

CONTRACT

BETWEEN

THE STATE OF MISSISSIPPI

DIVISION OF MEDICAID

OFFICE OF THE GOVERNOR

AND

A CARE COORDINATION ORGANIZATION (CCO)

State of Mississippi
Office of the Governor
Division of Medicaid
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201-1399

CONTRACT BETWEEN THE STATE OF MISSISSIPPI
DIVISION OF MEDICAID, OFFICE OF THE GOVERNOR

AND

This Contract is entered into this _____ day of _____, 2010 between the State of Mississippi, Office of the Governor, Division of Medicaid, with a principal place of business located at 550 High Street in the City of Jackson, County of Hinds, State of Mississippi and _____, 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 _____, in the City of _____, County of _____ State of _____.

WHEREAS, the State of Mississippi, Office of the Governor, Division of Medicaid ("Division") is charged with the administration of the Mississippi State Plan for Medical Assistance in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, (the "Act") and Miss. Code Ann. §43-13-101 et. seq. (1972, as amended);

WHEREAS, _____ ("Contractor") is an entity eligible to enter into a full risk capitated contract in accordance with Section 1903(m) of the Social Security Act and 42 CFR §438.6(b) and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR §438.2. The Contractor is licensed appropriately as defined by the Department of Insurance of the State of Mississippi pursuant to Miss. Code Ann. §83-41-305 (1972, as amended);

WHEREAS, the Division desires to contract with a Coordinated Care Organization (CCO) to obtain services for the benefit of certain Medicaid beneficiaries and the Contractor has provided to the Division continuing proof of the 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 the Division relies in entering into this Contract.

NOW THEREFORE, in consideration of the monthly payment of predetermined capitation rates by the Division, the full assumption of risk by the Contractor, and the mutual promises and benefits contained herein, the parties hereby agree as follows:

SECTION 1 - GENERAL PROVISIONS

1.1 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 to be a part of this 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.

1.2 State and Federal Law

At all times during the term of this Contract and in the performance of every aspect of this Contract, the Contractor shall strictly adhere to all applicable federal and state law (statutory and case law), regulations and standards, as have been or may hereinafter be established, specifically including without limitation, the policies, rules, and regulations of the Division.

Both parties that enter into this Contract understand that before the Contract can be executed, the Contract must be approved by the Centers for Medicare and Medicaid Services.

1.3 Representatives for the Division and the CCO

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

The Chief Executive Officer or a comparable representative shall serve as Contract Officer for the Contractor, with full decision-making authority for the Coordinated Care Organization, 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.

1.4 Notices

All notices pursuant to this Contract shall be deemed duly given upon delivery, if delivered by hand (against receipt), or facsimile, or three (3) calendar days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the address set forth below or to such other address as a party may designate by notice pursuant hereto.

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

1.5 Contractor Representations

The Contractor hereby represents and warrants to the Division that:

- a. The CCO has at least five (5) years of experience with a Medicaid program;
- b. The CCO is licensed in the State of Mississippi; or in the process of obtaining license in Mississippi to be effective by November 1, 2010, and licensed in another state;
- c. All of the information and statements contained in the MississippiCAN Contract Proposal and responses to additional letter inquiries submitted by the Contractor to the Division are true and correct as of the date of this Contract;
- d. A copy of the Proposal as approved by the Division is on file in the Contractor's office in Mississippi and any revisions to the Proposal as approved by the Division are posted in the Contractor's copy;
- e. There have been no material adverse changes in the financial condition or business operations of the Contractor since the date of the Application and the closing date of the most recent financial statements of the Contractor submitted to the Division;
- f. The CCO has not been sanctioned by a state or federal government within the last ten (10) years;
- g. The CCO has experience in contractual services providing the types of services described in the RFP and this Contract; and

- h. All covered services provided by the Contractor will meet the quality management standards of the Division, and will be furnished to Enrollees as promptly as necessary to meet each individual's needs.

1.6 Contractor Financial Reporting

The Contractor shall submit to the Division a copy of all quarterly and annual filings submitted to the Department of Insurance (DOI). A copy of such filing shall be submitted to the Division on the same day on which it is submitted to the Department of Insurance. Any revisions to a quarterly and/or annual DOI financial statement shall be submitted to the Division on the same day on which it is submitted to the DOI.

Throughout the duration of the Contract term, the 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 the Contractor shall enhance or update it upon request. Throughout the term of the Contract, the Contractor must notify the Division prior to making any changes to its basis of accounting.

The Department of Insurance regulates the financial stability of all appropriately licensed CCOs in Mississippi. The Contractor agrees to comply with all DOI standards.

The Contractor shall file with the Division, 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.

1.7 Ownership and Financial Disclosure

The Contractor shall comply with § 1318 of the Health Maintenance Organization Act (42 U.S.C. § 300e, et seq.), as amended, which requires the disclosure and justification of certain transactions between the Contractor and any related party, referred to as a Party in Interest. Transactions reported under 42 U.S.C. § 300e, et seq., as amended, must be justified as to their reasonableness and potential adverse impact on fiscal soundness.

The Contractor shall not knowingly have persons or their affiliate who is debarred, suspended, or otherwise excluded from participating in federal procurement activities as a director, officer, partner, or person with a beneficial ownership interest of more than 5% of the 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 the Contractor's obligations under this Contract.

Each Contractor, except Federally qualified Contractors, shall provide defined information on specified transactions with specified "parties in interest" for specified time periods as defined in the Public Health Services Act, §§ 1903(m)(2)(A)(viii) and 1903(m)(4).

Party in Interest:

- a. Any director, officer, partner, employee, or assignee responsible for management or administration of the Plan; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Plan; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of the Plan; or in the case of a Plan organized as a nonprofit corporation, an incorporator or Enrollee of such corporation under applicable State corporation law;
- b. Any organization in which a person described in subsection 1 is director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the Plan; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the Plan;
- c. Any person directly or indirectly controlling, controlled by, or under common control with the Plan;
- d. Any spouse, child, parent, or authorized agent of an individual described in subsections 1, 2 or 3 a, b, or c; or
- e. Any subcontractor of the Plan for the provision of items and services that is significant and material to the Contractor's obligations under its Contract with the State.

The information provided for transactions between the Contractor and a Party in Interest will include the following:

- a. The name of the Party in Interest in each transaction;
- b. A description of each transaction and, if applicable, the quantity of units involved;
- c. The accrued dollar value of each transaction during the calendar year; and
- d. A justification of the reasonableness of each transaction.

The Contractor shall notify the Division within five (5) calendar days after any publicly announced acquisition agreement, pre-merger agreement, or pre-sale agreement impacting the Contractor's ownership. Business transactions to be disclosed include, but are not limited to:

- a. Any sale, exchange, or lease of any property between the Contractor and a Party in Interest;
- b. Any lending of money or other extension of credit between the Contractor and a Party in Interest; and
- c. Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and a Party in Interest. Business transactions for purposes of this section do not include salaries paid to employees for services provided in the normal course of employment by the Contractor.

At least five (5) calendar days prior to any change in ownership, the Contractor must provide to the Division information concerning each Person with Ownership or Control Interest as defined in this Contract. This information includes but is not limited to the following:

- a. Name, address, and official position;
- b. A biographical summary;
- c. A statement as to whether the person with ownership or control interest is related to any other person with ownership or control interest such as a spouse, parent, child, or sibling;
- d. The name of any organization in which the person with ownership or control interest in the Contractor also has an ownership or control interest, to the extent obtainable from the other organization by the Contractor through reasonable written request; and
- e. The identity of any person, principal, agent, managing employee, or key provider of health care services who (1) has been convicted of a criminal offense related to that individual's or entity's involvement in any program under Medicaid or Medicare since the inception of those programs (1965) or (2) has been excluded from the Medicare and Medicaid programs for any reason. This disclosure must be in compliance with § 1128, as amended, of the Social Security Act, 42 USC §1320a-7, as amended, and 42 CFR § 455.106, as amended, and must be submitted on behalf of the Contractor and any subcontractor as well as any provider of health care services or supplies.

Federal regulations contained in 42 CFR § 455.104 and 42 CFR § 455.106 also require disclosure of all entities with which a Medicaid provider has an ownership or control relationship. The Contractor shall provide information concerning each Person with Ownership or Control.

The Contractor shall advise the Division, in writing, within five (5) business days of any organizational change or major decision affecting its Medicaid coordinated care 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.

Disclosure time periods:

- a. If the contract is being renewed or extended, the Contractor must disclose information on business transactions which occurred during the prior contract period.
- b. If the contract is an initial contract with Medicaid, but the Contractor has operated previously in the commercial or Medicaid markets, information on business transactions for the entire year proceeding the initial contract period must be disclosed.

Change of Ownership

A change of ownership of a Plan includes, but is not limited to, inter vivos 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 the Plan. 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.

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

Plans which undergo a change of direct ownership must notify the Division in writing prior to the effective date of the sale. The new owner must complete a new Contract with the Division and Enrollees will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract.

For entities with publicly traded parent companies, changes in beneficial ownership must be reported to the Division in writing within sixty (60) days of the end of each quarter.

1.8 Performance Standards

The Contractor shall perform all of the services and shall develop, produce and deliver to the Division all of the statements, reports, data, accountings, claims and documentation described herein, in compliance with all the provisions of this Contract, and the Division shall make payments to the Contractor on a capitated basis as described herein.

The Contractor shall acknowledge receipt of the Division's written, electronic, or telephonic requests for assistance, including case management evaluation requests, involving enrollees or providers *as expeditiously as the enrollee's health condition requires* or no later than two (2) business days from receipt of the request from the Division. The Contractor's acknowledgement must include a planned date of resolution. A detailed resolution summary advising the Division of the Contractor's action and resolution shall be rendered to the Division in the format requested. The Division's requests for case management services and/or requests for the Contractor to contact the enrollee/provider must occur within the time frame set forth by the Division.

The Division's urgent requests for assistance such as issues involving legislators, other governmental bodies, or as determined by the Division, must be given priority by the Contractor and completed in accordance with the request of and instructions from the Division. The Division shall provide guidance with respect to any necessary deadlines or other requirements. A resolution summary, as described by the Division, shall be submitted to the Division within deadlines established by the Division.

1.9 Division Policies and Procedures

The Contractor shall comply with all applicable policies and procedures of the Division, specifically including without limitation all policies and procedures applicable to each category of Covered Services for the MississippiCAN program which are also covered by the State Plan, 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 the Contractor with respect to Covered Services be more stringent than those specified in the applicable laws, policies and procedures.

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

- a. To the Division of Medicaid with its application for a Medicaid contract.
- b. Whenever it adopts the policy during the term of the contract.

- c. It must be consistent with the provisions of 42 CFR § 438.10.
- d. It must be provided to potentials before and during enrollment.
- e. It must be provided to enrollees within ninety (90) days after adopting the policy with respect to any particular service.

1.10 Administration, Management, Facilities and Resources

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

The Contractor shall be responsible for the administration and management of all aspects of the Plan and the performance of all of the covenants, conditions and obligations imposed upon the Contractor pursuant to this Contract. No delegation of responsibility, whether by subcontract or otherwise, shall terminate or limit in any way the liability of the Contractor to the Division for the full performance of this Contract. Medical management staffing shall be at a level that is sufficient to perform all necessary medical assessments and to meet all Mississippi Medicaid enrollees' case management needs at all times.

The CCO 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:

Executive Positions:

- Full time Chief Executive Officer, and/or Chief Operations Officer located in Mississippi.
- Chief Financial Officer
- Chief Medical Officer located in Mississippi.
- Chief Information Officer

Administrative Positions:

- Full time Provider Services Manager located in Mississippi.
- Full time Member Services Manager located in Mississippi.
- Quality Management Coordinator
- Utilization Management Coordinator
- Complaint/Grievance Coordinator
- Claims Administrator
- Other key personnel as identified by CCO.

The key personnel required to be located in Mississippi must be approved by the Division prior to assignment. The Division reserves the right to approve additional key positions as needed. Key management positions cannot be vacant for more than ninety (90) days.

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

The following are the minimum qualifications for staff and level of equipment:

- a. A designated Chief Executive Officer (Contract Officer), with decision-making authority, qualified by training and experience, to administer the day-to-day business activities conducted pursuant to this Contract;
- b. A Mississippi licensed physician to serve as Medical Director, who shall be responsible for all clinical decisions of the Plan, and who shall oversee and be responsible for the proper provision of Covered Services to Enrollees;
- c. A designated health care practitioner, qualified by training and experience, to serve as Quality Management Director;
- d. A designated person, qualified by training and experience, to be responsible for the Plan's utilization control;
- e. A designated person, qualified by training and experience in the processing and resolution of complaints and grievances;
- f. A designated person, qualified by training and experience, to be responsible for the medical record system;
- g. A designated person, qualified by training and experience, to be responsible for data processing and the provision of accurate and timely reports to the Division;
- h. Designated staff, qualified by training and experience, to be responsible for ensuring that all Plan Providers, and all Outside Providers to whom Enrollees may be referred, are properly licensed in accordance with federal and state law and regulations;

- i. Designated staff, qualified by training and experience, to be responsible for Enrollee Services;
- j. Designated staff, qualified by training and experience, to be responsible for Provider Services and network development;
- k. Designated staff, qualified by training and experience, to be responsible for marketing or public relations;
- l. Sufficient support staff to conduct daily business in an orderly manner, as determined through management and medical reviews; and
- m. Telecommunications with sufficient local and toll free lines and a call distribution and monitoring system sufficient to meet the needs of the Enrollees and providers 24 hours per day for consultation or referrals. This includes making available 24 hours, seven (7) days per week access by telephone to (1) a live voice, i.e., an employee of the Contractor or answering service personnel who will immediately page an on call medical professional who can make referrals for non-emergency services or give information/authorization about accessing services or how to handle medical problems during non-office hours or (2) an answering machine or other electronic device which directs the Enrollee or providers to the telephone number to use to contact the after-hours medical professional.

1.11 Base of Operations

The Contractor shall have an Administrative Office within fifteen (15) miles of the Division of Medicaid's High Street location in Jackson, Mississippi. The office must also have space for Division staff to work. The Mississippi Chief Executive Officer or person with comparable qualifications 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 or comparable person must be able to make decisions about coordinated care activities and shall represent the Contractor at meetings required by the Division. The Mississippi-based location must include a designee who can respond to issues involving systems and reporting, appeals, quality assessment, member services, EPSDT services management, pharmacy management, medical management, and case management.

CCOs must 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 disenrollments for other than loss of Medicaid eligibility. The health information system must collect data on enrollee and provider characteristics as specified by the State and on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.

CCOs will be required to operate both member and provider call centers. The member call center must be available to members 24 hours a day, seven days a week. The provider call center must operate during normal providers' business hours.

CCOs will be responsible for processing claims. The Division 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 Medicaid fee-for-service program. CCOs will be required to submit complete encounter data to the Division that meets federal requirements and allows the Division to monitor the program. CCOs that do not meet standards will be penalized.

1.12 Provider Network

The "provider network" is the panel of health service providers with which the CCO contracts for the provision of covered services to beneficiaries. All CCO contracted providers must also be enrolled in the Mississippi Medicaid program. CCOs will be required to recruit and maintain a provider network, using provider contracts as approved by the Division that includes all types of Medicaid providers and the full range of medical specialties necessary to provide the covered benefits, including contracts with out-of-state providers for medically necessary services. In establishing its provider network, CCOs will be required to contract with Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Access standards for the provider network will require the CCOs to insure that for primary care services members travel no more than sixty (60) minutes or sixty (60) miles in the rural regions and thirty (30) minutes or thirty (30) miles in the urban regions.

