor under this Contract, upon notice setting forth the services and retainage, DOM may withhold from Contractor payments in an amount commensurate with the costs anticipated to be incurred. If costs are incurred, DOM shall account to Contractor and return any excess to Contractor. If the retainage is not sufficient, Contractor shall immediately reimburse DOM the difference or DOM may offset from any payments due Contractor. Contractor will cooperate fully with the retained Contractor and provide any assistance it needs to implement the terms of its agreement for services for retainage.

Contractor shall cooperate with DOM or those procured resources in allowing access to facilities, equipment, data, or any other Contractor resources to which access is required to correct the failure. Contractor shall remain liable for ensuring that all operational performance standards remain satisfied.

G. **Action by the Mississippi Department of Insurance**

Upon receipt of official notice that the Mississippi Department of Insurance has taken action which resulted in Contractor being placed under administrative supervision, DOM will suspend further Enrollment of CHIP Members until notice is received from the Department of Insurance that administration supervision is no longer needed.

Upon receipt of official notice that the Mississippi Department of Insurance has taken action, which resulted in Contractor being placed in rehabilitation, DOM will immediately disenroll all Members who are CHIP Members and suspend further Enrollment of CHIP Members until notice is received from the Department of Insurance that Contractor has been rehabilitated. If DOM disenrolls CHIP Members before the end of the month, the Rehabilitator will be notified of the prorated amount of payment due to DOM for the days of the month not covered by Contractor for each CHIP Member and DOM shall be entitled to reimbursement for said amounts. Violation of this section may result in termination of the Contract by DOM.

H. **Option to Terminate**

This Contract may be terminated without cause by either party upon ninety (90) calendar day prior written notice to the other party. Termination shall be effective only at midnight of the last day of a calendar month. The option of Contractor to terminate this Contract prior to the end of the initial term or any renewal term shall be contingent upon performance of all obligations upon termination as defined in this Contract, and payment in full of any refunds, outstanding liquidated damages, or other sums due DOM pursuant to

this Contract.

I. Termination by DOM

1. General Requirements

   DOM shall have the right to terminate this Contract upon the occurrence of any of the following events:

   a. For default by Contractor;

   b. For convenience;

   c. For Contractor's bankruptcy, Insolvency, receivership, liquidation; and

   b. For non-availability of funds. (See also Section 4.3.4, Termination of Contract, of the Mississippi CHIP RFP for additional requirements.)

   At DOM's option, termination for reasons (a) through (d) listed herein may also be considered termination for convenience.

   The findings by the Executive Director of DOM of the occurrence of any of the events stated above shall be conclusive. DOM will attempt to provide Contractor with ten (10) calendar days' notice of sending the possible termination notice as described in this Contract.

2. Termination for Default by Contractor

   DOM may immediately terminate this Contract in whole or in part whenever DOM determines that Contractor has failed to satisfactorily perform its contractual duties and responsibilities and is unable to resolve such failure within a period of time specified by DOM and to the satisfaction of DOM, after considering the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

   Upon determination by DOM of any such failure to satisfactorily perform its contractual duties and responsibilities, DOM may notify Contractor of the failure and establish a reasonable time period in which to resolve such failure. If Contractor does not resolve the failure within the specified time period and does not resolve the failure to the satisfaction of DOM, DOM will notify Contractor that the Contract in full or in part has been terminated for default. Such notices shall be in writing and delivered to Contractor by certified mail, return receipt requested, or in person.

   If, after Notice of Termination for Default, it is determined that Contractor was not in default or that Contractor's failure to perform or make progress in performance was due to causes beyond the control and without error or negligence on the part of Contractor or any Subcontractor, the Notice of Termination shall be deemed to have been issued as a termination for the convenience of DOM, and the rights and obligations of the parties shall be governed accordingly.

In the event of Termination for Default, in full or in part as provided by this clause, DOM may procure, upon such terms and in such manner as DOM may deem appropriate, supplies or services similar to those terminated, and Contractor shall be liable to DOM for any excess costs for such similar supplies or services for the remainder of the Contract period. In addition, Contractor shall be liable to DOM for administrative costs incurred by DOM in procuring such similar supplies or services.

In the event of a Termination for Default, Contractor may, at DOM's discretion, be paid for those Deliverables which Contractor has delivered to DOM. Payments for completed Deliverables delivered to and accepted by DOM shall be at the Contract price.

The rights and remedies of DOM provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

3. Termination for Convenience

DOM may terminate performance of work under the Contract in whole or in part whenever and for any reason DOM shall determine that such termination is in the best interest of DOM.

In the event that DOM elects to terminate the Contract pursuant to this provision, it shall notify Contractor by certified mail, return receipt requested, or delivered in person. Termination shall be effective as of the close of business on the date specified in the notice, which shall be at least thirty (30) calendar days from the date of receipt of the notice by Contractor.

Upon receipt of Notice of Termination for convenience, Contractor shall be paid the following:

a. The Contract price(s) for completed Deliverables delivered to and accepted by DOM; and

b. A price commensurate with the actual cost of performance for partially completed Deliverables, which also requires acceptance by DOM.

4. Termination for Contractor Bankruptcy

In the event that Contractor shall cease conducting business in the normal course, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets, or shall avail itself of, or become subject to, any proceeding under the Bankruptcy Reform Act of 1978 (Pub.L. 95-598) or any other Federal or state statute relating to Insolvency or the protection of the rights of creditors, DOM may, at its option, terminate this Contract in whole or in part.

In the event DOM elects to terminate the Contract under this provision, it shall do so by

sending Notice of Termination to Contractor by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in such notice to Contractor. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, Contractor shall immediately so advise DOM.

Contractor shall ensure and shall satisfactorily demonstrate to DOM that all tasks related to the Subcontract are performed in accordance with the terms of this Contract.

J. **Procedure on Termination**

1. Notice of Termination

Upon termination of the Contract for any reason except as described in Section 15.G, Action by the Mississippi Department of Insurance, of this Contract, DOM will provide Contractor with a pre-termination conference. DOM will give Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the conference. After the conference, DOM will give Contractor written notice of the decision. If the decision is to affirm the termination, the notice will provide the effective date of the termination. DOM is required to notify Members of DOM's intent to terminate the Contract and give Members the opportunity to disenroll immediately from Contractor without cause with the option to enroll in another CCO, as appropriate.

If the Contract is terminated because Contractor is not in compliance with terms of this Contract and if directed by CMS, DOM cannot renew or otherwise extend this Contract for Contractor unless CMS determines that compelling reasons exist for doing so.

2. Contractor Responsibilities

Upon delivery by certified mail, return receipt requested, or in person to Contractor a Notice of Termination specifying the nature of the termination, the extent to which performance of work under the Contract is terminated, and the date upon which such termination becomes effective, Contractor shall:

a. Stop work under the Contract on the date and to the extent specified in the Notice of Termination (See also Section 4.3.3, Stop Work Order, of the Mississippi CHIP RFP for additional requirements.);

b. Place no further orders or Subcontracts for materials, services or facilities, except as may be necessary for completion of such portion of the work in progress under the Contract until the effective date of termination;

c. Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

d. Deliver to DOM within the time frame as specified by DOM in the Notice of Termination, copies of all data and documentation in the appropriate media and make

available all records required to assure continued delivery of services to Members and providers at no cost to DOM;

e. Complete the performance of the work not terminated by the Notice of Termination;

f. Take such action as may be necessary, or as DOM may direct, for the protection and preservation of the property related to the Contract which is in the possession of Contractor and in which DOM has or may acquire an interest;

g. Fully train DOM staff or other individuals at the direction of DOM in the operation and maintenance of the process;

h. Notify Contractor's Provider Network of the planned termination;

i. Reimburse DOM for additional costs related to mailings to Members and other stakeholders, additional Enrollment costs, additional procurement costs, attorney's fees, and Member notification;

j. Promptly transfer all information necessary for the reimbursement of any outstanding claims;

k. Promptly transfer all Member records, financial records, State and Federal data, such as encounter and quality data, and outstanding provider and/or Member Complaints, Grievances, and Appeals; and

l. Complete each portion of the Turnover Phase after receipt of the Notice of Termination. Contractor shall proceed immediately with the performance of the above obligations notwithstanding any allowable delay in determining or adjusting the amount of any item of reimbursable price under this clause.

Contractor has an absolute duty to cooperate and help with the orderly transition of the duties to DOM or its designated contractor following termination of the Contract for any reason.

3. DOM Responsibilities

Except for termination for Contractor's default, DOM will make payment to Contractor on termination and at Capitation Payment rate for the number of Members enrolled on the first day of the last month of operations. Contractor shall be reimbursed for partially completed Deliverables, accepted by DOM, at a price commensurate with actual cost of performance.

In the event of the failure of Contractor and DOM to agree in whole or in part as to the amounts to be paid to Contractor in connection with any termination described in this Contract, DOM shall determine on the basis of information available the amount, if any, due to Contractor by reason of termination and shall pay to Contractor the amount so

determined.

Contractor shall have the right of appeal, as stated under Section 16.J, Disputes, of this Contract from any such determination made by DOM.

K. **Temporary Management**

DOM can require the appointment of temporary management upon the finding by DOM that there is continued egregious behavior or substantial risk to the health of Members or to assure the health of Members during a time or for an orderly termination or reorganization of Contractor or until improvements are made to remedy Contract violations. Temporary management cannot be terminated until Contractor has the capability to ensure violations will not recur. If Contractor repeatedly fails to comply with Contract provisions, DOM may impose the sanction of temporary management and give Members the right to terminate Enrollment with Contractor.

L. **Excusable Delays**

Contractor and DOM shall be excused from performance under this Contract for any period that they are prevented from performing any services under this Contract as a result of an act of God, war, civil disturbance, epidemic, court order, government act or omission, or other cause beyond their control. Contractor must notify DOM within seven (7) calendar days in writing under circumstances in which Contractor seeks an excusable delay.

M. **Obligations Upon Termination**

Upon termination of this Contract, Contractor shall be solely responsible for the provision and payment for all covered services for all Members for the remainder of any month for which DOM has paid the monthly capitation rate. Upon final notice of termination, on the date, and to the extent specified in the Notice of Termination, Contractor shall:

1. Continue providing covered services to all Members until midnight (12:00 AM) on the last day of the calendar month for which a capitation rate payment has been made by DOM;

2. Continue providing all covered services to all infants of female Members who have not been discharged from the hospital following birth, until each infant is discharged;

3. Continue providing covered services to any Members who are hospitalized on the termination date, until each Member is discharged;

4. Arrange for the transfer of Members and Medical Records to other appropriate providers as directed by DOM;

5. Supply to DOM such information as it may request respecting any unpaid claims submitted by Non-Contracted Providers and arrange for the payment of such claims within the time periods provided herein;

6. Take such action as may be necessary, or as DOM may direct, for the protection of property related to this Contract, which is in the possession of Contractor and in which DOM has or may acquire an interest; and

7. Provide for the maintenance of all records for audit and inspection by DOM or its Agents, CMS and other authorized government officials; the transfer of all data and records to DOM or its Agents as may be requested by DOM; and the preparation and delivery of any reports, forms, or other documents to DOM as may be required pursuant to this Contract or any applicable policies and procedures of DOM.

The covenants set forth in this section shall survive the termination of this Contract and shall remain fully enforceable by DOM against Contractor. In the event that Contractor fails to fulfill each covenant set forth in this section, DOM shall have the right, but not the obligation, to arrange for the provision of such services and the fulfillment of such covenants, all at the sole cost and expense of Contractor and Contractor shall refund to DOM all sums expended by DOM in so doing.

SECTION 16 – FEDERAL, STATE, AND GENERAL REQUIREMENTS

Contractor agrees that all work performed as part of this Contract will comply fully with administrative and other requirements established by Federal and State laws, regulations, and guidelines, and assumes responsibility for full compliance with all such laws, regulations, and guidelines, and agrees to fully reimburse DOM for any loss of funds, resources, overpayments, duplicate payments, or incorrect payments resulting from noncompliance by Contractor, its staff, or agents, as revealed in any audit.

A. **Privacy/Security Compliance**

Contractor shall abide by all applicable Federal and/or State rules and/or regulations including, the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008 and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) of 2009) and its implementing regulations at 45 C.F.R. Parts 160, 162, and 164, including EDI, code sets, identifiers, security, and privacy provisions as may be applicable to the services under this Contract, and shall sign a Business Associate Agreement and any Data Use Agreement(s) and/or Nondisclosure Agreement(s) that DOM determines to be necessary.

To the extent that Contractor uses one (1) or more Subcontractors or agents to provide services under this Contract, and such Subcontractors or agents receive or have access to PHI, each such Subcontractor or agent shall sign an agreement with Contractor that complies with HIPAA.