As access to non-hospital based emergency care is an issue of concern, CCOs will be required to include non-hospital urgent and emergent care providers in their networks.

The Contractor, subcontractor, nor representatives of Contractor shall provide false or misleading information to providers in an attempt to recruit providers for the Contractor's network. The 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.

1.13 Physician Incentive Plan

The Contractor may operate a physician incentive plan (PIP) only if no specific payment can be made directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an Enrollee. Contracts must be in compliance with the requirements set forth in 42 CFR §§ 422.208 and 422.210.

The Contractor shall provide to the Division of Medicaid the following disclosure:

- a. Whether services not furnished by physician/group is covered by incentive plan. If the PIP does not cover services furnished by physician/group, no further disclosure is required.
- b. The type of incentive arrangement, e.g. withhold, bonus, capitation.
- c. Percentage of withhold or bonus, if applicable.
- d. Panel size, and if patients are pooled, the approved method used.
- e. If the physician/group is at substantial financial risk, the Contractor must report proof the physician/group has adequate stop-loss coverage, including amount and type of stop-loss.

1.14 Cultural Competency

The Contractor must demonstrate cultural competency in its dealing, both written and verbal, with enrollees and must understand that cultural differences between the provider and the member cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

SECTION 2 - CONTRACT TERM

2.1 Term

The term of this Contract shall begin on the date this Contract is executed and shall continue until December 31, 2013.

SECTION 3 - ELIGIBILITY

3.1 Persons Eligible for Enrollment

To be eligible to enroll in the MississippiCAN program (“Plan”) established pursuant to this Contract, a person must be a Beneficiary of Mississippi Medicaid (Beneficiary). In addition, a Beneficiary must be a resident of the State of Mississippi and be a targeted, high cost beneficiary.

Targeted, high cost Medicaid beneficiaries are defined as those individuals in a category of eligibility that has been determined by claims where beneficiaries in categories of

eligibility with an above average per member per month cost and more than 1,200 member months, excluding those persons in an institution, dual eligibles and waiver members. For the purposes of this program, targeted, high cost beneficiaries include:

- a. Medicaid beneficiaries eligible for Supplemental Security Income;
- b. Medicaid beneficiaries eligible for Disabled Child at Home;
- c. Medicaid beneficiaries eligible for Working Disabled;
- d. Medicaid beneficiaries eligible for Foster Care; and
- e. Medicaid beneficiaries eligible for Breast/Cervical Group.

3.2 Persons Ineligible for Enrollment

The following categories of Beneficiaries are not eligible to enroll in the Plan:

- a. Beneficiaries who are, at the time of application for enrollment or at the time of enrollment, domiciled or residing in an institution, including nursing facilities, hospital swing bed units, intermediate care facilities for the mentally retarded, mental institutions, psychiatric residential treatment facilities, or correctional institutions;
- b. Beneficiaries enrolled in Home and Community Based Services (HCBS) Waiver programs. HCBS beneficiaries can disenroll from the HCBS program and can choose to enroll in the Plan, if they would be eligible in a target population;
- c. Individuals who meet the eligibility requirements for both Medicaid and Medicare benefits.

3.3 Eligibility Determinations

The Division will be responsible for confirming the eligibility of Enrollees for enrollment in the Plan. The Division will re-determine eligibility annually and will provide the Contractor with information relative to each Enrollee's continued eligibility for enrollment.

SECTION 4 - ENROLLMENT & DISENROLLMENT

4.1 Enrollment- General

Eligibility criteria for the MississippiCAN will be the same as the eligibility criteria for Mississippi Medicaid. Beneficiaries determined Medicaid eligible within the target populations will be eligible to enroll in the Plan (see Section 3.1). The Plan will operate on a statewide basis.

Enrollment of eligible Beneficiaries in the target populations shall be voluntary. The Beneficiary has the ability to choose the CCO of his/her choice. However, the Division reserves the right to assign a Beneficiary to a specific Plan.

It shall be the responsibility of the Contractor to provide for a continuous open enrollment period throughout the term of the contract. Enrolled beneficiaries will have an open enrollment period during the ninety (90) days following their initial enrollment in a CCO during which they can enroll in a different CCO “without cause” or disenroll from the program “without cause”. There will be an open enrollment period at least once every twelve (12) months after the initial date.

The Contractor must have in place policies and procedures that are acceptable to the Division for notifying primary care providers of the enrollees assigned to them within five (5) business days of the date on which the CCO receives the enrollment report from the Division.

Enrollees who fail to make a voluntary CCO selection within thirty (30) days of their enrollment will be auto-assigned to a CCO by the Division. Auto-assignment rules will include provisions to:

- Review paid claims data within the past six months and assign enrollee to a CCO which has a contract with a primary care physician with whom the beneficiary has a history.
- Determine if a family member is assigned to a CCO and assign the enrollee to that CCO.
- If not, assign the enrollee to CCO with a primary care provider closest to enrollee’s home address. If multiple CCOs meet this standard, auto-assignment will occur using a random process.

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.

The Contractor shall be responsible for keeping its network of providers informed of the enrollment status of each enrollee. The Contractor shall be able to report and ensure enrollment to network providers through electronic means.

4.2 MississippiCAN Enrollment Packets

The Division will mail enrollment packets to all beneficiaries in the target populations. These packets will include the following: enrollment form, MississippiCAN information

sheet, provider network directories from each CCO, brochure or information sheet for marketing benefits of each CCO, and a self-addressed stamped envelope for return of the enrollment form to the Division.

The Division will generate enrollment forms for each beneficiary in the target populations. These forms will include beneficiary name (as shown on the Medicaid card), address, date of birth, space for provision of telephone number (if available), pregnancy indicator, identification of primary language of household, a list of the CCOs with check boxes for marking a selection, a blank for PCP selection, date enrollment form completed, enrollee's signature or signature of parent or guardian, authorization for release of medical records for the Division and Contractor, and disclosure of the responsibility of Enrollees to pay for unauthorized health care services obtained from Out-of-Network. Beneficiaries who cannot write can make their mark before a witness and the witness will provide his/her signature.

4.3 Enrollee Information Requirements

The following information requirements must be met:

- a. The Contractor shall provide all enrollment notices, informational materials, and instructional materials relating to Enrollees or potential Enrollees in a manner and format that may be easily understood.
- b. The Contractor shall make its written information available in the prevalent non-English languages in the State of Mississippi, in compliance with the Division's Limited English Proficiency Policy.
- c. The Contractor shall make oral interpretation services available free of charge to each Enrollee for all non-English languages.
- d. The Contractor shall notify Enrollees that oral interpretation services and interpretation services for the hearing impaired and vision-impaired are available and how to access those services.

At the time the Enrollee is first enrolled in the Plan, the Contractor must provide the following information:

- a. General information about the basic features of care coordination, which populations are excluded from enrollment and which are subject to mandatory enrollment, and the responsibilities of the Contractor for coordination of Enrollee care.

- b. Specific information about the CCO and the MississippiCAN Program, including benefits covered, names, locations, telephone numbers of, and the identification of providers in the Plan that are not accepting new patients.
- c. Benefits that are available through the Contractor, but are not covered under the State Plan, and how and where Enrollees may obtain those benefits and how transportation is provided.
- d. The Contractor shall notify all Enrollees of their right to request and obtain the information specified in this Contract at least annually.
- e. The Contractor shall furnish to each of its Enrollees the information specified in this Contract within fourteen (14) days after the Contractor receives notice of the Beneficiary's enrollment.
- f. The Contractor shall give each of its Enrollees thirty (30) days' written notice of any significant change in the information specified in this Contract before its intended effective date.
- g. The Contractor must give written notice within fifteen (15) days of notice or issuance of termination of a provider to each Enrollee who received primary care from, or was seen on a regular basis by, the terminated provider.
- h. Any restrictions on the Enrollee's freedom of choice among network providers.
- i. Enrollee rights and protections as specified in 42 CFR § 438.100.
- j. Information on grievance and fair hearing procedures as specified in 42 CFR § 438.10(g)(1).
- k. The amount, duration, and scope of benefits available under the Plan in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled.
- l. Procedures for obtaining benefits, including authorization requirements.
- m. The extent to which, and how, Enrollees may obtain benefits, including family planning services, from out-of-network providers and informs the Enrollees that there are no restrictions on the choice of provider from whom the Enrollee may receive family planning services and supplies.
- n. The extent to which, and how, after-hours and emergency coverage are provided, including:

- i. What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in 42 CFR § 438.114(a);
- ii. The fact that prior authorization is not required for emergency services;
- iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;
- iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Plan;
- v. The fact that Enrollees have a right to use any hospital or other setting for emergency care;
- vi. The post-stabilization care services rules set forth at 42 CFR § 422.113(c);
- vi. Policy on referrals for specialty care and for other benefits not furnished by the Enrollee's primary care provider;
- vii. Advance directives, as set forth in 42 CFR § 438.6(i)(2); and
- ix. Additional information that is available upon request, including information on the structure and operation of the CCO as set forth in 42 CFR § 438.6(h).

4.4 Enrollment Period

Each Enrollee shall be enrolled in the Plan for a continuous period of twelve (12) months, subject to meeting applicable Medicaid eligibility requirements or to disenrollment. Enrollment begins at 12:01 a.m. on the first day of the first calendar month for which the Enrollee's name appears on the Enrollee Listing Report, and is automatically renewed for consecutive twelve (12) month Enrollment Periods until the Enrollee is disenrolled.

4.5 CCO Enrollee Information Packet

The Contractor shall make every effort to provide each enrollee, prior to the first day of the month in which their enrollment starts, an information packet indicating the enrollee's first effective date of enrollment. The contractor must ensure the information is provided no later than fourteen (14) days after the Contractor receives notice of the Beneficiary's enrollment. The Contractor shall utilize at least first class or priority mail delivery

services as the medium for providing the member identification cards. The Division must receive a copy of this packet on an annual basis for review. At a minimum, the enrollee information packet shall include:

- a. An introduction letter.
- b. A MississippiCAN identification card.
- c. A Provider Directory listing names, locations, and telephone numbers, including identification of providers that are not accepting new patients. This includes, at minimum, information on primary care physicians, specialists, and hospitals. Additionally, this directory must identify any restrictions that could impact the enrollee's freedom of choice among network providers. [42 CFR § 438.10(f)(6)]
- d. An Enrollee Handbook.

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

4.6 Enrollee Handbook

The Contractor shall submit a copy of the Enrollee Handbook to the Division for approval thirty (30) calendar days prior to distribution. The Division will respond within thirty (30) calendar days of the date of the Division's receipt of the request. The Contractor must update the Enrollee Handbook annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or a red-lined handbook showing before and after language. The red-lined document may be submitted on paper or electronically. Such changes must be approved by the Division prior to dissemination to enrollees and shall be submitted to the Division at least thirty (30) calendar days prior to planned use. The Division will respond to changes within thirty (30) calendar days of the date of the Division's receipt of the request. If the Division has not responded to the Contractor within thirty (30) days from receipt of the Enrollee Handbook, the Contractor may proceed with its printing schedule. Any changes to content subsequent to printing shall be corrected through an addendum or subsequent printing mutually agreed upon between the Contractor and the Division. The Enrollee Handbook must include instructions advising enrollees about EPSDT and how to access such services.

The Contractor's Enrollee Handbook shall reflect a copy of the enrollee rights (as referenced in this Contract) as provided at open enrollment.

The Enrollee Handbook must be provided to each enrollee after the Contractor receives notice of the enrollee's enrollment and prior to the first day of the month in which their enrollment starts. Once a year the Division will notify coordinated care enrollees of their right to request and obtain this information from the Contractor. The Handbook must include at a minimum the following information:

- a. Table of Contents
- b. Enrollee Eligibility - Terms and conditions under which coverage may be terminated.
- c. Choosing or Changing a CCO - Procedures to be followed if the enrollee wishes to change CCOs.
- d. Choosing or Changing a Primary Care Provider - Information about choosing and changing Primary Care Providers and a description of the role of Primary Care Providers.
- e. Making Appointments and Accessing Care
 - i. Appointment-making procedures and appointment access standards.
 - ii. A description of how to access all services including specialty care and authorization requirements.
 - iii. The role of the Primary Care Provider and the Contractor in directing care.
- f. Enrollee Services
 - i. A description of all available Coordinated Care covered services, including EPSDT and other preventive services, and an explanation of any service limitations, referral and prior authorization requirements. The description shall include the procedures for obtaining benefits, including family planning services, from out-of-network providers.
 - ii. A description of the enhanced services that the Contractor offers.
 - iii. Instructions on how to contact Member or Customer Services of the Contractor and a description of the functions of Member or Customer Services.

- iv. Notification that each enrollee is entitled to a copy of his or her medical records and instructions on how to request those records from the Contractor.
 - v. Instructions on how to utilize the after-hours Medical Advice and Customer Services Department of the Contractor.
 - vi. A description of the Contractor's confidentiality policies.
 - vii. Instructions on how enrolled individuals may acquire services that are covered under Mississippi Medicaid but not under the MississippiCAN.
- g. Emergency Care
- i. The telephone number to be used by enrollees for assistance in obtaining emergency care.
 - ii. The definition of an emergency using the "prudent layperson" standard, 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. Enrollees are to be instructed to use the emergency medical services available or to activate emergency services by dialing 911.
 - iii. A description of how to obtain emergency transportation and other medically necessary transportation.
 - iv. How to appropriately use emergency services and facilities.
 - v. Information indicating that emergency services are available out-of-network without any financial penalty to the enrollee.
 - vi. Definition of and information regarding coverage of post-stabilization services in accordance with 42 CFR § 422.113(c) and the locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under this contract.
- h. Enrollee Identification Cards
- i. A description of the information printed on the identification card.
 - ii. A description of when and how to use the identification card.

i. Enrollee Responsibilities

- i. A description of procedures to follow if:
 - (a) The enrollee's family size changes;
 - (b) The enrollee's address changes;
 - (c) The enrollee moves out of state; and/or
 - (d) He or she obtains or has health coverage under another policy or there are changes to that coverage.
- ii. Actions the enrollee can make towards improving his or her own health, enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor.
- iii. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 CFR § 489.100 and 42 CFR § 438.6 (i)(3) and (4).
- iv. Information regarding the enrollee's repayment of capitation premium payments if enrollment is discontinued due to failure to report truthful or accurate information when applying for Medicaid.

j. CCO Responsibilities

Notification to the enrollee that if he or she has another health insurance policy to notify the Division. Additionally, inform the enrollee that the CCO will coordinate the payment of claims between the two (2) insurance plans.

k. Grievances and Appeals [42 CFR § 438.10(f)]

A description of the grievance and appeals procedures including, but not limited to, the issues that may be resolved through the grievance or appeals processes; the process for obtaining necessary forms; and procedures applicable to the process.

- i. Timeframes to register a grievance or appeal with the Contractor or the Division as described in this Contract.
- ii. The availability of assistance in the filing process.

- iii. The toll-free numbers that the enrollee can use to file a grievance or an appeal by telephone.
 - iv. A description of the continuation of benefits process as required by 42 CFR § 438.420 and information describing how the enrollee may request continuation of benefits, as well as information on how the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
- l. The telephone numbers to register complaints regarding providers and CCOs.
- m. Interpretation and Translation Services
 - i. Information on how to access oral interpretation services, free of charge, for any non-English language spoken. [42 CFR § 438.10(c)(5)(i)]
 - ii. A multilingual notice that describes translation services that are available and provides instructions explaining how enrollees can access those translation services. [42 CFR § 438.10(c)(5)(i)]
 - iii. Information on how to access the handbook in an alternative format for special needs individuals including, for example, individual's with visual impairments. [42 CFR § 438.10(d)(2)]
- n. Program Referral and Service Changes

When there are changes to covered services, benefits, or the process that the enrollee should use to access benefits, (i.e., different than as explained in the member handbook), the Contractor shall ensure that affected enrollees are notified of such changes at least fourteen (14) calendar days prior to their implementation. For example: changes to who they call for transportation services, changes to covered and/or enhanced benefits, as described in the Contractor's member handbook, etc.
- o. Additional Information that is available upon request, including the following:
 - i. Information on the structure and operation of the Contractor.