Contractor shall ensure that any agents and Subcontractors to whom it provides PHI received from DOM (or created or received by Contractor on behalf of DOM) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to Contractor in this Contract. DOM shall have the option to review and approve all such written agreements between Contractor and its agents and Subcontractors prior to their effectiveness or anytime thereafter.

B. **Conflict of Interest**

In accordance with 1932(d)(3) of the Act, Contractor shall comply with conflict of interest safeguards with respect to officers and employees of DOM having responsibilities relating to this Contract. Such safeguards shall be at least as effective as described in the Federal Procurement Policy Act (41 U.S.C. §§ 2101-2107) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

Contractor shall have no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Contractor shall not employ any individual or entity having any such known

interests, including subsidiaries or entities that could be misconstrued as having a joint relationship, and shall not employ immediate family members of providers in Contractor's CHIP Provider Network. No public official of the State of Mississippi and no official or employee of DOM, HHS, CMS, or any other State or Federal agency which exercises any functions or responsibilities in the review or approval of this Contract or its performance shall voluntarily acquire any personal interest, direct or indirect, in this Contract or any Subcontract entered into by Contractor. Contractor hereby certifies that no officer, director, employee, or agent of Contractor, any Subcontractor or supplier and person with an ownership or control interest in Contractor, is also employed by the State of Mississippi or any of its agencies, DOM's Agent, or by HHS, CMS or any agents of HHS or CMS or is a public official of the State of Mississippi. In addition, such violation will be reported to the State Ethics Commission, Attorney General, and appropriate Federal law enforcement officers for review. This Contract will be terminated by DOM if it is determined that a conflict of interest exists.

C. **Offer of Gratuities**

The receipt or solicitation of bribes, gratuities, and kickbacks is strictly prohibited.

No elected or appointed officer or other employee of the Federal Government or of the State of Mississippi shall benefit financially or materially from this Contract. No individual employed by the State of Mississippi shall be permitted any share or part of this Contract or any benefit that might arise therefrom.

Contractor certifies that no Member of Congress, nor any elected or appointed official, employee or Agent of the State of Mississippi, HHS, CMS, or any other Federal agency, has or will benefit financially or materially from this Contract. This Contract will be terminated by DOM if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from Contractor, its agents, employees, Subcontractors, or suppliers.

See also Section 4.7, Representation Regarding Contingent Fees, and Section 4.15.10, Bribes, Gratuities, and Kickbacks Prohibited, of the Mississippi CHIP RFP for additional requirements.

D. **Contractor Status**

1. Independent Contractor

   It is expressly agreed that Contractor is an independent Contractor performing professional services for DOM and is not an officer or employee of the State of Mississippi or DOM. It is further expressly agreed that the Contract shall not be construed as a partnership or joint venture between Contractor and DOM.

   Contractor shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should Contractor default on these or other responsibilities jeopardizing Contractor's ability to perform services effectively, DOM,

in its sole discretion, may terminate this Contract.

Contractor shall not purport to bind DOM, its officers or employees, nor the State of Mississippi, to any obligation not expressly authorized herein unless DOM has expressly given Contractor the authority to do so in writing.

Contractor shall give DOM immediate notice in writing of any action or suit filed, or of any claim made by any party which might reasonably be expected to result in litigation related in any manner to this Contract or which may impact Contractor's ability to perform.

No other agreements of any kind may be made by Contractor with any other party for furnishing any information or data accumulated by Contractor under this Contract or used in the operation of this program without the written approval of DOM. Specifically, DOM reserves the right to review any data released from reports, histories, or data files created pursuant to this Contract.

In no way shall Contractor represent itself directly or by inference as a representative of the State of Mississippi or DOM except within the confines of its role as a Contractor for DOM. DOM's approval must be received in all instances in which Contractor distributes publications, presents seminars, or workshops, or performs any other outreach.

Contractor shall not use the DOM name or refer to the Contract, and the services provided therein, directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from DOM.

2. Employment of DOM Employees

Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the Contract, any professional or technical personnel who are or have been at any time during the period of the Contract in the employ of DOM, without the written consent of DOM. Further, Contractor shall not knowingly engage in this project, on a full-time, part-time, or other basis during the period of the Contract, any former employee of DOM who has not been separated from DOM for at least one (1) year, without the prior written consent of DOM.

Contractor shall give priority consideration to hiring interested and qualified adversely affected State employees at such times as requested by DOM to the extent permitted by this Contract or applicable State law, such as the Mississippi Ethics in Government Act. Miss. Code Ann. §§ 25-4-101 through 25-4-119.

3. Personnel Practices

All employees of Contractor involved in the CHIP function will be paid as any other employee of Contractor who works in another area of their organization in a similar position. Contractor shall develop any and all methods to encourage longevity in Contractor's staff assigned to this Contract.

Employees of Contractor shall receive all benefits afforded to other similarly situated employees of Contractor.

4. Property Rights

No property rights inure to Contractor except for compensation for work that has already been performed, as provided for under this Contract.

E. **Provider Exclusions**

DOM will not reimburse Contractor for services rendered by any provider that is excluded from participation by Medicare, Medicaid, including any other states' Medicaid program, or CHIP, except for Emergency Services.

Contractor must comply with 42 C.F.R. § 455.436 and ensure that all Contractor's providers and Subcontractor entities screen their employees for excluded persons. Contractor must communicate this obligation to all providers and Subcontractors upon credentialing and re-credentialing and upon renewal of any Subcontracts.

Contractor must search the following sources for names of any individual or entity upon provider enrollment, re-enrollment, and at least monthly thereafter to capture exclusions and reinstatements: HHS-OIG's List of Excluded Individuals and Entities (LEIE), CMS' Medicare Exclusion Databank (MED), the State Board of Examiners, and the System for Award Management (SAM). The process shall also include routine checks of the following databases: Social Security Administration's Death Master File, the National Plan, and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB), and Health Integrity and Protection Databank (HIPDB). These searches must include any providers, entities, and individuals with ownership or control interests in any entity to ensure that the State does not pay Federal funds to excluded providers or entities.

DOM may impose civil monetary penalties against Contractor if they employ or enter into a contract with excluded individuals or entities to provide items or services to CHIP Members.

F. **Compliance with Federal Laws**

Contractor and its Subcontractors shall comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. § 7606), Section 508 of the Clean Water Act (33 U.S.C. § 1368), Executive Order 11738, and applicable United States Environmental Protection Agency (EPA) regulations, which prohibit the use under non-exempt Federal contracts, grants, or loans of facilities included on the EPA list of Violating Facilities. Contractor shall report violations to the applicable grantor Federal agency and the EPA Assistant Administrator for Enforcement.

Contractor and its Subcontractors shall abide by mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Contract issued in compliance with the Energy Policy and Conservation Act (Pub. L.94-

163).

Contractor shall comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in PPACA.

G. **Assignment**

This Contract and any payments which may become due hereunder, shall not be assignable by Contractor except with the prior written approval of DOM. The transfer of five percent (5%) or more of the beneficial ownership in Contractor at any time during the term of this Contract shall be deemed an assignment of this Contract. DOM shall be entitled to assign this Contract to any other agency of the State which may assume the duties or responsibilities of DOM relating to this Contract. DOM shall provide written notice of any such assignment to Contractor, whereupon DOM shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.

H. **No Waiver**

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract will be waived except by the written agreement of the parties, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever shall not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply; and until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence.

I. **Severability**

In the event that any part, term, or provision of this Contract (including items incorporated by reference) is declared by the courts or other judicial body to be illegal, unlawful, void, or unenforceable, then both DOM and Contractor shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, then it shall not be affected by such declaration or finding, shall continue in full force and effect, and all remaining provisions shall be binding upon each party to this Contract and be fully performed. If the laws or regulations governing this Contract should be amended or judicially interpreted so as to render the fulfillment of this Contract impossible or economically infeasible, as determined jointly by DOM and Contractor, then both DOM and Contractor shall be discharged from any further obligations created under the terms of this Contract.

J. **Disputes**

Any disputes regarding the terms and conditions of this Contract which cannot be disposed of by agreement between the parties shall be decided by the Executive Administrator of

DOM. Such decision shall be in writing and mailed or otherwise furnished to Contractor. The decision of the Executive Administrator shall be final and conclusive, unless within ten (10) calendar days following the date of such decision Contractor mails or otherwise furnishes a written Appeal to DOM's Executive Director.

The decision of the Executive Director, or his or her duly authorized representative for the determination of such Appeals, shall be final and conclusive. Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its Appeal. Contractor shall proceed diligently with the performance of this Contract in accordance with the decision rendered by DOM's Executive Administrator until a final decision is rendered by the Executive Director or his or her representative.

1. Cost of Litigation

   In the event that DOM deems it necessary to take legal action to enforce any provision of the Contract, Contractor shall bear the cost of such litigation, as assessed by the court, in which DOM prevails. Neither the State of Mississippi nor DOM shall bear any of Contractor's cost of litigation for any legal actions initiated by Contractor against DOM regarding the provisions of the Contract. Legal action shall include administrative proceedings.

2. Attorney Fees

   Contractor agrees to pay reasonable attorney fees incurred by the State and DOM in enforcing this Contract or otherwise reasonably related thereto.

K. **Proprietary Rights**

Ownership of all information and data developed, derived, documented, or furnished by Contractor resulting from this Contract resides with DOM, State of Mississippi. DOM shall have unlimited use of this information to disclose, duplicate, or utilize for any purposes whatsoever.

1. Ownership of Documents

   Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation and works of any similar nature, DOM shall have the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose whatsoever and to have others do so. If the material is qualified for copyright, Contractor may copyright such material, with approval of DOM, but DOM shall reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such materials, in whole or in part, and to authorize others to do so.

2. Ownership of Information and Data

   DOM, HHS, CMS, the State of Mississippi, and/or their Agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data

developed, derived, documented, or furnished by Contractor or its agents, employees, representatives, assignees, and Subcontractors under this Contract.

Contractor agrees to grant in its own behalf and on behalf of its agents, employees, representatives, assignees, and Subcontractors to DOM, HHS, CMS, and the State of Mississippi and to their officers, Agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Contractor.

Excluded from the foregoing provisions in this subsection, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by Contractor independent of this Contract. Contractor is and shall remain the owner of all rights, title, and interest in and to the Proprietary Tools, including all copyright, patent, trademark, trade secret, and all other proprietary rights thereto arising under Federal and State law, and no license or other right to the Proprietary Tools is granted or otherwise implied. Any right that DOM may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

3. Licenses, Patents, and Royalties

DOM does not tolerate the possession or use of unlicensed copies of proprietary software. Contractor shall be responsible for any penalties or fines imposed as a result of unlicensed or otherwise defectively titled software.

Contractor, without exception, shall indemnify, save, and hold harmless DOM and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or non-patented invention, process, or article manufactured by Contractor. DOM will provide prompt written notification of a claim of copyright or patent infringement.

Further, if such a claim is made or is pending, Contractor may, at its option and expense, procure for DOM the right to continue use of, replace, or modify the article to render it non-infringing. If none of the alternatives are reasonably available, Contractor agrees to take back the article and refund the total amount DOM has paid Contractor under this Contract for use of the article.

If Contractor uses any design, device, or materials covered by letters, patent, or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

L. **Omissions**

In the event that either party discovers any material omission in the provisions in this Contract which such party believes is essential to the successful performance of this Contract, both parties shall negotiate in good faith with respect to such matters for the purpose of making such adjustments as may be necessary to reasonably perform the

objectives of this Contract, provided that such adjustments do not adversely affect the interests of either party.

M. **Entire Agreement**

This Contract, together with all attachments, represents the entire agreement between Contractor and DOM with respect to the subject matter stated herein and supersedes all other contracts and agreements between the parties.

No modification or change to any provision of this Contract shall be effective unless it is in writing, has the prior approval of CMS, and is signed by a duly authorized representative of Contractor and DOM as an amendment to this Contract. This Contract shall be amended whenever and to the extent required by changes in Federal or State law or regulations.

The Executive Director of DOM or designated representative may, at any time, by written order delivered to Contractor at least thirty (30) calendar days prior to the commencement date of such change, make administrative changes within the general scope of the Contract. If any such change causes an increase or decrease in the cost of the performance of any part of the work under the Contract an adjustment commensurate with the costs of performance under this Contract shall be made in the Capitation Payment rate or delivery schedule or both. Any claim by Contractor for equitable adjustment under this clause must be asserted in writing to DOM within thirty (30) calendar days from the date of receipt by Contractor of the notification of change. Failure to agree to any adjustment shall be a dispute within the meaning of Section 16.J, Disputes, of this Contract. Nothing in this clause, however, shall in any manner excuse Contractor from proceeding diligently with the Contract as changed.