- ii. Physician incentive plans as set forth in 42 CFR § 438.6(h).

4.7 Enrollee Identification Card

a. Enrollment Verification

The Division, or its duly authorized representative, shall provide the Contractor on a monthly basis a listing of all Coordinated Care enrollees who have selected or been assigned to the Contractor's plan. The listing, or "enrollment report," shall be provided to the Contractor sufficiently in advance of the enrollee's enrollment effective date to permit the Contractor to fulfill its identification card issuance and primary care provider notification responsibilities, described elsewhere in this Contract. Should the enrollment report be delayed in its delivery to the Contractor, the applicable timeframes for identification card issuance and primary care provider notification shall be extended by one (1) business day for each day the enrollment report is delayed. The Division and the Contractor shall reconcile each enrollment report as expeditiously as is feasible.

The Contractor must have in place policies and procedures that are acceptable to the Division for notifying primary care providers of the enrollees assigned to them within five (5) business days of the date on which the CCO receives the enrollment report from the Division.

The Contractor must have in place policies and procedures to ensure that out-of-network providers can verify enrollment in the Contractor's plan prior to treating a patient for non-emergency services. The Contractor must provide within five (5) business days of the date on which the CCO receives the enrollment report from the Division, the ability to verify enrollment by telephone or by another timely mechanism.

b. Enrollee Identification Card

The Contractor shall provide each enrollee an identification card that is recognizable and acceptable to the Contractor's network providers. The Contractor's identification card must also serve as sufficient evidence of coverage for non-participating providers. The Contractor's identification card will include, at a minimum, the name of the enrollee, the Mississippi Medicaid identification number, the name and address of the Contractor, the name of the enrollee's primary care provider, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, and a Contractor identification number, if applicable. The Contractor must submit and receive approval of the identification card from the Division prior to production of the cards.

The Contractor shall provide each enrollee an identification card, prior to the first day of the month in which their enrollment starts. The Contractor must mail all enrollee identification cards, utilizing at least first class or priority mail delivery services, in envelopes marked with the phrase “Return Services Requested.”

The Contractor shall provide the Division on a monthly basis the date and the number of identification cards mailed to new members enrolled each month. Additionally, the Contractor shall submit a monthly report of returned I.D. cards. The report must identify all returned cards, with the enrollee’s Mississippi Medicaid identification number, first/last name, incorrect address, and correct address, if available.

4.8 Orientation of New Enrollees

The Contractor shall provide each new Enrollee, within fourteen (14) calendar days following enrollment, written information with respect to the following:

- a. Qualifications (specialty, board certification, special areas of expertise) of Plan Providers, the procedures for selecting an individual physician, and how selection is made by the Contractor for Enrollees who do not select an individual physician;
- b. Each service location including the address, telephone numbers, office hours, and procedures for scheduling appointments;
- c. Benefits and services included in Covered Services; any limitations or exclusions applicable to Covered Services;
- d. Enrollee rights and responsibilities, including the right to formulate advance directives and to make decisions regarding organ donation;
- e. Referral policy for specialty care;
- f. Provisions for after-hours and emergency care;
- g. Procedures for obtaining emergency and non-emergency transportation available under the Plan;
- h. Procedures for changing primary care providers within the Plan;
- i. Referral policy for Family Planning Services;

- j. Policies regarding the appropriate treatment of minors, including information pertaining to EPSDT services;
- k. Any limitations that may apply to services obtained from Outside Providers, including a disclosure of the responsibility of Enrollees to pay for unauthorized health care services obtained from Outside Providers, and the procedures for obtaining authorization for such services;
- l. Circumstances under which an Enrollee may disenroll or be involuntarily disenrolled from the Plan;
- m. Procedures for notifying Enrollees of the termination or change in any benefits, services, or service locations;
- n. Procedures for voicing complaints and grievances or recommending changes in policies and services; and
- o. Procedures for appealing adverse determinations affecting coverage, benefits or enrollment to the Division.

4.9 Enrollee Information Materials

All written materials provided to Enrollees, including all marketing materials, Plan booklets, descriptions and information, policies and procedures, disclosures, and notices, shall be written in language that does not exceed the sixth (6th) grade level of reading comprehension. Enrollee information materials must be submitted to the Division for prior approval.

4.10 Enrollee Rights and Responsibilities

In accordance with 42 CFR § 438.100, the Contractor shall have written policies and procedures regarding enrollee rights and shall ensure compliance of its staff and affiliated providers with any applicable Federal and State laws that pertain to enrollee rights. Policies and procedures shall include compliance with: Title VI of the Civil Rights Act of 1964, as implemented at 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. At a minimum such enrollee rights include the right to:

- a. Receive information in accordance with 42 CFR § 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 enrollee'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 CFR §§ 164.524 and 164.526.
- g. Free exercise of rights and the exercise of those rights do not adversely affect the way the Contractor and its providers treat the enrollee.
- h. Be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210.

The written policies and procedures shall also address the responsibility of Enrollees to pay for unauthorized health care services obtained from Outside Providers and their right to know the procedures for obtaining authorization for such services. The Contractor shall also have policies addressing the responsibility of each Enrollee 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 Enrollees shall be included in the Enrollee information materials provided to new Enrollees. A copy of the Contractor's policies and procedures regarding Enrollee rights and responsibilities shall be provided to all Plan Providers and any Outside Providers to whom Enrollees may be referred.

4.11 Enrollee Protections

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

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

- b. Payment for services provided by the Contractor if the Contractor has not received payment from the State for the services, or if the provider, under contract or other arrangement with the 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 the Contractor that are in excess of the amount that normally would be paid by the enrollee if the services had been received directly from the Contractor; and
- d. The Contractor agrees to honor and be bound by Section 1128B(d)(1) of the Balanced Budget Act of 1997 which protects Enrollees against balance billing by subcontractors.

4.12 Communication Standards

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

The Contractor shall ensure that documents for its membership, such as the enrollee handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch-Kincaid total readability level that does not exceed the sixth (6th) grade level of reading comprehension. The document must set forth the Flesch-Kincaid 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.) Additionally, the Contractor shall ensure that written membership material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited. [42 CFR § 438.10(d)(1)(ii)]

The Contractor must make available enrollee handbooks in languages other than English when five percent (5%) of the Contractor's enrolled population is non-English speaking and speaks a common language.

The Contractor must institute a mechanism for all enrollees who do not speak English to communicate effectively with their primary care provider and with Contractor staff and subcontractors.

Oral interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education. [42 CFR § 438.10(c)(4)] Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the enrollee, a family enrollee or a friend. In addition, the Contractor must provide TTY/TDD services for the hearing impaired.

All enrollment, disenrollment and educational documents and materials made available to Coordinated Care enrollees by the Contractor must be submitted to the Division for its review annually, unless specified elsewhere in this contract.

4.13 Enrollee Education Program

The Contractor must develop, administer, implement, monitor, and evaluate a program to promote health education services for its new and continuing Coordinated Care enrollees, as indicated below. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch-Kincaid total readability of sixth (6th) grade level of reading comprehension or below. (These requirements shall not apply to language that is mandated by Federal or State laws, regulations or agencies.) The Contractor shall maintain a written plan for health education and prevention which is based on the needs of its enrollees. The Contractor shall submit an annual health education and prevention plan to the Division. At a minimum, the education plan shall describe topics to be delivered via printed materials, audiovisual or face-to-face communications and the time frames for distribution. Any changes to the education plan must be approved by the Division prior to implementation.

The Contractor will be responsible for developing and maintaining enrollee education programs designed to provide the enrollee with clear, concise, and accurate information about the Contractor's health plan. Additionally, the Contractor will provide the Division annually with a copy of all member health education materials, including any newsletters sent to its members.

The CCOs are expected to participate as partners with providers and beneficiaries in arranging for the delivery of health care services that improve health status in a cost effective way. The Division expects CCOs to connect beneficiaries to a medical home and implement comprehensive care management programs for the targeted populations. Care management will include a method to coordinate services with behavioral health providers, social services agencies and out-of-state providers to improve care and quality outcomes.

CCOs will be required to develop disease state management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, hemophilia, and organ transplants.

All CCOs will be expected to have a comprehensive health education program that will support the disease management programs.

CCOs will develop a comprehensive utilization management program to ensure the medical necessity of all services provided.

4.14 Enrollee Listing Report

The Division's fiscal agent will prepare an Enrollee Listing Report, prior to the first (1st) day of each month, listing all Enrollees enrolled in the CCO for that month. Adjustments will be made to each Enrollee Listing Report to reflect corrections and the enrollment or disenrollment of Enrollees reported to the fiscal agent on or about the twenty-fifth (25th) day of the preceding month. The fiscal agent will prepare a weekly roster listing all new Enrollees and a monthly report listing all disenrolled or closed files. The Enrollee Listing Report will be transmitted to the Contractor by electronic media. The Enrollee Listing Report shall serve as the basis for capitation payments to the Contractor for the ensuing month.

4.15 Marketing

The CCOs will not have the ability to directly market to the targeted beneficiaries. The Division will be responsible for creating a process to provide information about choice of CCOs and enroll the beneficiaries into their chosen CCO. All marketing of potential enrollees will be handled by the Division. No separate enrollment broker will be procured.

The Contractor shall develop marketing materials such as written brochures and fact sheets, which comply with the information requirements set forth herein. Marketing plans and materials shall not mislead, confuse, or defraud the Enrollees or the Division. Specifically, the Contractor cannot make any assertion or statement, whether written or oral, that the Beneficiary must enroll in the Contractor's Plan in order to obtain benefits or in order to not lose benefits or that the Contractor is endorsed by CMS, the federal or state government, or similar entity. The Contractor shall submit all marketing materials to the Division prior to distribution.

The Contractor shall develop and maintain procedures to log and resolve marketing complaints, including procedures that address the resolution of complaints against the Contractor, its employees, affiliated providers, agents, or contractors. 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 the Contractor and the complainant must be forwarded to the Division 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 beneficiaries. An organization may be subject to sanctions if it offers or gives something of value to a recipient that the organization knows or should know is likely to influence the

beneficiary'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 Medicaid. Additionally, organizations are prohibited from offering rebates or other cash inducements of any sort to beneficiaries.

a. Marketing Services

The Contractor shall:

- i. Submit to the Division for prior written approval complete marketing activities annually.
- ii. Submit all new and/or revised marketing and informational materials to the Division before their planned distribution. The Division will approve, deny, or ask for modifications to the materials within thirty (30) days of the date of receipt by the Division. (42 CFR § 438.104)
- iii. The Contractor may distribute marketing materials to Medicaid beneficiaries where the beneficiary is currently enrolled with the Contractor.
- iv. Coordinate and submit to the Division all of its schedules, plans, and informational materials for community education, networking and outreach programs. The schedule shall be submitted to the Division at least two (2) weeks prior to any event.
- v. Assure that all marketing and informational materials shall set forth the Flesch-Kincaid readability scores at or below sixth (6th) grade reading level and certify compliance therewith.
- vi. Be subject to a fine or other sanctions if it conducts any marketing activity that is not approved in writing by the Division. (42 CFR § 438.700).

b. Allowable CCO Marketing Activities

The Contractor may engage in the following promotional activities:

- i. Notification to the public of the CCO in general in an appropriate manner through appropriate media, throughout its enrollment area.
- ii. Distribution through the Division or the Division's agent of promotional materials pre-approved by the Division.

- iii. Pre-approved informational materials for television, radio, and newspaper dissemination.
- iv. Marketing and/or networking at community sites or other approved locations for name recognition, which must be prior approved by the Division.
- v. Hosting or participating in health awareness events, community events, and health fairs, pre-approved by the Division, in which the Division also participates or provides observation of CCO participation. Prior approved non-cash promotional items are permitted, but not for solicitation purposes. The Division will be responsible for supplying copies of the benefit charts, if distributed at such events.
- vi. The Contractor is allowed to offer non-cash incentives to their enrolled members for the purposes of rewarding for compliance in immunizations, prenatal visits, or participating in disease management, etc. The 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 the Contractor's plan. The Contractor must submit all incentive award packages to the Division for approval prior to implementation.

c. Prohibited Marketing and Outreach Activities

The following are prohibited marketing and outreach activities targeting prospective enrollees under this Contract:

- i. Engaging in any informational or marketing activities which could mislead, confuse, or defraud enrollees or misrepresent the Division. (42 CFR § 438.104)
- ii. Directly or indirectly, conducting door-to-door, telephonic, or other "cold call" marketing of enrollment at residences and provider sites. (42 CFR § 438.104)
- iii. Direct mailing. All mailings must be processed through the Division or its agent to members of the Contractor.
- iv. Making home visits for marketing or enrollment.
- v. Offering financial incentive, reward, gift, or opportunity to eligible enrollees as an inducement to enroll in the Contractor's plan other than

to offer the health care benefits from the Contractor pursuant to their contract or as permitted above.

- vi. Continuous, periodic marketing activities to the same prospective enrollee, e.g., monthly or quarterly give-aways, as an inducement to enroll.
- vii. Using the Division eligibility database to identify and market its plan to prospective enrollees or any other violation of confidentiality involving sharing or selling enrollee lists or lists of eligibles with any other person or organization for any purpose other than the performance of the Contractor's obligations under this Contract.
- viii. Engaging in marketing activities which target prospective enrollees 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.
- ix. Contacting enrollees who disenroll from the plan by choice after the effective disenrollment date except as required by this Contract or as part of a Division approved survey to determine reasons for disenrollment.
- x. Engaging in marketing activities which offer potential enrollees a rebate or a discount in conjunction with the sale of any private insurance, as a means of influencing enrollment or as an inducement for giving the Contractor the names of prospective enrollees. (42 CFR § 438.104)
- xi. No enrollment related activities may be conducted at any marketing, community, or other event.
- xii. No educational or enrollment related activities may be conducted at Department of Human Services offices unless authorized in advance by the Division.
- xiii. No assertion or statement (whether written or oral) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity. (42 CFR § 438.104)
- xiv. No assertion or statement that the recipient must enroll with the Contractor in order to keep from losing benefits. (42 CFR § 438.104)

4.16 Disenrollment

An Enrollee must be disenrolled from the Plan if the Beneficiary:

- a. No longer resides in the State of Mississippi;
- b. Is deceased;
- c. No longer qualifies for medical assistance under one of the Medicaid eligibility categories in the targeted population.

The Contractor must notify the Division within three (3) days of their request that an Enrollee is disenrolled for a reason listed above and provide written documentation of disenrollment. Disenrollment shall be effective on the first day of the calendar month for which the disenrollment appears on the Enrollee Listing Report.

The Contractor shall not disenroll an Enrollee because of an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from Enrollee's special needs (except when Enrollee's continued enrollment in the CCO seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.) The Contractor must file a request to disenroll an Enrollee with the Division in writing stating specifically the reasons for the request if the reasons are for other than those specified above.

An Enrollee may request disenrollment without cause during the ninety (90) days following the date the Division sends the Enrollee notice of enrollment or the date of the Enrollee's initial enrollment, whichever is later, during the annual open enrollment period, upon automatic reenrollment if the temporary loss of Medicaid eligibility has caused the Enrollee to miss the annual disenrollment opportunity, or when the Division imposes an intermediate sanction on the Contractor as specified in this Contract.