Any provision of this Contract which is in conflict with Federal and State CHIP statutes, regulations, or CMS policy guidance shall be automatically amended to conform to the provisions of those laws, regulations, and policies. Such amendment of the Contract will be effective on the effective date of the statutes or regulations necessitating it, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

N. **Employment Practices**

Contractor must act affirmatively to ensure that employees, as well as applicants for employment, are treated without discrimination because of their race, color, religion, gender, national origin, age, marital status, political affiliation, genetic information, or disability.

Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. Contractor agrees to post in conspicuous places, available to employees and applicants for employment notices setting forth the provisions of this clause.

Contractor shall, in all solicitations or advertisements for employees placed by or on behalf

of Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, gender, national origin, age, marital status, political affiliation, genetic information, ancestry, limited English proficiency, physical handicap, disability, or any other consideration made unlawful by Federal, State, or local laws, except where it relates to a bona fide occupational qualification or requirement.

Contractor shall comply with the non-discrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. Contractor shall comply with related State laws and regulations, if any.

Contractor shall comply with the Civil Rights Act of 1964 (Pub.L. 88-352), and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Rehabilitation Act of 1973 (29 U.S.C. § 701 *et seq.*), as amended, and related State laws and regulations, if any.

If DOM finds that Contractor is not in compliance with any of these requirements at any time during the term of this Contract, DOM reserves the right to terminate this Contract or take such other steps as it deems appropriate, in its sole discretion, considering the interests and welfare of the State.

See also Section 4.12, Compliance with Laws, and Section 4.15.8, E-Verification, of the Mississippi CHIP RFP for additional requirements.

O. **Lobbying**

Contractor certifies, to the best of its knowledge and belief, that no Federal appropriated funds have been paid or will be paid, by or on behalf of Contractor to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, Contractor shall complete and submit "Disclosure Form to Report Lobbying," in accordance with its instructions.

This certification is a material representation of fact upon which reliance is placed when entering into this Contract. Submission of this certification is a prerequisite for making or entering into this Contract imposed under Section 1352 of Title 31, United States Code. Failure to file the required certification shall be subject to civil penalties for such failure.

Contractor shall abide by lobbying laws of the State of Mississippi.

P. **Transparency**

See also Section 4.14.3, Release of Public Information, and Section 4.14.4, Transparency, of the Mississippi CHIP RFP for additional requirements.

IN WITNESS WHEREOF, the parties have executed this Contract to be effective as of the **1st day of July, 2015.**

FOR
DOM:

DIVISION OF MEDICAID
IN THE OFFICE OF THE
GOVERNOR STATE OF
MISSISSIPPI

BY: _____
David J. Dzielak, Ph. D.
EXECUTIVE DIRECTOR

FOR
CONTRACTOR:

UnitedHealthcare of Mississippi, Inc.

BY: _____
Jocelyn Chisholm Carter, J.D.
PRESIDENT & CHIEF
EXECUTIVE OFFICER

STATE OF MISSISSIPPI
COUNTY OF _____

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **David J. Dzielak, Ph.D.,** in his official capacity as the duly appointed **Executive Director** of **the Division of Medicaid in the Office of the Governor,** an administrative agency of the State of Mississippi, who acknowledged to me, being first duly authorized by said agency that he signed and delivered the above and foregoing written Contractual Agreement for and on behalf of said agency, and as its official act and deed on the day and year therein mentioned.

GIVEN under my hand and official seal of office on this the 8th **day of** July, **A. D., 2015.**

Sharon O. White
NOTARY PUBLIC

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 63600 SHARON O. WHITE Commission Expires July 31, 2015 RANKIN COUNTY

MY COMMISSION EXPIRES:
July 31, 2015

STATE OF MS
COUNTY OF Rankin

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, **Jocelyn Chisholm Carter, J.D.,** in her official capacity as the duly appointed **President and Chief Executive Officer of UnitedHealthcare of Mississippi, Inc.,** who acknowledged to me, being first duly authorized by said entity that she signed and delivered the above and foregoing written Contractual Agreement for and on behalf of said entity, and as its official act and deed on the day and year therein mentioned.

GIVEN under my hand and official seal of office on this the 8th **day of** July, **A. D., 2015.**

STATE OF MISSISSIPPI NOTARY PUBLIC ID # 63600 SHARON O. WHITE Commission Expires July 31, 2015 RANKIN COUNTY

Sharon O. White
NOTARY PUBLIC

MY COMMISSION EXPIRES:
July 31, 2015

EXHIBIT A: CAPITATION RATES

(Attached under a separate cover)

EXHIBIT B: COVERED SERVICES

This Exhibit is provided for reference only within this Contract. The State Child Health Plan shall supersede this Exhibit. Contractor shall comply with all requirements of the State Child Health Plan and 42 C.F.R. § 457 (as applicable).

Table A. Services

Covered Service	Description
Inpatient hospital services. (Section 2110(a)(1) of the Social Security Act)	Must be pre-certified as medically necessary and includes the following: 1. Hospital room and board (including dietary and general nursing services); 2. Use of operating or treatment rooms; 3. Anesthetics and their administration; 4. Intravenous injections and solutions; 5. Physical therapy; 6. Radiation therapy; 7. Oxygen and its administration; 8. Diagnostic services, such as x-rays, clinical laboratory examination, electrocardiograms, and electroencephalograms; 9. Drugs and medicines, sera, biological and pharmaceutical preparations used during hospitalization which are listed in the hospital's formulary at the time of hospitalization, including charges for "take home" drugs; 10. Dressings and supplies, sterile trays, casts, and orthopedic splints; 11. Blood transfusions, including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies; 12. Psychological testing when ordered by the physician and performed by a full-time employee of the hospital subject to limitations; 13. Intensive, coronary, and burn care unit services; 14. Occupational therapy; and 15. Speech therapy.
Outpatient hospital services. (Section 2110(a)(2) of the Social Security Act)	See Physician Services and Surgical Services.
Physician services.	Includes the following: 1. In-hospital medical care; 2. Medical care in the physician's office, Member's home, or elsewhere; 3. Surgery; 4. Dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled Child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an accidental injury. Covered medical expense must be

Covered Service	Description
	5. Administration of anesthesia; 6. Diagnostic services, such as clinical laboratory examinations, x-ray examinations, electrocardiograms, electroencephalograms, and basal metabolism tests; 7. Radiation therapy; 8. Consultations; 9. Psychiatric and psychological service for nervous and mental conditions; 10. Physicians assisting in surgery, where appropriate; 11. Emergency care or surgical services rendered in a practitioner's office including but not limited to surgical and medical supplies, dressings, casts, anesthetic, tetanus, serum and x-rays; 12. Well-Child assessments, including vision screening, laboratory tests and hearing screening, according to recommendations of the U.S. Preventive Service Task Force; and 13. Routine immunizations (according to ACIP guidelines) -Vaccine is purchased and distributed through the State Department of Health. The health plan will reimburse providers for the administration of the vaccine.
Surgical services. (Section 2110(a)(4) of the Social Security Act)	Certain surgeries must be pre-certified as medically necessary. Benefits are provided for the following covered medical expenses furnished to the Member by an ambulatory surgical facility: 1. Services consisting of routine pre-operative laboratory procedures directly related to the surgical procedure; 2. Pre-operative preparation;
Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5) of the Social Security Act)	Covered as medical services under Physician Services.
Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person. (Section	The following drugs and medical supplies are covered: 1. Legend drugs (Federal law requires these drugs be dispensed by prescription only); 2. Compounded medication of which at least one ingredient is a legend drug; 3. Disposable blood/urine glucose/acetone testing agents (e.g., Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes- Tape); 4. Disposable insulin needles/syringes; 5. Growth hormones; 6. Insulin; 7. Lancets; 8. Legend contraceptives; 9. Retin-A; 10. Fluoride supplements (e.g., Gel-Kam, Luride, Prevident, sodium fluoride tablets); and

Covered Service	Description
2110(a)(6) of the Social Security Act)	11. Vitamin and mineral supplements, when prescribed as replacement therapy. The following are excluded: 1. Anabolic steroids (e.g., Winstrol, Durabolin); 2. Anorectics (any drug used for the purpose of weight loss) with the exception of Dexadrine and Adderall for Attention Deficit Disorder; 3. Anti-wrinkle agents (e.g., Renova); 4. Charges for the administration or injection of any drug; 5. Dietary supplements; 6. Infertility medications (e.g., Clomid, Metrodin, Pergonal, Profasi); 7. Minerals (e.g., Phoslo, Potaba); 8. Minoxidil (Rogaine) for the treatment of alopecia; 9. Non-legend drugs other than those listed as covered; 10. Pigmenting/depigmenting agents; 11. Drugs used for cosmetic purposes; 12. Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g., Nicorrette, Nicoderm, etc.); 13. Therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances, regardless of intended use, except those listed as covered, such as insulin needles and syringes; 14. Any medication not proven effective in general medical practice; 15. Investigative drugs and drugs used other than for the FDA approved diagnosis; 16. Drugs that do not require a written prescription; 17. Prescription Drugs if an equivalent product is available over the counter; and 18. Refills in excess of the number specified by the practitioner or any refills dispensed more than one (1) year after the date of practitioner's original prescription.
Laboratory and radiological services. (Section 2110(a)(8) of the Social Security Act)	Certain diagnostic tests must be pre-certified.
Prenatal care and prepregnancy family planning services and supplies. (Section 2110(a)(9) of the Social Security Act)	Infertility services are excluded.

Covered Service	Description
Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services. (Section 2110(a)(10) of the Social Security Act)	1. Benefits for covered medical expenses are paid for medically necessary inpatient psychiatric treatment of a Member. 2. Benefits for covered medical expenses are provided for partial hospitalization. 3. Certification of medical necessity by Contractor's UM program is required for admissions to a hospital. Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.
Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a State-operated mental hospital and including community-based services. (Section 2110(a)(11 of the Social Security Act)	Benefits for covered medical expenses for treatment of nervous and mental conditions on an outpatient basis. Benefits for mental/nervous conditions do not include services where the primary diagnosis is substance abuse.
Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). (Section 2110(a)(12) of the Social Security Act)	Rental of durable medical equipment is covered for temporary therapeutic use; provided, however, at Contractor's discretion, the purchase price of such equipment may be allowed. To be durable medical equipment, an item must be (1) made to withstand repeated use; (2) primarily used to serve a medical purpose; (3) generally not useful to a person in the absence of illness, injury or disease; and (4) appropriate for use in the Member's home. Prosthetic or orthotic devices necessary for the alleviation or correction of conditions arising from accidental injury, illness, or congenital abnormalities are covered services. Benefits are available for the initial placement, fitting, and purchase of prosthetic or orthotic devices that require a prescription by a physician and for the repair or replacement when medically necessary. Shoes are not covered except for the following: (1) a surgical boot which is part of an upright brace; (2) one pair of mismatched shoes annually in instances where a foot size disparity is greater than two sizes; and (3) a custom fabricated shoe in the case of a significant foot deformity.
Disposable medical supplies. (Section 2110(a)(13) of the Social Security Act)	Supplies provided under the plan which are medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a Member to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease, and are appropriate for use in the Member's home.

Covered Service	Description
Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home) (See instructions). (Section 2110(a)(14) of the Social Security Act)	Services and supplies required for the administration of home infusion therapy regimen must be (1) medically necessary for the treatment of the disease; (2) ordered by a practitioner; (3) as determined by Contractor's UM program capable of safe administration in the home; (4) provided by a licensed home infusion therapy provider coordinated and pre-certified by Contractor's UM program ; (5) ordinarily in lieu of inpatient hospital therapy; and (6) more cost effective than inpatient therapy. Benefits for home health nursing services must be approved by Contractor's UM program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents ($10,000.00) annually.
Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting. (Section 2110(a)(15) of the Social Security Act)	Benefits include nursing services of an actively practicing Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered and supervised by a practitioner and when the services rendered require the technical skills of an RN or LPN. Benefits are provided for covered medical expense when performed by a nurse practitioner practicing within the scope of his or her license at the time and place service is rendered. Benefits for private duty nursing services are provided for an illness or injury that Contractor's UM program determines to be of such a nature and complexity that the skilled nursing services could not be provided by the hospital's nursing staff. A shift of eight (8) continuous hours or more is required for private duty nursing services. Benefits are also provided for nursing services in the home for illness or injury that Contractor's UM program determines to require the skills of an RN or LPN. Benefits for nursing services provided in a Member's home must be approved by Contractor's UM program in lieu of hospitalization. Benefits for nursing services are limited to ten thousand dollars and zero cents ($10,000.00) annually. (This limit does not apply to nurse practitioner services.) No nursing benefits are provided for: 1. Services of a nurse who ordinarily lives in the Child's home or is a member of the Child's family; 2. Services of an aide, orderly or sitter; or 3. Nursing services provided in a personal care facility. Benefits are provided for confinement in a skilled nursing facility for up to sixty (60) days per Benefit Period, subject to UM requirements.