An Enrollee may request disenrollment from the CCO for cause if the CCO does not, because of moral or religious objections, cover the service the Enrollee seeks, the Enrollee needs related services to be performed at the same time, not all related services are available within the network, the Enrollee's primary care provider or another provider determines receiving the services separately would subject Enrollee to unnecessary risk, poor quality of care, lack of access to services covered under the Plan, or lack of access to providers experienced in dealing with the Enrollee's health care needs. Enrollee requests for disenrollment must be directed to the Division either orally or in writing.

The effective date of any approved disenrollment will be no later than the first day of the second month following the month in which the Enrollee or the Plan files the request with the Division.

4.17 Disenrollment of Nursing Home Residents

Enrollees who become Nursing Home Residents must be disenrolled from the Plan. For Enrollees who become Nursing Home Residents before the 15th of a month, the Contractor will be required to refund the monthly capitation payment for that Enrollee to the Division. For Enrollees who become Nursing Home Residents on or after the 15th of a month, the Contractor will be allowed to keep the monthly capitation payment for that Enrollee.

4.18 Re-enrollment

An Enrollee who is disenrolled solely because s/he loses Medicaid eligibility for a period of two (2) months or less will be automatically reenrolled in the same CCO with which s/he was previously enrolled. There shall be no retroactive enrollment in the MississippiCAN program.

4.19 Delay of Enrollment Due To Hospitalization

Enrollees who are inpatients in hospitals, other than those listed in this Contract, at the scheduled time of enrollment are restricted from enrollment with the CCO until the first day of the month following discharge.

An enrollee who is discharged from one hospital and admitted to another hospital within twenty-four (24) hours (facility to facility transfers) for continued treatment of the same diagnosis shall not be considered discharged under this section.

SECTION 5 - BENEFITS

5.1 Covered Services

The Contractor shall provide the Covered Services allowed under MississippiCAN. The Contractor shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. An emergency medical condition is 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.

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

- a. An Enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes of placing the health of the individual (or pregnant woman and unborn child) in serious jeopardy, or would not have resulted in serious impairment to bodily functions, or would not result in serious dysfunction of any bodily part.
- b. The Plan instructed the Enrollee to seek emergency services. The Contractor shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms, refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's primary care provider, Contractor, or Division of the Enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services. An Enrollee 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 patient. The attending emergency physician, or the provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor for coverage and payment.

The Contractor shall cover and pay for post-stabilization care and services in accordance with the provisions of 42 CFR § 422.113(c). Post-stabilization care and services are covered services related to an emergency medical condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition.

The Contractor is financially responsible for post-stabilization care services obtained within or outside the Contract that are not pre-approved by a Plan provider or other Plan representative, but administered to maintain, improve or resolve the enrollee's stabilized condition if:

- The Contractor does not respond to a request for pre-approval within one hour;
- The Contractor cannot be contacted; or
- The Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a Plan physician and the treating physician may

continue with care of the patient until a Plan physician is reached or one of the criteria of 42 CFR § 422.113(c) is met.

The Contractor must not charge Enrollees when post-stabilization care services it has not pre-approved ends. Post-stabilization care services not approved by the Plan end when:

- A Plan physician with privileges at the treating hospital assumes responsibility for the Enrollee's care;
- A Plan physician assumes responsibility for the Enrollee's care through transfer;
- A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or
- The Enrollee is discharged.

5.2 Services Not Covered

a. Behavioral Health Services

Contractors will not be responsible for coverage of behavioral health services. Behavioral health services are defined as any inpatient or residential treatment for mental disorders; any outpatient hospital mental health treatment (revenue codes 90X and 91X or procedure codes 908XX); any procedure using procedure code 908XX; other mental health services using HCPCS codes for programs described in Medicaid Policy Sections 15 or 21; and any service outlined in the approved waivers for IDDD or SED (MYPAC).

The Contractor will be responsible for coverage of all drugs, including psychotropic drugs, for Members as many of these medicines are prescribed by primary care physicians.

b. Non-emergency Transportation Services

Contractors will not be responsible for coverage of non-emergency transportation services. The Division has an existing contract with a provider for these services. However, the Contractor will be required to coordinate with the non-emergency transportation provider for provision of these services to Members.

c. Inpatient Hospital Services

Contractors will not be responsible for coverage of inpatient hospital services. However, the Contractor will be responsible for coverage of services billed by physicians and other providers during a hospital stay (including, but not limited to, physician surgeries, inpatient physician visits, etc).

5.3 Accessibility

The Contractor shall ensure that all Covered Services are as accessible to Enrollees (in terms of timeliness, amount, duration, and scope) as those services are to non-enrolled Beneficiaries in the service area; and that no incentive is provided, monetary or otherwise, to providers for withholding from Enrollees medically necessary services. The Contractor shall make available accessible facilities, service locations, and personnel sufficient to provide Covered Services consistent with the requirements specified in this Contract.

Emergency medical services shall be available within thirty (30) minutes typical travel time to Enrollees twenty-four (24) hours a day, seven (7) days a week, either in the facilities of providers who have contracted with the Contractor or through arrangements approved by the Division with other providers. The Contractor must assure that primary care physician services are available, on a timely basis, to comply with the following standards: urgent care - within one day; routine sick patient care - within one week; and well care - within one month.

The Contractor must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

Each 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 physician who has hospital admitting privileges. All Plan providers must be accessible to Enrollees and must maintain a reasonable schedule of operating hours.

The Division shall have the right to periodically review the adequacy of service locations and hours of operation, and will require corrective action to improve Enrollee access to services. The Contractor shall be responsible for full payment for services received by Enrollees outside the Plan because the Plan services were not available as required pursuant to the terms of this contract.

The Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of the Enrollee who is his or her patient for the following:

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

- b. Any information the Enrollee needs in order to decide among all relevant treatment options;
- c. The risks, benefits, and consequences of treatment or non-treatment;
- d. The Enrollee'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.

5.4 Choice of Health Professional

Each Enrollee shall be allowed to choose his or her primary care health professional from among all the available Plan Providers to the extent possible, reasonable, and appropriate. The Contractor's panel of Plan Providers shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency. If the Enrollee does not choose a primary health care professional, the Contractor may assign the Enrollee a primary health care professional. An Enrollee who has received prior authorization from the Contractor for referral to a specialist or for inpatient care shall be allowed to choose from among all the available specialists and hospitals within the Plan to the extent possible, reasonable, and appropriate.

If an Enrollee's primary care provider, specialist, or other provider is no longer available to the Enrollee through the Plan, the Contractor shall have a plan to ensure continuity and coordination of care and to assist the Enrollee in selecting a Plan Provider. The Plan shall include notice to the Enrollees affected by the loss of the provider, information about selecting a new provider, and a date after which Enrollees who are undergoing an active course of treatment cannot use the provider who is no longer among the Plan Providers.

The Contractor must have written policies and procedures for assigning each of its enrollees to a primary care provider. Any changes or modifications to these policies and procedures must be submitted by the Contractor to the Division at least thirty (30) calendar days prior to implementation and must be approved by the Division. These policies and procedures shall include the features listed below:

a. Providers Qualifying as Primary Care Providers (PCP)

The following types of specialty providers may perform as Primary Care Providers:

- i. Pediatricians;
- ii. Family and General Practitioners;

- iii. Internists;
- iv. Obstetrician/Gynecologists;
- v. Nurse Practitioners;
- vi. Physician Assistants;
- vii. Specialists who perform primary care functions, e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics; or
- viii. Other providers approved by the Division.

b. Specialists as PCPs

Enrollees with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their primary care provider be a specialist. The Contractor shall make a good faith effort to ensure that a child for whom the PCP is a specialist receives EPSDT services, including immunizations and dental services. The Contractor shall have in place procedures for ensuring access to needed services for these enrollees or shall grant these PCP requests, as is reasonably feasible and in accordance with Contractor's credentialing policies and procedures.

c. Enrollee Choice of PCP

The Contractor shall offer each enrollee covered under this Contract the opportunity to choose from at least two (2) PCPs affiliated with the Contractor based on availability.

d. Default Assignment of PCP

If the enrollee does not request an available PCP within thirty (30) days of enrollment with a Contractor, then the Contractor must assign the new enrollee to a PCP within its network within sixty (60) days of enrollment, taking into consideration such known factors as current provider relationships (as indicated on the Health Status Survey Questionnaire), language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The Contractor then must notify the enrollee in writing, on or before

the first effective date of enrollment with the Contractor, of his or her PCP's name, location, and office telephone number.

e. Change of PCP

The Contractor must allow enrollees to select or be assigned to a new PCP when requested by the enrollee, when the Contractor has terminated a PCP, or when a PCP change is ordered as a part of the resolution to a formal grievance proceeding. When an enrollee changes his or her PCP, the Contractor must make the enrollee's medical records or copies thereof available to the new PCP within ten (10) business days from receipt of request.

5.5 Provider Discrimination Prohibited

The 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 on the basis of the license or certification. The Contractor shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. Nothing in this provision, however, shall require the Contractor to contract with providers beyond the number necessary to meet the needs of Enrollees or preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees. The 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 Social Security Act.

5.6 Default Provider Enrollment Process

Default provider enrollment by the Plan will be through equivalent distribution among delivering health care professionals who are enrolled in the Program and have the capacity to serve additional Enrollees. At program implementation and thirty (30) days post implementation, the Contractor is required to offer participation in its provider network to qualified delivering Health Care Professionals who agree to the participation requirements. Afterwards the Contractor will offer open enrollment at least annually. Each provider must meet required qualifications to participate as a program provider.

5.7 Authorization of Services

The Contractor will not provide authorization for inpatient hospital services. Providers will continue to seek authorization from the agency's QIO Contractor.

The Contractor must define service authorization in a manner that at least includes an Enrollee's request for the provision of a service. The Contractor must have in place written policies and procedures for the processing of requests for initial and continuing authorizations of services. The Contractor must have a mechanism to ensure consistent application of review criteria for authorization decisions that includes consultation with the requesting provider when appropriate. Any decision 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 health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease. The Contractor must notify the requesting provider and the Enrollee in writing of any decision by the Contractor to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements specified in 42 CFR § 438.404. For standard authorization decisions, the Contractor must provide notice within fourteen (14) calendar days following receipt of the request for services with a possible extension of up to fourteen (14) additional calendar days if the Enrollee or the provider requests an extension or the Contractor justifies to the Division a need for additional information and how the extension is in the Enrollee's best interest. Expedited authorization decisions are those in which a provider indicates or the Contractor determines that following the standard authorization decision timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor must provide decision notice no later than three (3) working days after receipt of the request for service for an expedited authorization request with a possible extension of up to fourteen (14) additional calendar days if the Enrollee or the provider requests an extension or the Contractor justifies to the Division a need for additional information and how the extension is in the Enrollee's best interest. Compensation to individuals or utilization management entities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Enrollee.

5.8 Case Management

The Contractor shall be responsible for the management and continuity of medical care for all Enrollees through the following minimum functions:

- a. Each Enrollee must be allowed to choose his or her primary care health professional to the extent reasonable and appropriate. Continuity of care with that provider will be ensured by scheduling all routine visits with that provider unless the Enrollee requests otherwise.

- b. Appropriate referral and scheduling assistance for Enrollees needing specialty health care services, including those identified through EPSDT.
- c. Documentation of referral services and medically indicated follow-up care in each Enrollee's medical record.
- d. Monitoring and treatment of Enrollees with ongoing medical conditions according to appropriate standards of medical practice.
- e. Documentation in each medical record of all urgent care, emergency encounters, and any medically indicated follow-up care.
- f. Coordination of hospital discharge planning.
- g. Determination of the need for non-covered services and referral of Enrollees to the appropriate service setting, utilizing assistance as needed from the Division.
- h. Coordination with other health and social programs such as Individuals with Disabilities Education Act (IDEA), Part B and Part C; 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.
- i. Ensuring that Enrollees 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 restrict a health care provider's ability to advise patients about medically necessary treatment options violate federal law and regulations.
- j. Ensuring that Medicaid providers are not limited in the scope of practice, as defined by federal and state law, in providing services to Plan Enrollees.
- k. Ensuring that when a provider is no longer available through the Plan, the Contractor allows Enrollees who are undergoing an active course of treatment to have continued access to that provider for a limited period of time.
- l. The Contractor shall provide for a second opinion from a qualified health care professional within the network, or arrange for the Enrollee to obtain one outside the network, at no cost to the Enrollee.

- m. If the Network is unable to provide necessary medical services covered under the contract to a particular Enrollee, the Contractor must adequately and timely cover these services out of network for the Enrollee, for as long as the Contractor is unable to provide them. The out-of-network providers must coordinate with the Contractor with respect to payment.
- n. The Contractor must produce a treatment plan for Enrollees determined to need a course of treatment or regular care monitoring. The treatment must be developed by the Enrollee's primary care provider with Enrollee participation, and in consultation with any specialists caring for the Enrollee.

5.9 Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT)

The Division requires that the Contractor cooperate to the maximum extent possible with efforts to improve the health status of Mississippi citizens, and to actively participate in the increase of screening percentages. Toward that end, the Contractor shall provide the full range of EPSDT services as defined in, and in accordance with, the Division's policies and procedures for EPSDT and the provisions of this Contract. Such services shall include, without limitation, periodic health screenings and appropriate and up-to-date immunization using the ACIP Recommended Immunization Schedule of all Enrollees age one (1) or under one, in accordance with the Periodicity Schedule established for EPSDT services, including periodic examinations for vision, dental, and hearing and all medically necessary services. The Contractor shall identify and immunize all Enrollees age one (1) or under one whose medical records do not indicate up-to-date immunizations. The following minimum elements are to be included in the Periodic Health Screening Assessment:

- a. Comprehensive health and development history (including assessment of both physical and mental development);
- b. Comprehensive unclothed physical examination;
- c. Immunizations appropriate to age and health history;
- d. Assessment of nutritional status;
- e. Laboratory tests (including finger stick hematocrit and urinalysis (dip-stick) and sickle cell screen if not previously performed); Blood lead levels must be tested pursuant to the EPSDT provider manual. TB skin testing and RPR serology testing must be done if indicated;
- f. Developmental assessment; and

- g. Health education and anticipatory guidance.

5.10 Referrals for Services Not Covered Under the Contractor

The Contractor shall refer Enrollees to providers enrolled in the Medicaid fee-for-service programs for all medically necessary services not covered under the Plan. The Contractor shall have written policies and procedures for the referral of Enrollees for Non-covered services which shall provide for the smooth transition to Outside Providers and assistance to Enrollees in obtaining a new primary care physician, if appropriate. These procedures shall be applicable to the referral of Enrollees to Outside Providers upon disenrollment, irrespective of the reasons for disenrollment.

5.11 Advance Directives

The Contractor shall develop, document, and maintain advance directive policies that comply with 42 CFR § 422.128 and with State law. The Contractor shall provide adult enrollees with written information on its advance directives policies. The Contractor shall inform the Enrollees as to the implementation of those rights according to State law. Any written information provided by the Contractor must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of change. The Contractor must also inform the Enrollees that complaints concerning noncompliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health.

5.12 Payment of Providers

The Contractor shall reimburse Providers as follows:

- a. The Contractor shall reimburse Outside Providers for the following Covered Services:
 - i. Specialty care for which the Contractor has referred the Enrollee to an Outside Provider.
 - ii. Out-of-area services provided to an Enrollee in accordance with the Contractor's approved plan for out of area services.
- b. Federally Qualified Health Centers (FQHC) - The Contractor shall reimburse FQHCs at the same encounter rate as paid by the Division.
- c. Rural Health Centers (RHC) - The Contractor shall reimburse RHCs at the same encounter rate as paid by the Division.