Covered Service	Description
Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2110(a)(16) of the Social Security Act)	Benefits are allowed for elective abortion only when documented to be medically necessary in order to preserve the life or physical health of the mother.

Dental services. (Section 2110(a)(17) of the Social Security Act) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)	Covered dental services are limited to two thousand dollars and zero cents ($2,000.00) each calendar year 1. Benefits will be provided for preventive and diagnostic dental care as recommended by the American Academy of Pediatric Dentistry (AAPD). a. Bitewing X-rays - as needed, but no more frequently than once every six (6) months; b. Complete Mouth X-ray and Panoramic X-ray - as needed, but no more frequently than once every twenty-four (24) months; c. Prophylaxis - one every six (6) months; must be separated by six (6) full months; d. Fluoride Treatment - limited to one (1) each six (6) month period; e. Space Maintainers - limited to permanent teeth through age fifteen (15) years; and f. Sealants - covered up to age fourteen (14) years, every thirty-six (36) months. 2. Benefits are provided for restorative, endodontic, periodontic, and surgical dental services, as indicated below, and are limited to two thousand dollars and zero cents ($2,000.00) each calendar year. a. Amalgam, Silicate, Sedative and Composite Resin Fillings including the replacement of an existing restoration; b. Stainless steel crowns to posterior and anterior teeth; c. Porcelain crowns to anterior teeth only; d. Simple extraction; e. Extraction of an impacted tooth; f. Pulpotomy, pulpectomy, and root canal; and g. Gingivectomy, gingivoplasty, and gingival curettage. Other Dental Services (The calendar year maximum does not apply to these services.) 1. Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the enrolled Child is covered under the program. Injury to teeth as a result of chewing or biting is not considered an accidental injury. 2. Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the enrolled Child requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center, or dental office. These services must be pre-certified. 3. No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. Diagnosis and surgical treatment for temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a practitioner or dentist, is subject to a lifetime maximum benefit of five thousand dollars and zero cents ($5,000.00) per Member. This lifetime maximum will apply regardless of whether the temporormandibular / craniomandibular joint disorder was caused by an accidental injury or was congenital in nature.

Covered Service	Description
DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to Children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to Children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP Children. (Section 2103(b)(5) of the Social Security Act)	State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits: 1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule). 2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule). 3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999). 4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999). 5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999). 6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999). 7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999). 8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999). 9. Emergency Dental Services. Periodicity Schedule. The State has adopted the American Academy of Pediatric Dentistry periodicity schedule. See Table B for CHIP Dental Covered Services.
Inpatient substance abuse treatment services and residential substance abuse treatment services. (Section 2110(a)(18) of the Social Security Act)	Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse, as follows: 1. Benefits for covered medical expenses are provided for medically necessary inpatient stabilization and residential substance abuse treatment. 2. Benefits for covered medical expenses are provided for the treatment of substance abuse, whether for alcohol abuse, drug abuse, or a combination of alcohol and drug abuse. 3. Certification of medical necessity by Contractor's UM program is required for admissions to a hospital or residential treatment center.
Outpatient substance abuse treatment services. (Section 2110(a)(19) of the Social Security Act)	1. Benefits are provided for covered medical expenses for medically necessary intensified outpatient programs in a hospital, an approved licensed alcohol abuse or chemical dependency facility, or an approved drug abuse treatment facility. 2. Benefits are provided for covered medical expenses for substance abuse treatment while not confined as a hospital inpatient. 3. Benefits for substance abuse do not include services for treatment of nervous and mental conditions.

Covered Service	Description
Care management services. (Section 2110(a)(20) of the Social Security Act)	Medical Care Management may be performed by the UM program for those Children who have a catastrophic or chronic condition. Through medical Care Management, the UM program may elect to (but is not required to) extend covered benefits beyond the benefit
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders. (Section 2110(a)(22) of the Social Security Act)	Benefits are provided for physical therapy services specified in a plan of treatment prescribed by the Member's practitioner and provided by a licensed physical therapist. Benefits are provided for medically necessary occupational therapy services prescribed by the Member's practitioner and specified in a treatment plan. Occupational therapy services must be provided by a licensed occupational therapist. Benefits are provided for medically necessary speech therapy services prescribed by the Member's practitioner and specified in a treatment plan. Speech therapy is not covered
Hospice care (concurrent, in the case of an individual who is a child, with care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made). (Section 2110(a)(23) of the Social Security Act)	Benefits are provided for inpatient and home hospice services, subject to UM requirements. Benefits for hospice services are limited to an overall lifetime maximum of fifteen thousand dollars and zero cents ($15,000.00).
Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (Section 2110(a)(24) of the Social Security Act) (See instructions)	Benefits may be provided in a facility, home, school, or other setting if recognized by State law and only if the service is prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law, performed under the general supervision or at the direction of the physician, or furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of license. Benefits are provided for general anesthesia service when requested by the attending physician and performed by an anesthesiologist or a certified registered nurse anesthetist practicing within the scope of his or her license at the time and place service is rendered. Transplant Benefits: 1. Any human solid organ or bone marrow/stem cell transplant is covered, provided the following applies: a. The Member or provider obtains prior approval from Contractor's UM program; b. The condition is life-threatening; c. Such transplant for that condition is the subject of an ongoing phase III clinical trial;

Covered Service	Description
	d. Such transplant for that condition follows a written protocol that has been reviewed and approved by an institutional review board, Federal agency or other such organization recognized by medical specialists who have appropriate expertise; and e. The Member is a suitable candidate for the transplant under the medical protocols used by Contractor's UM program. 2. In addition to regular benefits, benefits are provided for surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ transplant procedure. 3. Benefits are provided for transportation costs of recipient and two other individuals to and from the site of the transplant surgery and reasonable and necessary expenses for meals and lodging of two (2) individuals at the site of transplant surgery. Reasonable and necessary expenses for transportation, meals, and lodging of two (2) other individuals are provided. Only those expenses which are incurred at the time of the transplant surgery are eligible for reimbursement. Travel expenses incurred as a result of pre-operative and post-operative services are not eligible for reimbursement. Only actual travel expenses supported by receipts are reimbursed. In any event, the total benefits for transportation, meals, and lodging are limited to ten thousand dollars and zero cents ($10,000.00). 4. If a covered solid organ or tissue transplant is provided from a living donor to a human transplant recipient: a. The following expenses are covered: • A search for matching tissue, bone marrow, or organ. • Donor's transportation. • Charges for removal, withdrawal, and preservation. • Donor's hospitalization. b. When only the recipient is a Member in the program, the donor is entitled to donor coverage benefits. The donor benefits are limited to only those not available to the donor from any other source. This includes, but is not limited to, other insurance coverage or any government program. Benefits provided to the donor will be paid under the recipient's contract. c. When both the recipient and the donor are enrolled in the program, the donor is entitled to benefits under the donor's contract. d. When only the donor is a Plan participant, the donor is not entitled to donor coverage benefits. No benefits are provided to the non-member transplant recipient. e. If any organ or tissue is sold rather than donated to the Member, no benefits are payable for the purchase price of such organ or tissue.
Medical transportation. (Section 2110(a)(26) of the Social Security Act)	Professional ambulance services to the nearest hospital, which is equipped to handle the Member's condition in connection with covered hospital inpatient, care; or when related to and within seventy-two (72) hours after accidental bodily injury or medical emergency whether or not inpatient care is required.

Covered Service	Description
Limitations and Exclusions:	1. For convalescent, custodial, or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician for an Member who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall benefits be provided if the Member was admitted to a hospital for his or her own convenience or the convenience of his or her physician, or that the care or treatment provided did not relate to the condition for which the enrolled Child was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent to provide benefits only for the services required in relation to the condition for which the enrolled Child was hospitalized and then only during such time as such services are medically necessary. 2. For cosmetic purposes, except for correction of defects incurred by the Member while covered under the program through traumatic injuries or disease requiring surgery. 3. For sex therapy or marriage or family counseling. 4. For custodial care, including sitters and companions. 5. For equipment that has a non-therapeutic use (such as humidifiers, air conditioners or filters, whirlpools, wigs, vacuum cleaners, fitness supplies, etc.). 6. For procedures, which are experimental/investigative in nature. 7. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment for subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic Complaints of the feet. 8. For services and supplies related to infertility, artificial insemination, intrauterine insemination, and in vitro fertilization regardless of any claim to be medically necessary. 9. For services which Contractor's UM program determines are not medically necessary for treatment of injury or illness. 10. For services provided under any Federal, state, or governmental plan or law including but not limited to Medicare except when so required by Federal law. 11. For nursing or personal care facility services i.e., extended care facility, nursing home, or personal care home, except as specifically described elsewhere. 12. For treatment or care for obesity or weight control including diet treatment, gastric or intestinal bypass or stapling, or related procedures regardless of any claim of medical necessity or degree of obesity. 13. For inpatient rehabilitative services consisting of the combined use of medical, social, educational, or vocational services, or any such services designed to enable Members disabled by disease or injury to achieve functional ability, except for acute short-term care in a hospital or rehabilitation hospital as approved by Contractor's UM program. 14. For outpatient rehabilitative services consisting of pulmonary rehabilitation, or the combined use of medical, social, educational or vocational services, or any such services designed to enable Members disabled by disease or injury to achieve functional ability, except for physical, occupational, or speech therapy services specified in a plan of treatment prescribed by the Member's physician and provided by a licensed therapist. 15. For care rendered by a provider, (physician or other provider) who is related to the covered Member by blood or marriage or who regularly resides in the enrolled Child's household. 16. For services rendered by a provider not practicing within the scope of his license at the time and place service is rendered.

Covered Service	Description
	17. For treatment related to sex transformations regardless of claim of medical necessity or for sexual function, sexual dysfunction or inadequacies not related to organic disease. 18. For reversal of sterilization regardless of claim of medical necessity. 19. For elective abortion unless documented to be medically necessary in order to preserve the life or physical health of the mother. 20. For charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, or to obtain Medical Records or information required to adjudicate a claim. 21. For travel, whether or not recommended by a physician, except as provided for under transplant benefits. 22. Because of diseases contracted or injuries sustained as a result of war, declared or undeclared, or any act of war. 23. For treatment of any injury arising out of or in the course of employment or any sickness entitling the Member to benefits under any Workers' Compensation or Employer Liability Law. 24. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party makes settlement or is legally responsible; provided, however, that if the Member is unable to recover from the responsible party, benefits shall be provided. 25. For refractive surgery such as radial keratotomy and other procedures to alter the refractive properties of the cornea.

Table B. CHIP Dental Covered Services

Dental procedures not listed within Table B are not Covered Services under the CHIP. Members are subject to a two thousand dollars and zero cents ($2,000.00)
annual maximum.