Within thirty (30) days following the date the claim is received by the Contractor from an Outside Provider, the Contractor shall process each clean claim, and for other claims the Contractor shall notify the provider of the status (pend, deny, or other reason) of the claim and if applicable, the reason the claim cannot be paid. Claims for Emergency Medical Services and Family Planning Services shall be paid at the applicable Medicaid fee-for-service rate in the absence of an agreement otherwise between the Contractor and the Outside Provider. The Contractor shall submit to the Division its criteria for authorization or denial of payment for services rendered by Outside Providers. The Division shall review all such criteria for conformity with Medicaid policy and must approve the criteria prior to implementation by the Contractor. The Contractor shall distribute its criteria for approval or denial of outside services to all Outside providers to whom Enrollees are referred and shall distribute its criteria for approval of outside Emergency Services to all facilities providing Emergency Medical Services known to the Contractor and located within a thirty (30) mile radius. All criteria shall be kept current.

The Contractor shall have written policies and procedures, in form and content acceptable to the Division, providing a mechanism for Providers to appeal the denial of claims by the Contractor. If a claim is denied following completion of the Contractor's internal appeals procedure, the Contractor shall provide written notice of the denial to the Provider and the Division. Notice to the Provider shall include a statement that the Provider may appeal the determination to the Division; the procedure for submitting an appeal to the Division; and any forms required for an appeal. The Division shall make the final determination as to whether the Contractor is obligated to pay a claim pursuant to the section and shall provide written notice to the Contractor and the Provider setting forth its determination. The Contractor shall pay each claim within thirty (30) calendar days following the date of each notice by the Division indicating that it has made a final determination requiring payment of the claim by the Contractor.

5.13 Payments from Enrollees

Enrollees utilizing medical services which are not medically necessary or who obtain Covered Services from Outside Providers without prior authorization and referral by the Contractor shall be responsible for payment in full of all costs associated with such services.

The Contractor shall not require any co-payments, deductibles or other cost sharing by Enrollees for Covered Services under this Contract, nor may the Contractor charge Enrollees for missed appointments. Neither shall Enrollees who are insured under private health plans be required to pay any portion of the medical fees for Covered Services under this contract, even during the deductible periods of these other health plans.

5.14 Medically Necessary Services

Medically necessary services are defined as services, supplies, or equipment provided by a licensed health care professional that:

- a. Are appropriate and consistent with the diagnosis or treatment of the patient's condition, illness, or injury;
- b. Are in accordance with the standards of good medical practice consistent with the individual patient's condition(s);
- c. Are not primarily for the personal comfort or convenience of the Enrollee, family, or Provider;
- d. Are the most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Enrollee;
- e. Are furnished in a setting appropriate to the patient's medical need and condition and, when applied to the care of an inpatient, further mean that the Enrollee's medical symptoms or conditions require that the services cannot be safely provided to the Enrollee as an outpatient;
- f. Are not experimental or investigational or for research or education;
- g. Are provided by an appropriately licensed practitioner; and
- h. Are documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

The only limitation on services for children is that they are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an EPSDT screen, periodic or interperiodic, whether or not such services are covered or exceed the benefit limits in the Medicaid State Plan. All services determined to be medically necessary must be covered.

5.15 Clinical Laboratory Improvement Act (CLIA)

The Contractor must ensure that all laboratory testing sites providing services under the contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.

SECTION 6 - QUALITY MANAGEMENT

6.1 Quality Management System and Quality Improvement Program

The Contractor shall implement and operate an internal quality management (QM) system and quality improvement (QI) program in compliance with 42 CFR § 438.240 which:

- a. Provides for review by appropriate health professionals of the process followed in providing Covered Services to Enrollees;
- b. Provides for systematic data collection of performance and patient outcomes;
- c. Provides for interpretation and dissemination of performance and outcome data to Plan providers and Outside Providers approved for referrals for specialty;
- d. Provides for the prompt implementation of modifications to the Contractor's policies, procedures and/or processes for the delivery of Covered Services as may be indicated by the foregoing;
- e. Provides for the maintenance of sufficient encounter data to identify each practitioner providing services to Enrollees, specifically including the unique physician identifier for each physician; and
- f. Complies with Miss. Code Ann. § 83-41-313 *et. seq.* (1972, as amended), of the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plan Protection Act and Miss. Code Ann. § 83-41-409 (1972, as amended) of the Patient Protection Act of 1995.

The Contractor will have a written description of the QM program that focuses on health outcomes and that includes the following:

- a. Detailed objectives, a definition of the scope of the program, planned projects or activities for the year and the methodology for identifying other projects that require evaluation.
- b. Composition of the QM committee.
- c. Procedures for remedial action when deficiencies are identified.
- d. Specific types of problems requiring corrective action.

- e. Provisions for monitoring and evaluating corrective action to ensure that actions for improvement have been effective.
- f. Procedures for provider review and feedback on results.
- g. Semi-annual planned evaluation of the QM program as part of the Internal Audit that includes:
 - i. Description of completed and ongoing QI activities including case management effectiveness evaluation;
 - ii. Identified issues, including tracking of issues over time;
 - iii. Trending of measures to assess performance in quality of clinical care and quality of service to Enrollees; and
 - iv. An analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service to Enrollees; and overall effectiveness of the QM program.
- h. The Contractor must have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- i. The Contractor must identify opportunities to access health care disparities.

The Contractor will submit a copy of this evaluation to the Division semi-annually. The QM program description will be submitted to the Division for written approval prior to implementation and annually thereafter. The Division reserves the right to expand the QM Program as needed to assure quality beneficiary care.

Upon request, the Contractor will make available to its Enrollees and practitioners information about the Plan's QI program and a report on the Plan's progress in meeting its goal.

6.2 Quality Management Committee

The Contractor must operate under a formal organizational structure for the implementation and oversight of the internal quality management program. The formal organizational structure must include at a minimum, the following:

- a. Established parameters of operation including specifics regarding role, function and structure;

- b. A designated health care practitioner, qualified by training and experience, to serve as the QM director;
- c. A committee Enrolleeship which includes representatives from the provider groups as well as clinical and non-clinical areas of the organization;
- d. A senior executive who is responsible for program implementation;
- e. Substantial involvement in QM activities by the Contractor's Medical Director;
- f. QM activities must be distinctly separate from the Utilization Review activities and that distinction must be well defined;
- g. The QM committee must meet on a regular basis 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;
- h. Records that document the committee's activities, findings, recommendations, actions, and results; and
- i. Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

6.3 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. These measures shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed by providers in the Plan who can recommend adoption of clinical practice guidelines to the Contractor, updated annually and communicated to those whose performance will be measured against them. Material resources and manpower that have the education, experience and training to effectively carry out the program function will be provided by the Contractor. Clinical guidelines are provided by the Contractor to physicians and other providers in the Plan as appropriate. Clinical issues arising through monitoring and evaluation activities shall be analyzed by appropriate clinicians and, as appropriate, corrective action taken to improve services. The Contractor has a plan for reviewing the guidelines at least every two (2) years and updates them as appropriate.

The Contractor, on an annual basis, shall measure provider performance against at least two (2) of the clinical guidelines and provide the Division a copy of the results of the study.

The Contractor must look for opportunities to address disparities in health care, which shall be included in the Quality Improvement Plan.

6.4 Utilization Review

The Plan will provide for a system of utilization review consistent with the requirements of 42 CFR § 456 and in accordance with Miss. Code Ann. § 41-83-1 et. seq. (1972, as amended).

The Contractor shall have a written Utilization Review Program description which outlines the program structure and accountability and includes, at a minimum:

- a. Criteria and procedures for the evaluation of medical necessity of medical services for beneficiaries;
- b. Criteria and procedures for pre-authorization and referral that include appeal mechanisms for providers and beneficiaries;
- c. Mechanisms to detect and document underutilization as well as over utilization of medical services;
- d. Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs;
- e. Availability of utilization review criteria to providers;
- f. Involvement of actively practicing, board certified physicians in the program to supervise all review decisions and to review denials for medical appropriateness;
- g. Availability of physician reviewer to discuss determinations by telephone with physicians who request such;
- h. Evaluation of new medical technologies and new application of existing technologies and criteria for use by Plan Providers; and
- i. Annual utilization review program review to determine effectiveness and need for changes.

6.5 Credentialing

The Contractor shall verify and certify to the Division that all Plan Providers and any Outside Providers to whom Enrollees may be referred are properly licensed in accordance with all applicable State law and regulations, are eligible to participate in the Medicaid program, and have in effect appropriate policies of malpractice insurance as may be required by the Contractor and the Division. The Contractor shall maintain a file for each provider containing a copy of the provider's current license issued by the State and such additional information as may be specified by the Division. 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 the Division. The Contractor shall allow practitioners to review the information submitted in support of the practitioner's credentialing application. The Contractor shall notify a practitioner of any information obtained during the credentialing process that varies substantially from the information provided to the Contractor by the practitioner. The Contractor shall have a procedure for practitioners to correct erroneous information. The Contractor shall make available to practitioners the Contractor's confidentiality requirements to ensure that all information obtained in the credentialing process is confidential except as otherwise provided by law.

In all contracts with health care professionals, the Contractor must comply with the requirements specified in 42 CFR § 438.214 which include selection and retention of providers, credentialing and recredentialing requirements and non-discrimination.

6.6 Internal Audit and Report

The Contractor shall semi-annually review, evaluate, and modify, as necessary, the quality management system, including the medical record system, data collection system and system for checking provider credentials, as well as all quality management policies and procedures, grievance procedures, clinical care standards, practice guidelines and patient protocols, Enrollee utilization, access to Covered Services, and treatment outcomes. The Contractor shall prepare a report to the Division, detailing the semi-annual review, completed activities and corrective actions, corrective actions which are recommended or in progress, and the results of all clinical, administrative and Enrollee satisfaction surveys conducted during the immediately preceding year. The report shall set forth any proposed modifications to the quality management system or policies and procedures. Any such modifications shall be approved in writing by the Division prior to implementation.

6.7 Fraud and Abuse Program

The Contractor shall have internal controls, policies and procedures, and a compliance plan to guard against fraud and abuse. Specifically, the Contractor shall have written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards subject to approval by the Division. At a minimum, the plan shall include the following:

- a. The designation of a compliance officer and a compliance committee that is accountable to senior management.
- b. Effective training and education for the compliance officer and the Contractor's employees.
- c. Effective lines of communication between the compliance officer and the Contractor's employees.
- d. Enforcement of standards through well publicized disciplinary guidelines.
- e. Provision for internal monitoring and auditing.
- f. Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Contract.

The Contractor shall report Enrollee or provider fraud or abuse which it had reasonable cause to suspect, or should have had reasonable cause to suspect, immediately to the Division, and shall cooperate with the Division regarding the investigation. Failure to do so could result in criminal and/or civil penalties.

- a. The information to be reported on providers must include the provider name, address, provider number, phone number; the name, title, address, agency and phone number of the person making the report; and details of the report such as information source, names, and list of attached documentation.
- b. The information to be reported regarding Enrollees must include the Enrollee's name, address, Medicaid identification number; the name, title, address, agency and phone number of the person making the report; and details of the report.
- c. Quarterly the Contractor must report the number of complaints of fraud and abuse made to the Division that warrant preliminary investigation and the following is to be reported for each case of suspected fraud and abuse that warrants a full investigation: provider name and number, source of complaint, type of provider, nature of complaint, approximate range of dollars involved, and the legal/administrative disposition of the case.

6.8 Studies

The Contractor shall conduct an annual Enrollee satisfaction survey beginning six (6) months following enrollment regarding quality, availability, accessibility and satisfaction of care. A description of the methodology to be used in conducting the survey, the percentage of the Enrollees to be surveyed and other survey requirements will be provided to the Plan by the Division. To ensure comparability of results, all Enrollees will receive the same set of questions. The results of the survey and action plans derived from these results must be filed with the Division at least ninety (90) days following completion.

The Contractor shall also perform a minimum of four focused studies each year on topics prevalent and significant to the population served. Due to the critical importance of the area of obesity to the Medicaid 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 study from the following topics: Hypertension, Diabetes, Asthma, Congestive Heart Disease, Hemophilia, and Organ Transplants. All studies are to be completed within ninety (90) days prior to the end of the contract year. The Contractor must assure the Division that QM studies are based on adverse or questionable health outcomes, quality issues affecting access to care or other QM studies related specifically to the quality of services provided.

The Contractor shall maintain and make available to the Division, CMS, Office of Inspector General (OIG), the Medicaid Fraud Control Unit, 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 the Division, concerning quality management activities and corrective actions.

In addition to those set forth herein, CMS, in consultation with the State, and other stakeholders, may specify additional performance measures and topics for performance improvement projects to be undertaken by the Contractor.

6.9 Medical Audit

The Division shall conduct, at minimum, annual medical audits of the Contractor during which the Division will identify and collect management data including information on the use of services and enrollment and disenrollment policies to ensure that the Contractor furnishes quality and accessible health care to enrolled beneficiaries. The Division will review any of the Contractor's policies and procedures for compliance with the terms of this Contract and any policies and procedures for Plan Services.

The Division shall also procure an annual external review with follow-up review of the quality, appropriateness and timeliness of health care services, provided by or on behalf of the Contractor, by an independent peer review organization under contract with the Division or a private accreditation body and the Contractor shall cooperate with the party conducting this review. This evaluation shall be based upon the documentation present in medical records, personal interviews, aggregate data, complaints, grievances or other data received from Enrollees or providers. The Division will investigate any suspected cases of fraud and abuse in the delivery of services.

6.10 EPSDT Audit

In conjunction with the medical audit, complete EPSDT claims data for the Contractor and a sample of medical records will be evaluated by the Division to determine compliance by the Contractor with the requirements of this Contract for provision of EPSDT Services to Enrollees under age twenty-one (21).

The Contractor must achieve a screening rate of eighty-five percent (85%) and an immunization rate of ninety percent (90%) in order to be in compliance with this contract. For a child who has been enrolled from birth through 12 months, compliance with the EPSDT 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.

The Contractor shall bear no refund obligation related to this section during the initial contract period. For all renewal periods following the initial contract period, failure to achieve the above screening rate shall require the Contractor to refund to the Division the following amount:

- Achievement of <85% screening and 90% immunization rate (the lowest rate shall be considered to be the rate for both screenings and immunizations) will require a refund of \$10 per Enrollee for all Enrollees under age 12 mos.
- The Division will publish the achievement of screening rates of eighty-five percent (85%) or greater to the Medicaid population and the medical community in the applicable service area. The Division will require its Contractor to make all screening rates known to potential enrollees in required educational and marketing presentations.

SECTION 7 – ENROLLEE NOTICES, GRIEVANCES AND APPEALS PROCEDURES

The Contractor shall have a timely and organized grievance system, with written policies and procedures for resolving informal and formal complaints/grievances filed by Enrollees, which provides for prompt resolution, assures the participation of individuals with authority to require corrective action, and is approved in writing by the Division.

The Contractor shall ensure that enrollees are sent written notice of any adverse action which informs enrollees of their right to appeal through the CCO as well as their right to access the Division's State Fair Hearing system. The Contractor shall provide to all network providers and subcontractors information about the grievance and appeals systems to the specifications described in 42 CFR § 438.10(g)(1) at the initiation of all such contracts.