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D0120	PERIODIC ORAL EVALUATION	YES	0	19	1 EVERY 6 MONTHS	NO
D0140	LIMITED ORAL EVALUATION - PROBLEM FOCUSED	YES	0	19	N/A	NO
D0145	ORAL EVALUATION FOR MEMBER UNDER 3	YES	0	3	1 EVERY 6 MONTHS	NO
D0150	COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED MEMBER	YES	0	19	1 EVERY 6 MONTHS	NO
D0210	INTRAORAL-COMPLETE SERIES (INCLUDING BITEWINGS)	YES	0	19	1 EVERY 24 MONTHS	NO
D0220	INTRAORAL-PERIAPICAL-FIRST FILM	YES	0	19	N/A	NO
D0230	INTRAORAL-PERIAPICAL-EACH ADDITIONAL FILM	YES	0	19	N/A	NO
D0240	INTRAORAL-OCCLUSAL FILM	YES	0	19	N/A	NO
D0270	BITEWING-SINGLE FILM	YES	0	19	1 EVERY 6 MONTHS	NO
D0272	BITEWINGS-TWO FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0273	BITEWINGS - THREE FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0274	BITEWINGS-FOUR FILMS	YES	0	19	1 EVERY 6 MONTHS	NO
D0320	TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION	[3] SEE TMJ DISORDER BENEFIT	0	19	[3] SEE TMJ DISORDER BENEFIT	YES
D0321	OTHER TEMPOROMANDIBULAR JOINT FILMS, BY REPORT	[3] SEE TMJ DISORDER BENEFIT	0	19	[3] SEE TMJ DISORDER BENEFIT	YES
D0330	PANORAMIC FILM	YES	0	19	1 EVERY 24 MONTHS	NO
D1110	PROPHYLAXIS-ADULT - AGE 14+	YES	14	19	1 EVERY 6 MONTHS	NO
D1120	PROPHYLAXIS-CHILD - AGE 0 -13	YES	0	13	1 EVERY 6 MONTHS	NO
D1208	TOPICAL APPLICATION OF FLUORIDE	YES	0	19	1 EVERY 6 MONTHS	
D1351	SEALANT - PER TOOTH	YES	0	14	1 EVERY 36 MONTHS **MOLARS ONLY**	NO
D1510	SPACE MAINTAINER - FIXED - UNILATERAL	YES	0	15	PERMANENT TEETH **ONLY**	NO

D1515	SPACE MAINTAINER - FIXED - BIILATERAL	YES	0	15	PERMANENT TEETH **ONLY**	NO

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D1520	SPACE MAINTAINER - REMOVABLE UNILATERAL	YES	0	15	PERMANENT TEETH **ONLY**	NO
D1525	SPACE MAINTAINER - REMOVABLE BILATERAL	YES	0	15	PERMANENT TEETH **ONLY**	NO
D1550	RECEMENTATION OF SPACE MAINTAINER	YES	0	15	N/A	NO
D1555	REMOVAL OF FIXED SPACE MAINTAINER	YES	0	15	N/A	NO
D2140	AMALGAM-ONE SURFACE, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2150	AMALGAM-TWO SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2160	AMALGAM-THREE SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2161	AMALGAM-FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	YES	0	19	N/A	NO
D2330	RESIN BASED COMPOSITE-ONE SURFACE, ANTERIOR	YES	0	19	N/A	NO
D2331	RESIN BASED COMPOSITE-TWO SURFACES, ANTERIOR	YES	0	19	N/A	NO
D2332	RESIN BASED COMPOSITE-THREE SURFACES, ANTERIOR	YES	0	19	N/A	NO
D2335	RESIN BASED COMPOSITE-FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE	YES	0	19	N/A	NO
D2391	RESIN BASED COMPOSITE-ONE SURFACE, POSTERIOR	YES	0	19	N/A	NO
D2392	RESIN BASED COMPOSITE-TWO SURFACES, POSTERIOR	YES	0	19	N/A	NO
D2393	RESIN BASED COMPOSITE-THREE SURFACES, POSTERIOR	YES	0	19	N/A	NO
D2394	RESIN BASED COMPOSITE-FOUR OR MORE SURFACES POSTERIOR	YES	0	19	N/A	NO
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	YES	0	19	1 EVERY 5 YRS ANTERIOR TEETH ONLY	YES

D2751	CROWN-PORCELAIN FUSED TO	YES	0	19	1 EVERY 5 YRS	YES

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
	PREDOMINANTLY BASE METAL				ANTERIOR TEETH ONLY	
D2930	PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH	YES	0	19	N/A	NO
D2931	PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH	YES	0	19	N/A	YES
D2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	YES	0	19	ANTERIOR TEETH ONLY	NO
D2940	SEDATIVE FILLING	YES	0	19	N/A	NO
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	YES	0	19	N/A	NO
D3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	YES	0	19	N/A	NO
D3230	PULPAL THERAPY (RESORBABLE FILLING) ANTERIOR PRIMARY TOOTH	YES	0	6	N/A	NO
D3240	PULPAL THERAPY (RESORBABLE FILLING) POSTERIOR PRIMARY TOOTH	YES	0	10	N/A	NO
D3310	ANTERIOR (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D3320	BICUSPID (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D3330	MOLAR (EXCLUDING FINAL RESTORATION)	YES	0	19	1 PER LIFETIME PER TOOTH	PRE-AUTH & RETRO REVIEW
D4210	GINGIVECTOMY OR GINGIVOPLASTY - FOUR OR MORE CONTIGUOUS TEETH	YES	0	19	1 EVERY 36 MONTHS	YES
D4211	GINGIVECTOMY OR GINGIVOPLASTY- 1 TO 3 TEETH PER QUADRANT	YES	0	19	1 EVERY 36 MONTHS	YES
D4341	PERIODONTAL SCALING AND ROOT PLANING- FOUR OR MORE TEETH, PER QUADRANT	YES	10	19	2 QUADS PER VISIT 4 QUADS PER YEAR	YES
D4342	PERIODONTAL SCALING AND ROOT PLANING- ONE TO THREE TEETH, PER QUADRANT	YES	10	19	2 QUADS PER VISIT 4 QUADS PER YEAR	YES

D5110	COMPLETE UPPER	' SEE ACCIDENTAL	0	19	' SEE ACCIDENTAL	YES

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
		INJURY BENEFIT			INJURY BENEFIT	
D5120	COMPLETE LOWER	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES
D5211	UPPER PARTIAL-RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES
D5212	LOWER PARTIAL-RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES
D5213	UPPER PARTIAL-CAST METAL FRAMEWORK WITH RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES
D5214	LOWER PARTIAL-CAST METAL FRAMEWORK WITH RESIN BASE (INCL. ANY CONVENTIONAL CLASPS, RESTS & TEETH)	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES
D7140	EXTRACTION, ERUPTED OR EXPOSED TOOTH (ELEVATION AND/OR FORCEPS REMOVAL)	YES	0	19	1 PER LIFETIME PER TOOTH	NO
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING ELEVATION	YES	0	19	1 PER LIFETIME PER TOOTH	NO
D7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7240	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7241	REMOVAL OF IMPACTED TOOTH-COMPLETELY BONY	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	YES	0	19	1 PER LIFETIME PER TOOTH	YES
D7270	TOOTH REPLANTATION AND/OR STABILIZATION	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES
D7780	FACIAL BONES - COMPLICATED REDUCTION WITH FIXATION	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES

D7810	OPEN REDUCTION OF DISLOCATION	' SEE ACCIDENTAL INJURY BENEFIT	0	19	' SEE ACCIDENTAL INJURY BENEFIT	YES

CDT Code	Description of Procedure	Covered Benefit	Min Age	Max Age	Limitation	Auth Required
D7820	CLOSED REDUCTION OF DISLOCATION	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D7830	MANIPULATION UNDER ANESTHESIA	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D7840	CONDYLECTOMY	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D7850	SURGICAL DISCECTOMY, WITH/WITHOUT IMPLANT	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D7860	ARTHROTOMY	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D7870	ARTHROCENTESIS	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D9220	DEEP SEDATION- GENERAL ANESTHESIA- FIRST 30 MINUTES	YES	0	19	[2] WHEN CLINICALLY NECESSARY	YES
D9221	DEEP SEDATION- GENERAL ANESTHESIA- EACH ADDITIONAL 15 MINUTES	YES	0	19	[2] WHEN CLINICALLY NECESSARY	YES
D9230	ANALGESIA, ANXIOLSIS, INHILATION OF NITROUS OXIDE	YES	0	7	ALLOWABLE WITH RESTORATIVE PROCEDURES ONLY 1 PER VISIT/DAY	NO
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN	YES	0	19	N/A	NO
D9310	CONSULTATION - DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN	YES	0	19	N/A	NO
D9951	OCCLUSAL ADJUSTMENT - LIMITED	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES
D9952	OCCLUSAL ADJUSTMENT - COMPLETE	[1] SEE ACCIDENTAL INJURY BENEFIT	0	19	[1] SEE ACCIDENTAL INJURY BENEFIT	YES

Notes:

1. ***ACCIDENTAL INJURY BENEFIT - THE CALENDAR YEAR MAXIMUM DOES NOT APPLY TO THESE SERVICES***

Benefits are provided for dental care, treatment, dental surgery, and dental appliances made necessary by accidental bodily injury to sound and natural teeth (which are free from effects of impairment or disease) effected solely through external means occurring while the Member is covered under the plan. Injury to teeth as a result of chewing or biting in not considered accidental injury. **FOR ACCIDENTAL INJURY BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURE CODES FOR PRE-AUTHORIZATION APPROVAL.**

No benefits will be provided for orthodontics, dentures, occlusion reconstruction, or for inlays unless such services are provided pursuant to an accidental injury as described above or when such services are recommended by a physician or dentist for the treatment of severe craniofacial anomalies or full cusp Class III malocclusions. **FOR ORTHODONTIC BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURE CODES FOR PRE-AUTHORIZATION APPROVAL.**

2. ***ANESTHESIA BENEFITS***

Benefits are provided for anesthesia and for associated facility charges when the mental or physical condition of the Member requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center, or dental office.

3. ***TMJ COVERAGE BENEFIT***

Benefits are provided for diagnosis and surgical treatment of temporomandibular joint (TMJ) disorder or syndrome and craniomandibular disorder, whether such treatment is rendered by a Practitioner or dentist, subject to a lifetime maximum benefit of five thousand dollars and zero cents ($5,000.00) per Member. This lifetime maximum will apply regardless of whether the temporomandibular – craniomandibular joint disorder was caused by an accidental injury or was congenital in nature. **FOR TMJ BENEFITS – SUBMIT A TREATMENT PLAN WITH PROCEDURES FOR PRE-AUTHORIZATION APPROVAL.**

EXHIBIT C: EXTERNAL QUALITY REVIEW

Section 1932(c)(2) of the Act requires states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including the evaluation of quality outcomes, timeliness, and access to services. The requirements for External Quality Review (EQR) were further outlined in 42 C.F.R. Parts 433 and 438: External Quality Review of Medicaid Managed Care Organizations. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. Pursuant to Section 2103(f) of the Act and this Contract, such requirements apply to Contractor.

The results of the EQR are made available, upon request, to specified groups and to interested stakeholders. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and UM systems, and program oversight. DOM requires that Contractor:

1. Actively participate in planning and developing the measures to be utilized with DOM and the EQRO. The quality leadership team will be given an opportunity to provide input into the measures to be utilized;

2. Accurately, completely, and within the required time frame i dentify eligible
a. Members to the EQRO;

3. Correctly identify and report the numerator and denominator for each measure;

4. Actively encourage and require providers, including Subcontractors, to provide complete and accurate provider Medical Records within the time frame specified by the EQRO;

5. Demonstrate how the results of the EQR are incorporated into Contractor's overall QM program and demonstrate progressive improvements during the term of the Contract;

6. Improve encounter data in an effort to decrease the need for extensive provider
a. Medical Record reviews;

7. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438; and

8. Ensure that data, clinical records, and workspace located at Contractor's work site are available to the independent review team and to DOM, upon request.

EXHIBIT D: MEDICAL LOSS RATIO (MLR) REQUIREMENTS

Contractor is required to rebate a portion of the Capitation Payment to DOM in the event Contractor does not meet the eighty-five percent (85%) MLR standard. This Exhibit describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention, 4) payment of any rebate due to DOM, and 5) monetary penalties that may be assessed against Contractor for failure to meet requirements.

A. Reporting Requirements

1. General Requirements

   For each MLR Reporting Year, Contractor must submit to DOM the Medical Loss Ratio Rebate Calculation Report, a report which complies with the requirements that follow concerning Capitation Payments received and expenses related to CHIP Members (referred to hereafter as MLR Report).

2. Timing and Form of Annual MLR Report

   The report for each MLR Reporting Year must be submitted to DOM by April 1 of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by DOM.

3. Timing and Form of Quarterly MLR Report

   Contractor must report to DOM, on a quarterly basis, the MLR for the reporting period. The format will be specified by DOM.

4. Newer Experience

   If fifty percent (50%) or more of the total Capitation Payment received in an MLR Reporting Year is attributable to new Members with less than twelve (12) months of experience in that MLR Reporting Year, or if the MLR Reporting Year is less than a twelve (12) month period in any year, then the experience of these Members may be excluded from the year's MLR Report. If Contractor chooses to defer reporting of newer business in a current year, then the excluded experience must be added to the experience reported in the subsequent MLR Reporting Year.

5. Capitation Payments

   A Contractor must report to DOM the total Capitation Payments received from DOM for each MLR Reporting Year. Total Capitation Payments means all monies paid by DOM to Contractor for providing benefits and services as defined in the terms of the Contract.

B. **Reimbursement for Clinical Services Provided to Members**

The MLR Report must include direct claims paid to or received by providers, whose services are covered by the Subcontract for clinical services or supplies covered by DOM's Contract with Contractor. Reimbursement for clinical services as defined in this section is referred to as "incurred claims." Specific requirements include:

1. Incurred claims must include changes in unpaid claims between the prior year's and the current year's Unpaid Claims Reserves, including claims reported in the process of adjustment, percentage withholds from payments made to subcontracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

2. Incurred claims must include the change in claims incurred but not reported from the prior year to the current year. Except where inapplicable, the reserve should be based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency, or severity.

3. Incurred claims must include changes in other claims-related reserves.

4. Incurred claims must exclude rebates paid to DOM based upon prior MLR Reporting Year experience.

5. Adjustments to incurred claims:

    a. Adjustments that must be deducted from incurred claims:

        ii. Prescription drug rebates received by Contractor.

        ii. Overpayment recoveries received from providers.

    b. Adjustments that may be included in incurred claims:

        i. The amount of incentive and bonus payments made to providers

    c. Adjustments that must not be included in incurred claims:

        i. Amounts paid to third party vendors for secondary network savings.

            ii. Amounts paid to third party vendors for network development administrative fees, claims processing, and UM.

            iii. Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to a Member. For example, Medical Record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel, and Medical Record clerks

must not be included in incurred claims.

C. **Activities that Improve Health Care Quality**

1. General Requirements

The MLR may include expenditures for activities that improve health care quality, as described in this section.

2. Activity Requirements

Activities conducted by Contractor to improve quality must meet the following requirements:

1. The activity must be designed to:

a. Improve health quality;

b. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

c. Be directed toward individual Members or incurred for the benefit of specified segments of Members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-Members;

d. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations;

e. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations. Examples include the direct interaction of Contractor (including those services delegated by Subcontract for which Contractor retains ultimate responsibility under the terms of the Contract with DOM) with providers and the Member or the Member's representative (for example, face-to-face, telephonic, web-based interactions, or other means of communication) to improve health outcomes, including activities such as:

(a) Effective Care Management, Care Coordination, chronic disease management, and medication and care compliance initiatives including through the use of the Medical Homes model as defined in the Contract;

(b) Identifying and addressing ethnic, cultural, or racial disparities in

effectiveness of identified best clinical practices and evidence based medicine;

(c) Quality reporting and documentation of care in non-electronic format; and

(d) Health information technology to support these activities;

vi. Accreditation fees directly related to quality of care activities;

vii. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(b) Member-centered education and counseling;

(c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;

(d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and

(e) Health information technology to support these activities;

viii. Improve Member safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve Member safety, reduce medical errors, and lower infection and mortality rates include:

(a) The appropriate identification and use of best clinical practices to avoid harm;

(b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;

(c) Activities to lower the risk of facility-acquired infections;

(d) Prospective prescription drug utilization review aimed at identifying potential drug interactions;

(e) Any quality reporting and related documentation in non-electronic form for activities that improve Member safety and reduce medical errors; and

(f) Health information technology to support these activities.

ix. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include:

(a) Wellness assessments;

(b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(d) Actual rewards, incentives, bonuses, reductions in Co-Payments (excluding administration of such programs), that are not already reflected in payments or claims;

(e) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(f) Coaching or education programs and health promotion activities designed to change Member behavior and conditions (for example, smoking or obesity); and

(g) Health information technology to support these activities.

x. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

3. Exclusions

Expenditures and activities that must not be included in quality improving activities are:

a. Those that are designed primarily to control or contain costs;

b. The pro rata share of expenses that are for lines of business or products other than CHIP;

c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from DOM Capitation Payments;

d. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to HIPAA, 42 U.S.C. § 1320d-2, including the new ICD-10 requirements);

f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

g. All retrospective and concurrent UM;

h. Fraud prevention activities, other than Fraud detection/recovery expenses up to the amount recovered that reduces incurred claims;

i. The cost of developing and executing provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason;

j. Provider credentialing;

k. Marketing expenses;

l. Costs associated with calculating and administering individual Member or employee incentives;

m. That portion of prospective utilization that does not meet the definition of activities that improve health quality;

n. State and Federal taxes and regulatory fees; and

o. Any function or activity not expressly included in Section C.3, Exclusions, of this Exhibit D, unless otherwise approved by and within the discretion of DOM, upon adequate showing by Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring, or reporting health care quality improvement.

D. **Expenditures Related to Health Information Technology and Meaningful Use Requirements**

1. General Requirements

A Contractor may include as activities that improve health care quality such health

information technology expenses as are required to accomplish the activities that are designed for use by Contractor, contracted providers, or Members for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with HHS meaningful use requirements, including 42 C.F.R. Part 495 and 45 C.F.R. Part 170, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

a. Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services;

b. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers;

c. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

d. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA, URAC, or JCAHO, or costs for reporting to DOM on quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS® surveys or chart review of HEDIS® measures);

e. Advancing the ability of Members, providers, Contractor, or other systems to communicate Member centered clinical or medical information rapidly, accurately and efficiently to determine Member status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by Members and appropriate providers to monitor and document an individual Member's medical history and to support Care Management;

f. Reformatting, transmitting, or reporting data to national or international government-based health organizations, as may be required by DOM, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and

g. Provision of electronic health records, Member portals, and tools to facilitate Member self-management.

E. Other Non-Claims Costs

1. General Requirements

The MLR Report must include non-claims costs described in Section E.2, Non- Claims Costs Other, of this Exhibit D, and must provide an explanation of how Capitation Payments are used, other than to provide reimbursement for clinical services included in core benefits and services, expenditures for activities that improve health care q uality, and expenditures related to health information technology and meaningful use requirements.

2. Non-Claims Costs Other

The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation for clinical services to Members, or expenditures on quality improvement activities as defined above.

Expenses for administrative services include the following:

a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;

b. Loss adjustment expenses not classified as a cost containment expense;

c. Workforce salaries and benefits;

d. General and administrative expenses;

e. Community benefit expenditures.

F. **Allocation of Expenses**

1. General Requirements

Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business other than Mississippi CHIP must be reported on a pro rata share.

2. Description of the Methods Used to Allocate Expenses

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from Contractor activities in Mississippi. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

a. Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of

an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses;

b. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense; and,

c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, Capitation Payment ratios, or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

3. Maintenance of Records

Contractor must maintain and make available to DOM upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under Section F.2, Description of the Methods Used to Allocate Expenses, of this Exhibit D, were accurately implemented in preparing the MLR Report.

G. Formula for Calculating Medical Loss Ratio

1. Medical Loss Ratio

a. A Contractor's MLR is the ratio of the numerator and the denominator, as defined:

i. The numerator of Contractor's MLR for an MLR Reporting Year must be Contractor's incurred claims plus Contractor's expenditures for activities that improve health care quality.

ii. The denominator of Contractor's MLR must equal Contractor's Capitation Payments received from DOM reduced by amounts allocated for premium taxes, Health Insurer Tax, and other revenue-based assessments as determined by DOM.

b. A Contractor's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

2. Rebating Capitation Payments if the eighty-five percent (85%) Medical Loss Ratio Standard is Not Met

a. General Requirement

For each MLR Reporting Year, Contractor may be required to provide a rebate to DOM if Contractor's MLR does not meet or exceed the eighty-five percent (85%) requirement.

b. Amount of Rebate

For each MLR Reporting Year, Contractor may be required to rebate to DOM the difference between the total amount of Capitation Payments received by Contractor from DOM multiplied by the required MLR of eighty-five percent (85%) and Contractor's actual MLR.

c. Timing of Rebate

Contractor must provide any rebate owing to DOM no later than June 1 following the end of the MLR Reporting Year.

d. Late Payment Interest

If Contractor fails to pay any rebate owing to DOM in accordance within the time periods set forth in this Exhibit, Contractor must, in addition to providing the required rebate to DOM, pay DOM interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate, accruing from June 1.

EXHIBIT E: MEMBER GRIEVANCE AND APPEAL PROCESS

Contractor shall implement Member Grievance and Appeal policies and procedures in accordance with 42 C.F.R. § 457.1120 *et seq.*, 42 C.F.R. Part 438, Subpart F, and the State's Managed Care Quality Strategy, with the modifications that are incorporated in the Contract. Contractor shall not modify the Member Grievance and Appeal procedure without the prior approval of DOM, and shall provide DOM with a copy of the modification at least fifteen (15) calendar days prior to implementation.

A. First Level Review: Grievance Review

1. The Member, his or her representative, the legal representative of a deceased Member's estate, or a provider may initiate the Member Appeal process by filing a verbal or written Member Grievance within forty-five (45) calendar days of the incident, or at which time the Member has knowledge of the circumstances which would give rise to the Member Appeal, whichever comes first.

2. Contractor's Grievance and Appeals Coordinator will investigate the Member Appeal using applicable statutory, regulatory, and contractual provisions, as well as Contractor's written policies.

3. Within fifteen (15) calendar days after receipt of the Member Appeal, the Grievance and Appeals Coordinator or Medical Director, when necessary, will prepare and send a notice, outlining Contractor's determination, to the Member and provider.

4. The notice, which will be sent first class mail, will contain the following information:

    a. The title(s) and qualifying credential(s) of the person(s) participating in step one (1) of the Grievance Review process;

    b. A statement of the reviewer's understanding of the Member Appeal;

    c. The reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail;

    d. A reference to the evidence or documentation used as a basis for the decision; and

    e. If the decision is a denial, the notice must also include a clear description of the individual's right to and the process required for further review.

    Upon Member request, and for both a legitimate reason and a reasonable period, the fifteen (15) calendar day time frame reference in Section A.3 of this Exhibit E may be extended. The Member must be informed in writing that an extension of the time frame for this step could also extend the total Member Grievance and Appeal process time frame to more than ninety (90) days. Such notice shall be written in a

manner that is easily understood and that is not misleading or confusing.

5. Contractor is encouraged to resolve Member Grievances at this level, to include Contractor's Medical Director for all medical and/or quality of care issues, and, with Member approval where required, to include any other party that may assist in the resolution of the Grievance.

B. **Second Level Review: Grievance Reconsideration**

1. If the Member, his or her representative, or the provider is dissatisfied with Contractor's decision on a Member Appeal, the Member, his or her representative or the provider may send to Contractor a written statement containing an explanation of the Member Appeal and reason(s) for dissatisfaction with Contractor's decision. This written request must be received by Contractor within fifteen (15) calendar days of the Member's and/or provider's receipt of Contractor's decision.

2. Upon receipt of a step two (2) review request (Grievance Reconsideration), Contractor's Member Grievance and Appeal Coordinator shall determine if the request was submitted within the required time frame (i.e., whether the request was postmarked within fifteen (15) calendar days of Contractor's issuance of the step one (1) notice). The timeliness, or lack thereof, shall be noted on the request. Irrespective of whether the request was received within the required time frame, the request and any additional documentation shall be packaged, with the file from the step one (1) review, and given to a designated Contractor representative at a higher level than the Grievance and Appeals Coordinator (e.g., the Grievance and Appeals Coordinator's supervisor).

   If the step two (2) review request was not submitted within the required time frame, the designated step two (2) review must determine if an adequate explanation for its lack of timeliness exists such that an exception should be granted and the request reviewed. Examples of an adequate explanation may include a Member's inability to respond in a timely manner due to an acute medical episode, or a delay in deliver of the step one (1) notice due to an incorrect address on it. If the step two (2) reviewer determines that the request was not submitted within the required time frame and that an exception to the timeliness requirements is not appropriate, a notice must be issued as specified in Section B.3.d of this Exhibit E.

3. Contractor will investigate each Member Appeal using applicable statutory, regulatory, and contractual provisions, as well as Contractor's written policies. As part of the investigation, Contractor:

   a. May contact the Member and/or the appropriate provider by phone or in person;

   b. Will consult with its management, and /or Medical Director, as necessary, and, if the Member Appeal involves an adverse medical determination, Contractor's consulting providers who have appropriate expertise in the area which is the subject of the Member Appeal;

c. Contractor will render a decision on the Member Appeal within fifteen (15) calendar days of the receipt of the Member Appeal. Contractor will send a written decision to the Member and provider within the fifteen (15) calendar days of the receipt of the Member Appeal;

d. The written decision shall be in the form of a notice. The notice, which will be sent first class mail, shall contain the following information:

   i. The names(s), title(s) and qualifying credentials(s) of the person(s) participating in the Member Appeal review process;

   ii. A statement of the reviewer's understanding of the Member Appeal;

   iii. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

   iv. A reference to the evidence or documentation used as the basis for the decision; and

   v. If the decision is a denial, the notice must include a clear description of the individual's right to and the process required for further review.

   A notice of a timeliness denial must include the date the step one (1) notice was mailed, the date the step two (2) review request was received, and an explanation of the required time frame. The notice must also advise that timeliness denials by Contractor are not subject to review by an independent external review organization and include a description of the individual's right to pursue the matter in a court of appropriate jurisdiction.