The Contractor shall not be responsible for handling of appeals related to carved out services, such as transportation related to waiver services via the fee-for-service program.

7.1 Notice

The Contractor shall ensure that all Plan Enrollees are informed of the Contractor's complaint/grievance procedures. The Contractor shall provide to each Enrollee a handbook that shall include descriptions of the informal and formal complaint/grievance process. Enrollees shall have the right to grieve actions taken by the Contractor, including but not limited to disenrollment's initiated by the Contractor. Grievance forms shall be available from the Contractor upon request by the Enrollee. Enrollees shall have the right file a complaint/grievance in writing without the use of the Contractor's grievance form. Enrollees shall have the right to assistance from a personal representative during the grievance process. A provider can file a grievance on behalf of an enrollee. Notice of resolution of grievances shall include notification to the Enrollee of the right to appeal the decision to the Division after an appeal to the Contractor Board of Directors. The Contractor shall provide to its Plan Enrollees notice of grievance rights each time a covered service is denied, reduced and/or terminated.

7.2 Guidelines

The complaint/grievance procedures shall be governed by the following guidelines:

- a. The Contractor shall have a designated contact person(s) to receive complaints/grievances and be responsible for routing, processing and recording complaints/grievances for reporting purposes. The designated individual or body within the Contractor's plan having decision making authority as part of the complaint/grievance procedure shall be identified.
- b. The Contractor shall have sufficient support staff (clerical and professional) available to process complaints/grievances. The Contractor's staff shall be

educated concerning the importance of the complaint/grievance procedures and the rights of the Enrollee and providers.

- c. The Contractor shall have physician involvement in reviewing medically related complaints/grievances. Physician involvement in the grievance process should not be limited to the Enrollee's primary care physician, but must include at least one other physician in the same or similar specialty that typically manages that medical condition, procedure or treatment.
- d. The Board of Directors of the Contractor shall be responsible for reviewing appeals. The Board of Directors of the Contractor may delegate this authority to a Contractor grievance appeal committee. This delegation must be in writing.

7.3 Inquiries/Claims Filed By Enrollees

The Contractor shall provide a timely response to all inquiries received from enrollees or on behalf of enrollees while ensuring HIPAA compliance.

Additionally, in any instance where the Contractor receives a claim for payment filed by the enrollee, the Contractor shall respond to the enrollee, in writing, and at the time of any action affecting the claim. This response to the enrollee is required regardless of any response that the Contractor sends to the provider of service. The response shall inform the enrollee regarding approval or denial of coverage and shall detail any further action that is required in order to process the claim.

7.4 Notice of Adverse Action Process

The Contractor shall notify the requesting provider and shall provide written notice to enrolled (on the date of service) members whenever rendering an adverse decision. The contractor has the option to send the enrollee notice as an explanation of benefits statement or as a notice of adverse action. Any statement or notice must be in accordance with the definitions, content of notice, and required timeframes listed below.

- a. Definition of Adverse Action – Consistent with 42 CFR § 438.400, adverse action refers to the:
 - i. Denial or limited authorization of a service authorization request; including the type or level of service; or
 - ii. Reduction, suspension, or termination of a previously authorized service;
 - iii. Denial in whole or in part of a payment for a covered service for an enrolled member (except where the provider's claim is denied for

technical reasons including but not limited to prior authorization rules, referral rules, late filing, invalid codes, etc); or

- iv. Failure by the Contractor to render a decision within the timeframes required in this Contract; or
- v. The denial of an enrollee's request to exercise his right under 42 CFR § 438.52(b)(2)(ii) to obtain services outside of the network.

b. Content of Notice

The notice must be in writing and must meet the language and format requirements described in 42 CFR § 438.10.

The notice must explain the following:

- i. The action taken and the reasons for the action;
- ii. The enrollee's right to file an appeal with the CCO;
- iii. The enrollee's right to request a State fair hearing as described in this section;
- iv. The procedures for exercising appeal rights;
- v. The circumstances under which expedited resolution is available and how to request an expedited resolution; and
- vi. The circumstances under which the enrollee has the right to request that benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

b. Timing of Notice

The Contractor must mail the notice within the following timeframes:

- i. For termination, suspension, or reduction of previously authorized services, the notice must be issued at least ten (10) calendar days prior to the effective date of the intended adverse action, as required in 42 CFR § 431 Subpart E.

- ii. For denial of payment, the notice must be issued at the time of action affecting the claim.
- iii. For standard service authorization decisions that deny services, the notice must be issued within the timeframes specified in 42 CFR § 438.210(d).
- iv. For standard service authorization decisions that extend the review timeframe in excess of the standard fourteen (14) calendar days, the Contractor must mail the written notice no later than the 14th day to the enrollee, describing the reason for the decision to extend the timeframe and informing the enrollee of the right to file a grievance if he or she disagrees with that decision. Additionally, the Contractor must issue and carry out the review for the final determination as expeditiously as the enrollee's health condition requires and shall not exceed the date on which the extension expires.
- v. For service authorization decisions not reached within the required timeframes specified in this Contract, in accordance with 42 CFR § 438.210(d) (which constitutes a denial and is thus an adverse action), the notice must be issued on the date that the established timeframes for review expire.
- vi. For expedited service authorization decisions, the notice must be issued as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days after receipt of the request for service.
- vii. For expedited service authorization decisions where the Contractor has extended the three (3) working days turnaround time, as expeditiously as the enrollee's health condition requires, not to exceed the date on which the extension expires.

d. General Policies and Procedures for Grievances and Appeals

The Contractor shall have written policies and procedures that describe the grievance and appeals process and how it operates; and the process. These written directives shall describe how the Contractor intends to receive, track, review, and report all enrollee inquiries, grievances and appeals. The Contractor shall make any changes to its enrollee grievance and appeal procedures that are required by the Division. The procedures and any changes to the procedures must be submitted to the Division annually.

The Contractor shall provide grievance and appeal forms and/or written procedures to enrollees who wish to register written grievances or appeals. Additionally, the Contractor shall provide reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. The procedures must provide for prompt resolution of the issue and involve the participation of individuals with the authority to require corrective action. Specific requirements regarding enrollee notices, grievances, and appeals are contained in this Article.

The grievance and appeals processes must be integrated with the Contractor's process. The grievance and appeals process shall include the following:

- i. Procedures for registering and responding to grievances and appeals in a timely fashion;
- ii. Documentation of the substance of the grievance or appeal and the actions taken;
- iii. Procedures to ensure the resolution of the grievance or appeal in accordance with the requirements outlined in this Contract; and
- iv. Aggregation and analysis of these data and use of the data for quality improvement.

The Contractor must maintain a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision. This system shall distinguish Coordinated Care from commercial enrollees if the Contractor does not have a separate system for Coordinated Care enrollees.

7.5 Grievance Procedures

A grievance is defined as an expression of dissatisfaction about any matter other than an "action" as "action" is defined in this Contract. The Contractor's grievance process must allow the enrollee, or the enrollee's authorized representative (provider, family member, etc.) acting on behalf of the enrollee, to file a grievance either orally or in writing. The Contractor shall acknowledge receipt of each grievance. (Grievances received orally can be acknowledged orally.) The Contractor shall also ensure that the individuals who make decisions on grievances were not involved in any previous level of review or decision making. In any case where the reason for the grievance involves clinical issues or relates to denial of expedited resolution of an appeal, the Contractor shall ensure that the decision-makers are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease. [42 CFR § 438.406]

The Contractor must respond to all grievances as expeditiously as the enrollee's health condition requires, not to exceed 30 (thirty) days from the date of initial receipt of the

grievance. Grievances that are received telephonically may be responded to in-kind, and need not be followed-up with a written response, unless one is requested by the enrollee or the enrollee's authorized representative.

The grievance response shall include, but not be limited to, the decision reached by the Contractor; the reason(s) for the decision; the policies or procedures which provide the basis for the decision; and a clear explanation of any further rights available to the enrollee under the Contractor's grievance process.

7.6 Retention of Complaint/Grievance Records

A copy of verbal complaints logs and records of disposition or written grievances shall be retained for five (5) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular five-year period, whichever is later.

7.7 Appeal Process

The Contractor must define "appeal" as the request for review of an "action". The Contractor must resolve each appeal, and provide notice, as expeditiously as the enrollee's health condition requires, not exceeding forty-five (45) days from the day the Contractor receives the appeal.

The Contractor may extend the timeframes by up to fourteen (14) calendar days if the Enrollee requests the extension; or the Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest. For any extension not requested by the Enrollee, the Contractor must give the Enrollee written notice of the reason for the delay.

The Contractor must provide written notice of disposition. The written resolution notice must include results and date of appeal resolution. For decisions not wholly in the Enrollee's favor the resolution notice must include, the right to request a fair hearing from the Division information as to how to request the fair hearing with the Division, the right to continue to receive benefits pending a hearing, how to request the continuation of benefits. If the Contractor's action is upheld in a hearing, the Enrollee may be liable for the cost of any continued benefits.

The Contractor must continue the Enrollee's benefits until issuance of the final appeal decision or the Division fair hearing decision. If all of the following occurs:

- The Enrollee or the provider files the appeal timely.

- The services were ordered by an authorized provider.
- The period covered by the authorization has not expired.
- The Enrollee requests such an extension of benefits.

Timely filing means filing on or before the later of the following:

- Within ten (10) days of the Contractor mailing the notice of action.
- The intended effective date of the Contractor's proposed action.

If the Contractor continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The Enrollee withdraws the appeal.
- The Enrollee does not request a fair hearing within ten (10) days from when the Contractor mails an adverse decision.
- A Division fair hearing decision adverse to the Enrollee is made.
- The authorization expires or authorization service limits are met.

The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires if the services were not furnished with the appeal pending and the Contractor, the Division fair hearing officer reverse a decision to deny, limit, or delay services.

The Contractor must pay for disputed services, in accordance with State policy and regulations, if the Contractor or the Division fair hearing officer reverses a decision to deny authorization of services and the Enrollee received the disputed services while the appeal was pending.

The Contractor must establish and maintain an expedited review process for appeals, when the Contractor determines that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.

The Enrollee or provider may file an expedited appeal either orally or in writing. The Contractor must inform the Enrollee of the limited time available for the Enrollee to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.

The Contractor must resolve each expedited appeal and provide notice, as expeditiously as the Enrollee's health condition requires, not exceeding three (3) working days after the Contractor receives the appeal.

The Contractor may extend the timeframes by up to fourteen (14) calendar days if the Enrollees request the extension or the Contractor shows that there is need for additional information and how the delay is in the Enrollee's interest.

The Contractor must ensure that punitive action is not taken against a provider who either requests an expedited resolution or supports an Enrollee's appeal. If the Contractor denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard time frame of no longer than forty-five (45) days from the day the Contractor received the appeal with a possible fourteen (14) day extension, and give the Enrollee prompt oral notice of the denial and a written notice within two calendar days.

7.8 Appeals Process and Standard and Expedited Reviews

Enrollees have the right to appeal most adverse "action" issued by the Contractor, the Contractor's subcontractors or providers.

Appeals Process – The Contractor's appeals process must include the following requirements:

- a. Allow the enrollee, or enrollee's authorized representative (requires written consent from the enrollee) acting on behalf of the enrollee to file an appeal, either orally or in writing, and unless he or she requests an expedited resolution, must follow an oral filing with a written, signed, appeal. Per 42 CFR 438.02(b) a provider, acting on behalf of the enrollee and with the enrollee's written consent, may file a recipient appeal with the Contractor and through the State Fair Hearing Process, as described in this contract.
- b. Acknowledge receipt of each appeal.
- c. Ensure that the individuals who make decisions on appeals were not involved in any previous level of review or decision making.
- d. Ensure that the individuals who, if deciding on any of the following, are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.
 - i. An appeal of a denial that is based on lack of medical necessity.
 - ii. An appeal that involves clinical issues.
- e. Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing unless the enrollee or the provider appealing on the enrollee's behalf requests expedited resolution.

- f. Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the enrollee of the limited time available for this, especially in the case of expedited resolution.)
- g. Provide the enrollee and his or her representative opportunity, before and during the appeals process, to examine the enrollee's case file, including any medical records and any other documents and records considered during the appeals process.
- h. Include as parties to the appeal the enrollee and his or her representative or the legal representative of a deceased enrollee's estate.
- i. Continue benefits while the Contractor's appeal or the State fair hearing is pending, in accordance with 42 CFR § 438.420, when **all** of the following criteria are met:
 - i. The enrollee or the provider on behalf of the enrollee files the appeal within ten (10) calendar days of the Contractor's mail date of the notice of adverse action or prior to the effective date of the Contractor's notice of adverse action; and
 - ii. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and
 - iii. The services were ordered by an authorized provider; and
 - iv. The original period covered by the initial authorization has not expired; and
 - v. The enrollee requests extension of benefits.

If the final resolution of the appeal is adverse to the enrollee, that is, the Contractor's adverse action is upheld, the Contractor may pursue recovery of the cost of services furnished to the enrollee while the appeal was pending, to the extent that the services were furnished solely because of the requirements listed above, and in accordance with the policy described in 42 CFR §§ 431.230(b) and 438.420.

7.9 Standard Resolution

The Contractor shall respond in writing to standard appeals as expeditiously as the enrollee's health condition requires and shall not exceed the required calendar days from the initial date of receipt of the appeal. The Contractor may extend this timeframe by up

to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to the Division that a delay in rendering the decision is in the enrollee's interest. For any appeals decisions not rendered within the required calendar days where the enrollee has not requested an extension, the Contractor shall provide written notice to the enrollee of the reason for the delay.

For any appeal decision that is pending the receipt of additional information, the Contractor shall issue a decision within no more than forty-five (45) calendar days from the initial date of receipt of the appeal.

7.10 Expedited Resolution

The Contractor shall establish and maintain an expedited review process for appeals where either the Contractor or the enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall ensure that punitive action is neither taken against a provider that requests an expedited resolution nor supports an enrollee's appeal. In instances where the enrollee's request for an expedited appeal is denied, the appeal must be transferred to the timeframe for standard resolution of appeals.

The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal. The Contractor may extend this timeframe by up to an additional fourteen (14) calendar days if the enrollee requests the extension or if the Contractor provides evidence satisfactory to the Division that a delay in rendering the decision is in the enrollee's interest. For any extension not requested by the enrollee, the Contractor shall provide written notice to the enrollee of the reason for the delay. The Contractor shall make reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two (2) calendar days with a written notice of action.

All decisions to appeal must be in writing and shall include, but not be limited to, the following information:

- a. The decision reached by the Contractor;
- b. The date of decision;
- c. For appeals not resolved wholly in favor of the enrollee, the right to request a State fair hearing and how to do so; and

- d. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the Contractor.

7.11 State Fair Hearing Process

The Contractor shall educate its enrollees of their right to appeal directly to the Division. The enrollee has the right to appeal to the Division at the same time that he appeals to the Contractor; after he has exhausted his appeal rights with the Contractor; or instead of appealing to the Contractor.

Any adverse action or appeal that is not resolved wholly in favor of the enrollee by the Contractor may be appealed by the enrollee or the enrollee's authorized representative to the Division for a fair hearing conducted in accordance with 42 CFR § 431 Subpart E. Adverse actions include reductions in service, suspensions, terminations, and denials. Furthermore, the Contractor's denial of payment for Mississippi Medicaid covered services and failure to act on a request for services within required timeframes may also be appealed. Appeals must be requested in writing by the enrollee or the enrollee's representative within thirty (30) days of the enrollee's receipt of notice of adverse action unless an acceptable reason for delay exists. An acceptable reason shall include, but not be limited to, situations or events where:

- Appellant was seriously ill and was prevented from contacting the Contractor.
- Appellant did not receive notice of the Contractor's decision.
- Appellant sent the request for appeal to another government agency in good faith within the time limit;
- Unusual or unavoidable circumstances prevented a timely filing.