   The notice shall also explain that the individual may submit additional documentation with the request for consideration and that submission of a step three (3) request authorizes Contractor to share PHI with an independent external review organization

e. If the Member is dissatisfied with the result of Contractor's Member Appeal decision, he or she may continue the Member Appeal process by filing a written request along with additional information that may be available for reconsideration of the Member Appeal with Contractor, within fifteen (15) calendar days of receipt of Contractor's notice regarding the Member Appeal.

C. Third Level Review: Grievance Review by Independent External Review Organization

1. If the Member, his or her representatives, or the provider remains dissatisfied with Contractor's decision on the Member Appeal, he or she must send to Contractor a written statement restating the Member Appeal and the reason(s) for the dissatisfaction with Contractor's decision, along with any additional information pertinent to the Member Appeal. Upon request, Contractor must also provide the

opportunity to present this information in person.

Contractor must receive the written statement within fifteen (15) calendar days of the Member's and/or provider's receipt of Contractor's decision on the Member Appeal. If the step three (3) review request was not submitted within the required time frame, the designated step two (2) review must determine if an adequate explanation for its lack of timeliness exists such that an exception should be granted and the request reviewed.

2. Contractor will review the request for reconsideration and any new information that may have become available since the time the Member Appeal was first considered.

3. The individuals reviewing the reconsideration shall not be the same individuals that Contractor utilized in the initial determination when the Member Appeal was denied. In the event the third level Member Appeal review involves a final adverse determination being made by Contractor about the denial, reduction, suspension, or termination of health care services or treatment, other than for timeliness, the Grievance and Appeal Coordinator, within ten (10) calendar days of Contractor's receipt of the individuals third (3^{rd}) request, will refer all pertinent documentation relating to the request to Contractor's legal department for final determination. Contractor will refer the medical determinations to an external independent review organization for a final determination of the Appeal. Such documentation shall include:

   a. All files associated with the step one (1), step two (2), and step three (3) Member Appeals by Contractor's staff, including all documentation assembled during the reviews;

   b. The Member's pertinent Medical Records;

   c. The attending physician's recommendations;

   d. Consulting reports from appropriate health care professions;

   e. Other documents submitted by the Member, his/her representative, or a provider;

   f. Any applicable generally accepted practice guidelines, including those developed by the federal government, national or professional medical societies, boards or associations; and

   g. Any applicable clinical review criteria developed and/or used by Contractor.

   The independent external review organization must thoroughly review all documentation provided by Contractor and make a final determination regarding the Member Appeal. Such review and written notice to Contractor shall be completed within fifteen (15) calendar days of receipt. The notice to Contractor shall identify the qualifying credentials of the person(s) participating in the review and thoroughly explain the basis for the final determination.

4. Once the Third Level Member Appeal review is complete, Contractor shall send a notice, by first class mail outlining the determination, to the Member and provider. The notice shall contain:

   a. The title(s) and qualifying credential(s) of the person(s) participating in the reconsideration process, if applicable;

   b. A statement of the reviewer's understanding of the Member Appeal;

   c. The reviewer's decision in clear terms and the contract basis or the medical rationale in sufficient detail;

   d. A reference to the evidence or documentation used as the basis for the decision; and

   e. If the decision is a denial, a clear description of the individual's right to the process required for further review.

D. **Expedited Appeal Procedures**

1. Contractor shall provide an expedient review of a Member Appeal involving an urgent or emergency medical situation. This process is as follows:

   a. This process shall include all requests by Members concerning admissions, availability of care, continued stay, or health care services being received by a Member in an emergency situation where he or she has not been discharged from a facility (hospital). The request for an expedited review may be submitted by the Member, his or her representative, the legal representative of a deceased Member's estate, or a provider verbally to a designated representative of Contractor. Contractor will inform Members of the limited time available to present evidence and allegations of fact or law.

   b. In the expedited review process, all necessary information, including Contractor's decision, shall be transmitted between Contractor, the independent review organization (where applicable), the Member, his or her representative, or the provider by telephone, facsimile, or the most expeditious method.

   c. Contractor shall make a decision and notify the Member and his or her representative as expeditiously as the Member's medical condition requires, but in no event more than seventy-two (72) hours after the review is requested. Contractor shall provide written confirmation of its decision concerning an expedited Member Appeal within two (2) working days of providing notification of that decision if the initial notification was not in writing.

2. The written decision shall be in the form of a notice. The notice, which will be sent first class mail, shall contain the following information:

a. The title(s) and qualifying credential(s) of the person(s) participating in the Appeal review process;

b. The qualifying credentials of any independent external review organization staff participating in the review;

c. A statement of the reviewer's understanding of the Member Appeal;

d. The reviewer's decision in clear terms and the Contract basis or the medical rationale in sufficient detail;

e. A reference to the evidence or documentation used as the basis for the decision;

f. An explanation of how to request a reconsideration of a Member Appeal decision; and

g. If the decision is a denial, also a clear description of the individual's right to pursue the matter in a court of appropriate jurisdiction.

Exception: Upon Member request, and for both a legitimate reason and a reasonable period, the seventy-two hour (72) hour time frame referenced in Section D.1.c of this Exhibit E may be extended by up to fourteen (14) calendar days.

E. **Independent External Review Organization**

Contractor shall retain the services of an independent external review organization to review all adverse determinations as part of the step three (3) review process, for any expedited reviews and for any other medical review where external review is believed necessary and appropriate. At a minimum, the independent external review organization must:

1. Establish and maintain written policies and procedures that govern all aspects of standard and expedited review processes, which include procedures to ensure reviews are conducted within the specified time frames;

2. Provide toll free telephone services capable of receiving information on a twenty-four (24) hours per day, seven (7) days a week basis, that is capable of accepting, recording, or providing appropriate instructions to incoming callers during both normal business hours and other than normal business hours; and

3. Use qualified and impartial clinical peer reviewers who are skilled in the subject of the external review. Clinical peer reviewers must be:

   a. Currently licensed;

   b. Hold a current certification by a recognized United States medical specialty board in the area or areas appropriate to the subject of the external review; and

c. Knowledgeable about the recommended healthcare services or treatment through actual clinical experience.

Neither the independent external review organization nor the clinical peer reviewer assigned by the organization to conduct an external review may have a material, professional, familial, or financial interest with Contractor, the provider, or facility which is recommending the health care services or treatment that is the subject of the external review. Neither may the assigned clinical peer reviewer have a professional or familial interest with the Member for whom the review is being conducted.

The designation of an independent external review organization is subject to advance approval by DOM. Said approval will not be unreasonably withheld if it is shown to the satisfaction of DOM that all of the above requirements have been met.

F. **Policy and Procedure Requirements**

Contractor's Member Grievance and Appeal procedures shall meet the following requirements:

1. Resolving the Member Grievance and Appeal expeditiously by Contractor personnel at a decision-making level with authority to require corrective action.

2. Describing procedures for the submission and resolution of a Member Grievance or Appeal in accordance with this Exhibit.

3. Maintaining written documentation of each Member Grievance and Appeal, and the Actions taken by Contractor.

4. Distributing a written description and educating contracted providers of Contractor's Member Grievance and Appeal process and how providers can submit a Member Grievance or Appeal for a Member, or on their own behalf.

5. Designating a specific individual as Contractor's Grievance and Appeals Coordinator with the authority to administer the policies and procedures for resolution of a Member Grievance or Appeal, to review patterns/trends in Member Grievances and Appeals, and to initiate corrective action.

6. Ensuring that the individuals who make decisions on Member Grievances or Appeals are not involved in any previous level of review or decision-making. Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

   a. An Appeal of a Contractor denial that is based on lack of medical necessity;

   b. A Contractor denial that is upheld in an Expedited Resolution; and

c. A Member Grievance or Appeal that involves clinical issues.

7. Ensuring that punitive or retaliatory action is not taken against a Member or service provider that files a Member Grievance or an Appeal, or a provider that supports a Member's Grievance or Appeal.

8. Ensuring that there is a link between the Member Grievance and Appeal processes and the QM and UM programs.

9. Designating and training sufficient staff to be responsible for receiving, processing, and responding to Member Grievances and Appeals in accordance with the requirements in this Exhibit and the Contract.

EXHIBIT F: CHIP QUALITY MANAGEMENT

DOM will monitor the QM of Contractor and retains the right of advance written approval of all QM activities, in accordance with Section 1932(c)(1) of the Act. Contractor must design its QM program to assure and improve upon the accessibility, availability, and quality of care provided for CHIP. Contractor's QM programs must, at a minimum:

1. Contain a written program description, work plan, and program evaluation which meet requirements outlined in the Contract that focus on the areas of importance as identified by the Contract in collaboration with DOM;

2. Be based on and actively evaluate claims data Member demographic information, Member and provider surveys, and other data, as applies, and to use these data for the identification of prevalent medical conditions and barriers to care to be targeted for quality improvement;

3. Continuously evaluate the effectiveness of its activities and make adjustments to the program or to various methodologies or approaches based on these evaluations;

4. Contain written policies and procedures that meet the requirements outlined in the Contract, and monitor internal compliance with these policies and procedures; and

5. Maintain a structure and actively ensure that the program is implemented and overseen by professionals with adequate and appropriate experience in QM.

Contractor must submit to DOM for approval an improvement plan, as determined by DOM, and within time frames established by DOM, to resolve any performance or quality of care deficiencies identified by DOM. DOM must approve the improvement plan. Failure by Contractor to comply with requirements and improvement actions requested by DOM may result in the application of penalties.

Standard I: The scope of the QM program must be comprehensive in nature, and support the ability of CHIP to improve health outcomes and satisfaction for the Members. This includes, but is not limited to, assessment of access to care, barriers to care, quality of care, Care Management, and continuity of services. At a minimum, Contractor's QM programs, must:

1. Adhere to current Federal, State, and DOM rules and regulations.

2. Be developed and implemented by professionals with adequate and appropriate experience in QM.

3. Ensure that all QM activities and initiatives undertaken by Contractor are chosen based upon claims data, Member demographic information, Member and provider surveys, Medical Record review data, and other data as applies.

4. Contain policies and procedures for all functions of the QM program. The policies

and procedures must include ongoing review of the program provided by Contractor Ensuring that all demographic groups and special needs populations are addressed. Contractor must submit to DOM for approval all policies and procedures prior to initial implementation and upon significant changes.

5. Contain one (1) detailed written program description specific to CHIP, which must be approved by Contractor's Governing Body and DOM prior to implementation and on an ongoing basis as the program description is modified. The program description must address all standards, requirements, and objectives established by DOM and describe the goals, objectives, and structure of Contractor's QM program. At a minimum, it must be updated and submitted to DOM annually. The written program description must include:

    a. Standards and mechanisms to monitor Members to receive timely accessibility of primary care and specialty care, in accordance with time frames outlined in Section 7.B, Provider Network Requirements, of this Contract.

    b. Mechanisms for assessment, analysis, and reporting of the quality of care provided through Contractor including, but not limited to:

        i. Primary care;

        ii. Preventive care;

        iii. Acute and/or chronic conditions;

        iv. Care Management and care coordination, including coordination of Behavioral Health and physical health services;

        v. Continuity of care; and

        vi. Behavioral Health services.

    c. Assessment of the timely, accurate, and complete collection and/or analysis of Member and provider surveys.

6. Contractor must submit to DOM for approval the detailed annual work plans and timetables approved by Contractor's Governing Body prior to implementation, including:

    a. Individual(s) accountable for each task;

    b. Target dates for start dates;

    c. Target dates for completion of all phases of all QM activities;

    d. Updates on at least a quarterly basis;

e. Annual submission, which must include prospective QM initiatives for the year;

f. Data collection methods and analysis target dates;

g. Evaluation and reporting of findings to DOM;

h. Implementation of improvement actions where applicable; and

i. Status of each activity.

7. The annual QM program evaluation for CHIP will include:

   a. Description of completed and ongoing QM activities including Care Management effectiveness evaluation;

   b. Identified issues, including tracking of issues over time;

   c. Trending of measures to assess performance in quality of clinical care and quality of service to Members; and

   d. An analysis of whether there have been demonstrated improvements in Members' health outcomes, the quality of clinical care, and quality of service to Members; and overall effectiveness of the QM program (e.g., improved HEDIS® scores).

8. Include mechanisms and processes that ensure that related and relevant operational components, activities, and initiatives from the QM program are communicated and integrated into activities and initiatives undertaken by other departments within Contractor's organization, delegated Subcontractors, and Care Management programs.