Additionally, if the Contractor's notice is "defective," i.e., does not contain the required elements, cause may exist.

The Division reserves the right to sanction the Contractor per occurrence whenever it is identified that the Contractor has failed to provide notice or provides an incorrect notice of appeal rights.

For enrollee appeals, the Contractor is responsible for providing to the Division and to the enrollee an appeal summary describing the basis for the denial. For standard appeals, the appeal summary must be submitted to the Division and the enrollee at least ten (10) calendar days prior to the date of the hearing. For expedited appeals, (that meet the criteria set forth in 42 CFR § 438.410) the appeal summary must be faxed to the Division and faxed or overnight mailed to the enrollee, as expeditiously as the enrollee's health condition requires, but no later than four (4) business hours after the Division informs the Contractor of the expedited appeal. The Division may require that the CCO attend the

hearing either via telephone or in person. The CCO is responsible for absorbing any telephone/travel expenses incurred.

The Contractor shall comply with the Division's hearing process, no more or less and in the same manner as is required for all other Mississippi Medicaid evidentiary hearings. The Contractor shall comply with the Division's fair hearing decision. The Division's decision in these matters shall be final and shall not be subject to appeal by the Contractor.

7.12 Reversed Appeal Resolutions

In accordance with 42 CFR §438.424, if the Contractor's or the State fair hearing decision reverses a decision to deny, limit, or delay services, where such services were not furnished while the appeal was pending, the Contractor must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires. Additionally, in the event that services were continued while the appeal was pending, the Contractor must provide reimbursement for those services in accordance with the terms of the final decision rendered by the Division and with the terms of this contract and applicable regulations.

7.13 Contractor Grievance and Appeal Reporting

The Contractor shall maintain a health information system for both informal and formal complaints/grievances. The Contractor shall submit to the Division by the fifteenth (15th) day of the month after the end of each month, a mutually agreed upon summary report of all provider and recipient inquiries, grievances and appeals as illustrated in this contract.

The Contractor shall also submit to the Division by the fifteenth (15th) day of the month after the end of each month a detailed log of all recipient grievances and appeals and all provider grievances and appeals made on behalf of a recipient under this Contract.

- a. Grievance categories identified shall be organized or grouped by the following general guidelines:
 - i. Transportation
 - ii. Access to Services/Providers
 - iii. Provider Care and Treatment
 - iv. CCO Customer Service
 - iv. Payment and Reimbursement Issues

- v. Administrative Issues
- b. Appeal categories identified shall be organized or grouped by the following general guidelines:
 - i. Transportation
 - ii. CCO Administrative Issues
 - iii. Benefit Denial or Limitation
- c. The log shall contain the following information for each grievance or appeal:
 - i. The date of the communication;
 - ii. The enrollee's Mississippi Medicaid identification number;
 - iii. Whether the grievance or appeal was written or oral;
 - iv. Indication of whether the dissatisfaction was a grievance or an appeal;
 - v. The category, specified in subsection a, of each inquiry;
 - vi. A description of subcategories or specific reason codes for each grievance and appeal;
 - vii. The resolution (detailed information about how the complaint/grievance was resolved); and
 - viii. The resolution date.

The Contractor may use reports from its existing system, if the system meets the above-stated Division criteria.

The Contractor shall utilize the reported information in the Quality Management Program activities. The Contractor shall submit to the Division within thirty (30) days of filing a copy of any report regarding grievances or use of the complaint system required to be filed with the Mississippi Department of Insurance.

7.14 Division Review of Contractor Grievance Decisions

A final grievance decision by the Plan may be appealed by the Enrollee to the Division. The Division's appointed Hearing Officer will review the grievance record, gather additional information if necessary, and provide the Enrollee and his or her representative

or the representative of a deceased Enrollee's estate and the Plan an opportunity to be heard. The Hearing Officer will recommend a resolution of the grievance to the Executive Director of the Division. The Executive Director will render a final decision. The Division review of Plan grievances decisions will not exceed 90 days minus the number of days taken by the Plan to resolve the appeal internally. The decision by the Division shall be final, subject to appropriate judicial review.

For appeals that meet the criteria for expedited resolution, as expeditiously as the Enrollee's health condition requires, but no later than 72 hours after receipt of the request for appeal from the Enrollee or receipt of the file from the Contractor the Division will take final administrative action.

SECTION 8 - RECORDS AND REPORTS

8.1 Record System Requirements

The Contractor shall maintain detailed records evidencing the administrative costs and expenses incurred pursuant to this Contract; Enrollee enrollment status; provision of Covered Services; and all relevant medical information relating to individual Enrollees, for the purpose of audit and evaluation by the Division and other federal or state agencies. All records 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 or audit findings are unresolved, 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 the Contractor and approved by the Division.

8.2 Reporting Requirements

The 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. The Contractor shall provide such additional data and reports as may be requested by the Division. The Division will furnish the Contractor with the appropriate reporting formats, instructions, timetables for submission and such technical assistance in filing reports and data as may be permitted by the Division's available resources. The Division reserves the right to modify from time to time the form, content, instructions and timetables for the collection and reporting of data. In the event that the Contractor fails to submit any data or report required pursuant to this Contract accurately, in satisfactory form, and within the specified time frame, the Division shall have the right to withhold one percent (1%) of the next monthly capitation payment and each monthly capitation payment thereafter until the data or report is received by the Division.

The Contractor agrees to furnish to the Division, at no cost to the Division, any records, documents, reports, or data generated or required in the performance of this contract including, but not limited to, the following:

- a. Quarterly reports to the Division summarizing formal grievances and informal complaints and resolutions;
- b. Service encounter data for Enrollees under this contract;
- c. Copies of reports submitted to the Mississippi Department of Insurance;
- d. HEDIS reports;
- e. Reports and data generated by a subcontractor;
- f. Enrollee satisfaction surveys and focused studies; and
- g. Results of annual study of clinical guidelines.

The Contractor agrees to also provide a monthly management report, in the form and manner set forth by the Division of Medicaid, an executive-level monthly management report. This report shall be due no later than thirty (30) days following the end of the reporting month.

The monthly management report shall summarize the Contractor's experience in areas such as, but not limited to, the following:

- a. Member enrollment statistics and trends;
- b. Utilization statistics and trends;
- c. Claims processing statistics;
- d. Call center statistics;
- e. Provider network;
- f. Prior authorization;
- g. Member grievance;

- h. Quality and outcome measures;
- i. Pilots/initiatives;
- j. Key staffing updates;
- k. Recent successes;
- l. Issues and challenges; and/or
- m. Corrective action updates, if applicable.

The Monthly Management Report must be submitted under the Contractor's executive signature (executive director, chief executive officer, president, etc.). In addition, the Contractor shall document all telephone calls from Medicaid beneficiaries. This information must be available in the Contractor's Mississippi office for Division review upon request.

8.3 Financial Reports

The Contractor shall file, by June 30 of each calendar year, annual audited financial statements as of the end of such fiscal year, prepared by an independent Certified Public Accountant (CPA) on an accrual basis, in accordance with generally accepted accounting principles (GAAP) as established by the American Institute of Certified Public Accountants (AICPA). The Contractor shall also file, on or before the first day of March of each year, certified copies of the annual statement and reports as prescribed and adopted by the Department of Insurance, State of Mississippi, and required to be submitted to the Department of Insurance pursuant to Miss. Code Ann. § 83-41-317 (1972, as amended). The Division may request information in the form of a consolidated financial statement.

The Contractor shall file on or before forty-five (45) calendar days following the end of each calendar quarter, quarterly financial reports in form and content as prescribed by the National Association of Insurance Commissioners (NAIC).

The Contractor shall file with the Division, 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.

8.4 Notice of Legal Action

The Contractor shall provide written notice to the Division of any legal action or notice listed below, within ten (10) calendar days following the date the Contractor receives notice of the following:

- a. Any action, suit or counterclaim filed against it;
- b. Any regulatory action, or proposed action, respecting its business or operations;
- c. Any notice received from the Department of Insurance or the State Health Officer;
- d. Any claim made against the Plan by an Enrollee, subcontractor or supplier having the potential to result in litigation related in any way to this Contract;
- e. The filing of a petition in bankruptcy by or against a principal subcontractor or the insolvency of a principal subcontractor;
- f. The conviction of any person who has an ownership or control interest in the Contractor, any subcontractor or supplier, or who is an agent or managing employee of the 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 Social Security Act; and
- g. 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 the Division.

8.5 Enrollment Reports

The Contractor shall submit to the Division information respecting all new enrollments, disenrollments, reinstatements and circumstances affecting the enrollment status of Enrollees, as received by the Contractor, in a submission format approved by the Division. The Contractor shall review each Enrollee Listing Report upon receipt and shall submit all corrections to the Division on or before the fifteenth (15th) day of the month for which the Enrollee Listing Report is issued. Adjustments will be made to the next Enrollee Listing Report to reflect corrections, and the enrollment or disenrollment of Enrollees reported to the Division (and approved by the Division in the case of voluntary or involuntary disenrollment for cause) on or before the fifteenth (15th) calendar day of each month.

8.6 EPSDT Reports

The Contractor shall coordinate with the Division in developing a mechanism for the collection of statistical data required by the federal government. The Contractor will have in place a periodic notification system that will facilitate compliance with the EPSDT periodicity schedule.

8.7 Medical Records

The Contractor shall ensure the maintenance of current, detailed, organized medical records by health care providers for each Enrollee 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 Enrollees enrolled with the Contractor.

8.8 Third Party Liability (TPL) Audit

The Division or its designated agent shall periodically, at least annually, conduct a TPL audit of the Contractor. The Contractor shall make available specific data as requested to complete the audit.

8.9 Confidentiality of Records

The Contractor shall treat all information, including that relating to Enrollees and providers, which is obtained by the 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. The Division, 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 the Division, CMS, and the fiscal 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. The Division 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. The Contractor shall adhere to 42 CFR, Part 431, Subpart F and 45 CFR Parts 160 and 164, Subparts A and E to the extent these requirements are applicable to the obligations under this Contract.

8.10 Access to Records

Pursuant to the requirements of Title XIX, Section 1902(a)(27) of the Social Security Act, 42 CFR § 434.6(a)(5) and 42 CFR § 438.6, and Miss. Code Ann. §

43-13-118,121,229 (1972, as amended), the 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 the Division, 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 the Division, CMS, and the fiscal 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 the Contractor including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Division shall have unlimited rights to use, disclose, and duplicate, all information and data developed, derived, documented, or furnished by the Contractor and in any way relating to this Contract in accordance with applicable state and federal laws and regulations.

In accordance with 45 CFR § 74.48, the Contract awarded to the CCO 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 the CCO 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.

8.11 Health Information System

The 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 Medicaid eligibility. The Contractor must collect data on Enrollee and provider characteristics i.e. trimester of enrollment, tracking of appointments kept and not kept,

place of service, provider type, and make all collected data available to the Division, to CMS, to the Mississippi Department of Insurance, and to any other oversight agency of the Division.

8.12 Encounter Data

The Contractor is required to submit encounter data directly to the Division's fiscal agent. An encounter takes place any time an eligible Medicaid beneficiary Enrollee receives a service from a provider inside or outside the Plan network. Data shall be electronically submitted in a format and in a time frame provided by the Division. Contractor will be required to work with the Division and its fiscal agent to expand and/or adapt encounter data as required by regulatory agencies or changes in industry standards. These data requirements become effective when Enrollee services begin. Data submission should be completed at least once each month, but it may be completed as frequently as daily.

The Contractor will be responsible for ensuring the quality, integrity, validity and completeness of data submitted by its providers through a data validation process. Penalties for non-compliance may include civil, criminal and administrative sanctions and may include suspension or termination of Enrollee enrollment.

8.13 Data Certifications

All data, reports, documents, records, encounter data, and any other information required to be submitted to the Division by the Contractor shall be certified by one of the following: the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports to, the Contractor's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows: To the accuracy, completeness and truthfulness of the data; to the accuracy completeness and truthfulness of the documents. The Contractor must submit the certification at the time the certified data, documents, reports, records, encounter data, or other information is submitted to the Division.

SECTION 9 - CAPITATION PAYMENTS

9.1 Monthly Payments

On or before the tenth (10th) day of each month during the term of this Contract, the Division shall remit to the Contractor the capitation fee specified for each Enrollee listed on the Enrollee Listing report issued for that month. Payment is contingent upon satisfactory performance by the 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 the Contractor. The Contractor shall set up the necessary bank accounts and provide written authorization to the Division's fiscal agent to generate and process monthly payments through the Division's internal billing procedures.

9.2 Payment in Full

The Contractor shall accept the capitation rate paid each month by the Division as payment in full for all services to be provided pursuant to this Contract and all administrative costs associated therewith. Enrollees shall be entitled to receive all Covered Services for the entire period for which payment has been made by the Division. Any and all costs incurred by the Contractor in excess of the capitation payment will be borne in full by the Contractor. Interest generated through investment of funds paid to the Contractor pursuant to this Contract shall be the property of the Contractor.

9.3 Rate Adjustments

The Contractor and the Division 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 Medicaid services or 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. The Contractor agrees to refund any overpayment to the Division, and the Division agrees to pay any underpayment to the Contractor, within thirty (30) days following written notice by the Division. In addition, rates will be reviewed no less than annually and adjusted as deemed necessary by the Division subject to approval from the federal government as may be required.

9.4 Application of Sanctions

Payments provided for under this Contract will be denied for new Enrollees when, and for as long as, payment for those Enrollees is denied by CMS pursuant to 42 CFR § 438.730.

9.5 Refund and Recoupment

The Division may request and obtain a refund of, or it may recoup from subsequent payments, any payment previously made to the Contractor for an Enrollee who is determined to have been ineligible for enrollment in the Plan for any month. Upon notice by the Division of an Enrollee who is ineligible, the Contractor may recoup from the Provider the amounts paid for any provided Covered Services. The Contractor may not recoup from the Provider any payments for months in which no services were provided.

9.6 Reserve Account

All new Plans shall establish 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 (1972, as amended).

9.7 Reinsurance

The Contractor must obtain stop-loss insurance as evidence of its ability to accept risk for claims in excess of Fifty Thousand Dollars (\$50,000) annually per Enrollee for coverage of Enrollees for all services as required under this contract and additional services the Contractor may provide to Enrollees.

9.8 Third Party Resources

If an Enrollee has resources available for payment of expenses associated with the provision of Covered Services, other than those which are exempt under Title XIX of the Act, such resources are primary to the coverage provided by the Division and must be exhausted prior to payment by the Division. The capitation rates set forth in this Contract have been adjusted to account for the primary liability of third parties to pay such expenses. The Contractor shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for services rendered to Enrollees pursuant to this Contract. All funds recovered by the Contractor from third party resources shall be treated as income to the Contractor.

The Contractor may delay payment of a subcontractor or Outside Provider for up to sixty (60) days following the date of receipt of the claims by the Contractor in the event that a third party resource is identified from which the subcontractor or Outside Provider is obligated to collect payment. If payment is made by the third party directly to a subcontractor or Outside Provider within sixty (60) days following the date of service, the Contractor may pay the subcontractor or Outside 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) day period, the Contractor must pay the subcontractor or Outside Provider and obtain a refund of any subsequent payments made by the third party. The Contractor may not withhold payment from a subcontractor or Outside Provider for services provided to an Enrollee 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) days.