9. Include mechanisms and processes to assess the quality and appropriateness of care furnished to Members with special health care needs.

10. Include procedures for informing providers about the written QM program, and for securing cooperation with the QM program with all PCPs and community-based services.

11. Include procedures for feedback and interpretation of findings from analysis of quality data to PCPs, Care Management staff, community-based services, and Members and their family members.

12. Include mechanisms and processes that allow for the development and implementation of specific improvement actions in response to identified barriers and quality of care concerns within the QM program and the communication of the findings to DOM.

13. Cooperate and coordinate with State initiatives. Contractor must participate in State health initiatives. This may include, but is not limited to:

a. Provider outreach and education;

b. Member outreach and education;

c. Quality studies; and

d. Participation in workgroups.

Standard II: The organizational structures of Contractor must ensure that there is adequate support of the QM work plan. Contractor may determine that one (1) Governing Body and one (1) Quality Management Committee (QMC) will oversee all the QM activities.

1. The Governing Body must:

   a. Formally designate an entity, such as the QMC, to have the accountability for and oversight of all aspects of CHIP and evaluation of the effectiveness of the population served.

   b. Regularly receive written reports on the QM program activities that describe actions taken, progress in meeting objectives, and improvements made. The Governing Body reviews, on at least an annual basis, the written program description, work plan, and program evaluation of the QM program activities.

   c. Document actions taken by the Governing Body in response to findings from QM program activities and supply them to DOM upon request.

   d. Delegate a liaison that is directly accountable to DOM, the Governing Body, and the QMC for all QM activities and initiatives.

2. The QMC:

   a. Operates under policies and procedures that describe the role, structure, and function of the QMC that:

      i. Demonstrate that the QMC has oversight responsibility and input, including review and approval, for all QM program activities;

      ii. Ensure membership on the QMC and active participation by individuals, representative of the composition of the PCPs;

      iii. Document actions taken by the QMC in response to findings from QM program activities and supply them to DOM upon request;

      iv. Meet at least quarterly, and otherwise as needed; and

      v. Represent provider groups as well as clinical and non-clinical areas of the

organization.

b. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures and how these suggestions will be communicated with DOM.

3. Contractor must have sufficient material resources, and staff with the education, experience, and training to effectively implement the written QM program and related activities. Contractor must submit to DOM for approval the organizational chart and job descriptions prior to implementation.

Standard III: The QM program must include and implement methodologies that allow for the objective and systematic monitoring, measurement, and evaluation of the quality, appropriateness of care, and services provided to Members through quality of care studies and related activities, with a focus on identifying and pursuing opportunities for continuous and sustained improvement. The QM program must include professionally developed practice guidelines and standards of care appropriate to CHIP that are written in measurable and accepted professional formats, based on scientific evidence, applicable to PCPs for the delivery of certain types or aspects of health care, and regularly reviewed and updated.

1. The QM program must include clinical and/or quality indicators in the form of written, professionally developed, objective, and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

2. Practice guidelines and clinical indicators must be measurable and address the health care needs of the populations served by Contractor. The clinical areas addressed must include, but are not limited to:

   a. Pediatric and adolescent preventive care with a focus on Well-Baby and Well-Child services;

   b. DOM-defined clinical areas;

   c. Care Management related clinical outcomes and performance;

   d. Behavioral Health.

3. The QM program must provide practice guidelines, clinical indicators, and Medical Record keeping standards to all providers and appropriate Subcontractors. Contractor must also provide this information to Members upon request.

4. The QM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

   a. Person(s) or body responsible for making the final determinations regarding quality problems; and

b. Types of actions to be taken, such as:
   i. Education;
   ii. Follow-up monitoring and re-evaluation;
   iii. Changes in Contractor's processes, structures, and forms;
   iv. Informal counseling;
   vi. Assessment of the effectiveness of the actions taken; and
   vii. Reporting of issues to DOM.

5. The QM program must include methodologies that allow for the identification, tracking, verification, and analysis of outpatient quality of care concerns, Member quality of care Complaints, and quality of care referrals from other sources. Contractor must report findings from this analysis of quality of care concerns, Complaints, and referrals to DOM, with a discussion of how these findings will inform Contractor's quality improvement work plan and how Contractor will address these concerns. Contractor will include this information in the QM program evaluation.

6. The QM program must contain procedures for the completion of CAHPS® Member satisfaction surveys, and Contractor must conduct this survey annually. Contractor must report findings from this survey to DOM for the CHIP population, with a discussion of how the findings from the survey will inform Contractor's quality improvement work plan and effect changes to the program description.

7. The QM program must contain procedures for completion of a provider satisfaction survey of the PCPs serving CHIP, and must conduct this survey at least annually. Contractor must report findings from this survey to DOM, with a discussion of how the findings from the survey will inform Contractor's quality improvement work plan and effect changes to the program description.

Standard IV: Contractor must develop and implement mechanisms for integration of disease and health management programs that rely on prevention of complications as well as treatment of chronic conditions for Members identified through clinical and financial analysis of claims data provided by DOM, detailed health risk assessments, Member demographic information, and utilization patterns for preventive, secondary, and tertiary care.

Standard V: Contractor must have formal accountability for the QM program. If Contractor delegates this responsibility, Contractor must:

1. Have a detailed written description and work plan, approved by DOM, of the delegated activities, the delegate's accountability for these activities, and the frequency of reporting to Contractor and DOM.

2. Have written procedures approved by DOM for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

3. Document evidence to be submitted to DOM, of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans, quality meeting minutes, and regular specified reports.

4. Make available to DOM, and its authorized representatives, any and all records, documents, and data detailing its oversight of delegated QM program functions.

5. Ensure that delegated entities make available to DOM, and its authorized representatives, any and all records, documents, and data detailing the delegated QM program functions undertaken by the entity of behalf of Contractor.

6. Ensure the delegated entity adheres to the standards of the current Agreement.

Standard VI: Contractor must have written policies and procedures for record keeping on all of Contractor activities.

1. Contractor must ensure that these records are accurate, timely, and readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for records that promote maintenance of records in a legible, current, detailed, organized, and comprehensive manner that permits effective quality review.

2. DOM and/or its authorized Agents (i.e., any individual, corporation, or entity employed, contracted, or subcontracted with DOM) must be afforded prompt access to all records whether electronic or paper. All record copies are to be forwarded to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. DOM is not required to obtain written approval from a Member before requesting a Member's record from Contractor or any other agency.

Standard VII: Contractor must maintain systems that document implementation of the written QM program descriptions. Contractor must document that it is monitoring the quality of care across all services, all treatment modalities, and all sub-populations according to its written QM program description.

Standard VIII: Contractor must have standards and mechanisms to oversee the PCPs and report findings to DOM.

1. Contractor must oversee that the PCPs are adhering to:

   a. Federal, State, and DOM rules and regulations;

   b. PCP requirements;

c. Members' rights; and

d. Clinical and preventive guidelines of the program.

2. Contractor must submit to DOM for approval the initial versions and any revisions made to the following documents that relate to the QM program:

   a. Table of organization including job descriptions;

   b. Employee tools to include scripts, algorithms, and criteria;

   c. Program descriptions;

   d. Work plans;

   e. Program evaluations;

   f. Performance improvement projects;

   g. Focused studies; and

   h. Other documents related to the QM program, as designated by DOM.

3. DOM may request additional information from Contractor to assist in the determination of compliance with this Contract. To the extent possible, DOM shall provide reasonable advance notice of such reports. These may include:

   a. Committee meeting minutes;

   b. Work plan updates;

   c. Contractor documentation;

   d. Ad hoc reports and information;

   e. Contractor demonstrations; and

   f. Access to materials and the ability to observe during on-site evaluations.

EXHIBIT G: REPORTING REQUIREMENTS

This Exhibit is provided for reference only within this Contract. This Exhibit does not include all of the required reports and Deliverables under this Contract.

Contractor Report	Frequency	Time Frame
Monthly Management Report		
Enrollment Reports	Monthly	Fifth (5th) business day of second month following reporting period
Care Coordination		
Claims Processing Summary by Claim Type		
Member Enrollment Statistics and Trends		
Member Services Call Center Statistics		
Provider Network		
Prior Authorization and Denials		
Utilization Statistics and Trends		
Encounter Data Submission		
Member Grievances and Appeals (Summary)		
Enrollment		
New Member Identification Cards	Monthly	Within five (5) business days of request
Returned Member Identification Cards	Monthly	
Grievances and Appeals		
Detailed Log of Member Grievances and Appeals	Monthly	Within five (5) business days of request
Provider Network		
Accessibility and Availability Review	Quarterly and Annually	Thirtieth (30th) calendar day after the close of the quarter April first (1st)
Contracted Hospitals	Quarterly	Thirtieth (30th) calendar day after the close of the quarter
Network Geographic Access Assessment (GeoAccess)	Quarterly	
Provider Services Reports	Quarterly	

Contractor Report	Frequency	Time Frame
Provider Services Call Center Audit	Upon Request	Within five (5) business days of request
Provider Services Call Center Trainings	Upon Request	Within five (5) business days of request
Provider Training Manual and Plan	Initially and As Updated	Prior to Contract Go-Live and As Updated Prior to Use
Care Management		
Care Management Reports	Monthly	Fifth (5th) business day of second month following reporting period
CMS 416 Reports	Quarterly and Annually	Fifteenth (15th) business day after the close of the quarter Fifteenth (15th) business day of February for prior reporting year
Health Education and Marketing		
Enrollment, Disenrollment and Educational Materials Documentation of Review Dates	Annually	October first (1st)
Health Education and Prevention Work Plan	Annually	August fifteenth (15th) for the current state fiscal year
Health Education and Prevention Work Plan Updates	Quarterly	Thirtieth (30th) calendar day after the close of the quarter
Log of Completed Marketing Activities	Quarterly	Thirtieth (30th) calendar day after the close of the quarter
Marketing Work Plan	Annually	August fifteenth (15th) for the current state fiscal year
Member Health Education Materials (e.g., Member newsletters)	Annually	January fifteenth (15th) for the current calendar year
Member Information Packet	Annually	August fifteenth (15th) for the current state fiscal year
Member Services Call Center Audit	Upon Request	Within five (5) business days of request
Member Services Call Center Trainings	Upon Request	Within five (5) business days of request

Contractor Report	Frequency	Time Frame
Financial and Administrative		
Contractor Licensures	Annually	April first (1st)
DOI Filings	Quarterly and Annually	As specified by DOI
Encounter Data	Weekly	As specified by DOM
Encounter Data Completeness Plan	Annually	August fifteenth (15th) for the current state fiscal year
Enhanced Services	Annually	August fifteenth (15th) for the current state fiscal year
Fraud and Abuse Compliance Plan	Annually	August fifteenth (15th) for the current state fiscal year
Out-of-Pocket Maximum	Annually	August first (1st)
Medical Loss Ratio	Quarterly and Annually	Thirtieth (30th) calendar day after the close of the quarter and April first (1st)
Pharmacy Rebate Data	Semi-Annually	February first (1st) following the July thru December reporting period August first (1st) following the January thru June reporting period
Small and Minority Business Reporting	Annually	Contract signature date anniversary
Suspected Fraud and Abuse Cases	Quarterly	Thirtieth (30th) calendar day after the close of the quarter
Third Party Liability	Monthly	Thirtieth (30th) calendar day of every month
Quality Management (QM)		
CAHPS® Results	Annually	September thirtieth (30th)
HEDIS® Results	Annually	July thirty-first (31st)
Immunizations Report	Annually	July thirty-first (31st)

CHIPRA Performance Measure Results	Annually	August thirty-first (31st)
CHIPRA Performance Measure Result Updates	Quarterly	30th calendar day of the month after the close of the quarter
PIP Updates	Quarterly	Thirtieth (30th) calendar day of the month after the close of the quarter
PIP Results	Annually	August first (1st) following the reporting year

Contractor Report	Frequency	Time Frame
Provider Pay for Performance	Semi-Annually	April first (1st) following the October thru March reporting period October thirty-first (31st) following the April thru September reporting period
Provider Satisfaction Survey Questions and Methodology	Annually	August fifteenth (15th) for the current state fiscal year
Provider Satisfaction Survey Results	Annually	At least ninety (90) calendar days following the completion of the survey and no later than December first (1st) for the current calendar year
QM Program Description	Annually	August thirty-first (31st)
QM Program Evaluation	Annually	August thirty-first (31st)
QM Work Plan	Annually	August thirty-first (31st)
QM Work Plan Updates	Quarterly	Thirtieth (30th) calendar day after the close of the quarter
UM Program Description and Evaluation (specific to CHIP)	Annually	August thirty-first (31st)