The exception to the sixty (60) day delayed payment rule is for prescribed drugs which are paid pursuant to an approved waiver described in 42 CFR § 433.139(b)(2)(i) and for medical services provided to pregnant women and children as specified in 42 CFR §

433.139 (b)(2)(ii) and (3). These services must be paid to the subcontractor or Outside Provider and the Contractor must pursue recovery from the liable third party source.

The Contractor shall submit a report to the Division within thirty (30) days from discovery by the Contractor or subcontractor of any unknown third party resource or of the termination of a known resource. This report shall include Enrollee name, Medicaid ID number, dates of coverage, and third party resource.

9.9 Capitation Rates

The table below includes the capitation rates per member per month (PMPM) effective January 1, 2011 – December 31, 2011 varying by region and rate cell. Each CCO will be paid based on the distribution of members they have in each rate cell. In addition, CCO capitation payments will vary based on their members’ county of residence. Each county has been assigned to one of the following regions: north, central, or south.

**MississippiCAN Capitation Rates
Per Member Per Month (PMPM)
Effective January 1, 2011 – December 31, 2011**

Region	SSI / Disabled	Foster Care	Breast / Cervical Cancer
North	\$514.14	\$211.55	\$2,373.98
Central	\$541.77	\$222.92	\$2,501.56
South	\$574.82	\$236.52	\$2,654.16

The capitation rates for each rate cell will be further adjusted for each CCO using the combined Chronic Illness and Disability Payment System and Medicaid Rx risk adjuster (CDPS + Rx). The CDPS + Rx risk adjuster will be used to adjust for the acuity differences among the enrolled populations of each CCO. The CDPS + Rx weights will be specific to the non-inpatient services covered by MississippiCAN and calculated using Mississippi fee-for-service data.

SECTION 10 - INDEMNIFICATION AND INSURANCE

10.1 Indemnification

The Contractor, its successors and assignees shall indemnify, defend, protect, save, and hold harmless the Division and all enrolled Medicaid beneficiaries from and against all claims, suits, demands, actions, recovery, judgments and costs arising from any negligent

act or omission of the Contractor or any authorized subcontractor, or any employees or agents of either in the performance of this contract.

The Contractor, its successors and assignees shall indemnify, save, defend and hold the Division and all enrolled Medicaid beneficiaries harmless from any and all claims, demands, suits, actions, recovery, judgments, damages, liabilities, costs and expenses including reasonable attorney's fees and expenses, arising out of the death, bodily injury or damage to property or any Enrollee, agent, employee, business invitee or business visitor of the Contractor or subcontractor.

10.2 Insurance

The Contractor, its successors and assignees shall procure and maintain such insurance as is required by currently applicable federal and state law and regulation. Such insurance should include, but may not be limited to, the following:

- a. Liability insurance (general, errors of omissions, and directors and officers coverage);
- b. Fidelity bonding of persons entrusted with handling of funds;
- c. Workers compensation; and
- d. Unemployment insurance.

10.3 Protection Against Insolvency

The Contractor shall maintain a positive net worth, and such capital, additional surplus, line of credit and securities that equal to or exceed the minimum requirements established by the Mississippi Department of Insurance pursuant to Miss. Code Ann. Section 83-41-301 et. seq. (1972, as amended) as a condition for certification as a Health Maintenance Organization. The Contractor shall maintain appropriate Contractors and provisions for the fulfillment of its covenants and obligations pursuant to this contract in the event the Contractor or any material subcontractor or supplier should become insolvent. The Contractor shall submit to the Division for review and approval, a description and evidence of any arrangements made for protection against the risk of insolvency. The Contractor shall provide written notice to the Division at least sixty (60) days prior to the effective date of any change or modification in any such arrangements.

Medicaid enrollees will not be held liable, for the following:

- CCO's debts, in the event of insolvency;

- Covered services provided to the enrollee, for which the State does not pay the CCO;
- Covered services provided to the enrollee, for which the State, or the CCO does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement; and/or
- Liability 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 enrollee would owe if the CCO provided the services directly.

SECTION 11 - SUBCONTRACTAL RELATIONSHIPS AND DELEGATION

11.1 Right To Enter Into Other Contracts

The Division and the Contractor agree that each may contract for the provision or purchase of services for and from third parties not related to this contract arrangement.

The Division 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 the Division to perform functions related in whole or in part to Contractor services. The Contractor shall fully cooperate with such other contractors and the Division in all such cases.

11.2 Requirements

The Contractor has the right to subcontract for services specified under this contract. Any subcontract into which the Contractor enters with respect to performance under the contract shall in no way relieve the Contractor of the legal responsibility to carry out the terms of this contract. The Division will consider the 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 the Division.

The Contractor must oversee and will be held accountable for any functions and responsibilities that it delegates to any subcontractor. All subcontracts 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. The Contractor must monitor each subcontractor's performance on an ongoing basis and subject it to formal review at least once a year. If the Contractor identifies deficiencies or areas for improvement in the performance of any of its subcontractors, the 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 Medicaid provider. However, they are encouraged to enroll in order to provide services not covered under this Contract on a fee-for-service basis.

Subcontracts and subcontract revisions must be maintained and available for review at one central office in Mississippi designated by the Contractor and approved by the Division.

11.3 Remedies

The Division 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 the Contractor or require the termination of this Contract. Suspected fraud and abuse by any subcontractor will be investigated by the Division.

SECTION 12 - DEFAULT AND TERMINATION

12.1 Inspection and Monitoring

Pursuant to the requirements of 42 CFR § 438.6, the Division, CMS and other authorized federal or State personnel or the authorized representatives of these parties including, without limitation, any employee, agent, or contractor of the Division, CMS, the Fiscal Agent, the Division's Program Integrity Unit and the State Medicaid Fraud Control Unit, shall have the right to monitor and inspect the operations of the Contractor and any subcontractor or supplier for compliance with the provisions of this contract and all applicable federal and State law and regulations, with or without notice, at any time during the term of this contract. 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, disenrollment's, 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, utilization review and evaluation purposes, emphasis will be placed on case record validation during periodic monitoring visits to project sites. The Division shall prepare a report of its findings and recommendations and require the Contractor to develop corrective action plan to address any deficiencies.

12.2 Corrective Action

The Division may require corrective action in the event that any report, filing, examination, audit, survey, inspection, investigation or the like should indicate that the Contractor, any subcontractor or supplier is not in compliance with any provision of this contract, or in the event that the Division receives a complaint concerning the standard of care rendered by the Contractor, any subcontractor or supplier. The Division may also require the modification of any policies or procedures of the Contractor relating to the fulfillment of its obligations pursuant to this contract. The Division may issue a deficiency notice and may require a corrective action plan be filed within fifteen (15) calendar days following the date of the notice. A corrective action plan shall delineate the time and manner in which each deficiency is to be corrected. The plan shall be subject to approval by the Division, which may accept it as submitted, accept it with specified modifications or reject it. The Division 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 the Contractor with the opportunity to take corrective action. In appropriate instances, the Division may refer the matter to the State Medicaid Fraud Control Unit for investigation and possible criminal prosecution.

12.3 Liquidated Damages for Failure to Meet Contract Requirements

It is agreed by the Division of Medicaid and the Contractor that in the event of the Contractor's failure to meet the requirements provided in this Contract and/or all documents incorporated herein, damage will be sustained by the Division 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 the Contractor will pay the Division liquidated damages in the fixed amounts as stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed below but for the Division's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom. The Division may impose liquidated damages upon the Contractor when it fails to timely and accurately submit any reports under this Contract.

For each day that a deliverable is late incorrect or deficient, the Contractor shall be liable to the Division for liquidated damages in the amount of one thousand five hundred dollars (\$1,500.00) per calendar day, per file, report, encounter data submissions or other deliverable. With the exception of encounter data submissions, the Division will utilize the following guidelines to determine whether a report is correct and complete: (a) The report must contain 100 percent of the Contractor's data; (b) 99% of the required items for the report must be completed; and (c) 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by the Division.

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) day after the date on the written notice provided by the Division to the Contractor that the report remains incorrect or the deliverables remain deficient.

Failure to complete corrective action as described in Section 12.2 above, the Contractor shall pay liquidated damages in the amount of one thousand five hundred dollars (\$1,500.00) per calendar day for each day the corrective action is not completed in accordance with the timeline established in the Corrective Action Plan.

Any liquidated damages assessed by the Division shall be due and payable to the Division within thirty (30) calendar days after the 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 the Division without further notice. The collection of liquidated damages by the Division shall be made without regard to any appeal rights the Contractor may have pursuant to this contract. However, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Division will be returned to the Contractor.

Whenever liquidated damages for a single occurrence exceed two thousand five hundred dollars (\$2,500.00), Contractor staff will meet with Division staff to discuss the causes of the occurrence and to negotiate a reasonable plan for corrective action. Once a corrective action plan is agreed upon by both parties, collection of liquidated damages during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for correction of the problems that led to the occurrence. Should that date be missed by the 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 the Division, has been made.

12.4 Sanctions

If the Division determines that the Contractor has violated any provision of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the Division may impose sanction against the Contractor, and may include the following.

Network Access. If the Division determines that the Contractor has not met the provider network access standards established, the Division shall impose sanctions on the Contractor and require submission of a Correction Action Plan to the Division within ten (10) business days following imposition of sanctions. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment Report. Contractor will pay a fine in the amount of fifteen thousand dollars (\$15,000.00) for each month that the Contractor fails to meet the

provider network access standards. Further, should the Contractor fail to meet the provider network access standards for two (2) consecutive reporting, the Division shall immediately suspend enrollment of MississippiCAN members with the Contractor until such time as the 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 the Division.

Marketing Violations. If DOM determines that the Contractor has violated the requirements of the Contractor's obligations with respect to marketing and marketing materials, the Contractor will pay a fine in the amount of twenty-five thousand dollars (\$25,000.00) for each violation, in connection with one audit or investigation. Continued violations of this section may result in termination of the contract by the Division.

Claims Payment. If the Contractor fails to pay or deny at least ninety-eight percent (98%) of electronically filed clean claims in a given month within thirty (30) days of receipt, and/or at least ninety-eight percent (98%) clean paper claims in a given month within forty-five (45) calendar days of receipt, the Division shall deem this to be an instance of unsatisfactory claims performance and the Contractor will pay a fine of fifteen thousand dollars (\$15,000.00) for each month that such determination is made. Should the Contractor have two (2) consecutive months of unsatisfactory claims performance, the Division shall immediately suspend enrollment of MississippiCAN members with the contractor, until such time as the Contractor successfully demonstrates that all past due clean claims have been paid or denied. Continued violations of this section may result in termination of the contract by the Division.

Complaints. As used herein, the term "Medicaid Investigated Complaint" refers to a written member or provider complaint to the Division (or to another State agency or official and which is directed to the Division) where (a) Division staff are assigned to investigate and address the issues raised by the complaint, and (b) the Division concludes that the complaint is valid even if the disposition of the complaint is not resolved in favor of the complaining party. If the contractor is subject to more than three (3) Medicaid Investigated Complaints in any one month, the Contractor will pay civil monetary penalties of ten thousand dollars (\$10,000.00) for each such Medicaid Investigated Complaint above three (3) per month. Continued violations of this section may result in termination of the contract by the Division.

EPSDT Screening and Immunization. Achievement of <85% screening and 90% immunization rate (the lowest rate shall be considered to be the rate for both screenings and immunizations) will require a refund of one hundred (\$100) per Enrollee for all Enrollees under age 12 months. Continued violations of this section may result in termination of the contract by the Division.

If the Contractor fails to fulfill its duties and obligations pursuant to this contract, the Division may issue a written notice to the Contractor indicating the violation(s) and

advising the Contractor that failure to cure the violation(s) within a defined time span, to the satisfaction of the Division, may lead to the imposition of all or some of the sanctions listed below:

- a. Suspension of further enrollment after notification by the Division of a determination of a contract violation. Whenever the Division determines that the Contractor is out of compliance with this contract, the Division may suspend enrollment of new enrollees into the Contractor's Plan. The Division, when exercising this option, must notify the Contractor in writing of its intent to suspend new enrollment at least seven (7) working days prior to the beginning of the suspension period. The suspension period may be for any length of time specified by the Division, or may be indefinite. The Division may also notify existing Enrollees of the Contractor non-compliance and provide an opportunity to disenroll from the Plan or to re-enroll with another Plan;
- b. Suspension or recoupment of the capitation rate paid for any month for any Enrollee 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 the Division of a determination of a contract violation. Notwithstanding the provisions contained in this contract, the Division may withhold portions of capitation payments from the contractor as provided herein. Whenever the Division determines that the Contractor has failed to provide to an Enrollee any medically necessary items and/or Covered Services required under this contract, the Division may impose a fine of up to twenty five thousand dollars (\$25,000). The Contractor shall be given at least seven (7) days written notice prior to the withholding of any capitation payment.
- c. Suspension of capitation rates for months in which reports are not submitted as required in this contract after notification by the Division of a determination of a contract violation. Notwithstanding the provision contained in this contract, the Division may withhold portions of capitation payments from the contractor as provided herein. Whenever the Division determines that the Contractor has failed to submit any data or report required pursuant to this Contract accurately, in satisfactory form, and within the specified time frame, the Division shall have the right to withhold one percent (1%) of the next monthly capitation payment and thereafter until the data or report is received by the Division.
- d. Civil money penalties of no more than one hundred thousand dollars (\$100,000) for acts of discrimination against individuals or providers or misrepresentation of information to CMS or the Division.

- e. Civil money penalties of double the amount charged for imposing excess premiums or charges with the amount charged deducted from the penalty payment to the Division and returned to the individual concerned.
- f. Civil money penalties of no more than fifteen thousand dollars (\$15,000) for each individual not enrolled as result of discrimination up to a maximum of one hundred thousand dollars (\$100,000).
- g. Temporary management upon a finding by the Division that there is continued egregious behavior or substantial risk to the health of Enrollees.
- h. Notification to Enrollees of the right to disenroll without cause.
- i. Termination of this contract.

The Division will give the Contractor fifteen (15) days' written notice before sanctions as specified above are imposed which will include the basis and nature of the sanction.

12.5 Action by the Mississippi Department of Insurance

Upon receipt of official notice that the Mississippi Department of Insurance has taken action which resulted in the Contractor being placed under administrative supervision, the Division will suspend further enrollment of Medicaid beneficiaries 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 the Contractor being placed in rehabilitation, the Division will immediately disenroll all Enrollees who are Medicaid beneficiaries and suspend further enrollment of Medicaid beneficiaries until notice is received from the Department of Insurance that the Contractor has been rehabilitated. If the Division disenrolls Medicaid beneficiaries before the end of the month, the Rehabilitator will be notified of the prorated amount of payment due to the Division for the days of the month not covered by the Contractor for each Medicaid Enrollee and the Division shall be entitled to reimbursement for said amounts. Violation of this section may result in termination of the contract by the Division.

12.6 Option to Terminate

This contract may be terminated without cause by the Contractor upon ninety (90) calendar day's 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 the Contractor to terminate

this contract prior to the end of the initial term or any renewal term shall be contingent upon the payment of liquidated damages, performance of all obligations upon termination as defined in this contract, and payment in full of any refunds or other sums due the Division pursuant to this contract.

12.7 Termination by the Division

The Division shall have the right to terminate this Contract upon the occurrence of any of the following events:

- a. The Contractor, its subcontractors or suppliers violate or fail to comply with any applicable provision of federal or State law or regulations;
- b. The conduct of the Contractor, any subcontractor or supplier, or the standard of services provided by or on behalf of the Contractor threatens to jeopardize the health or safety of any Enrollee or fails substantially to provide medically necessary items and services required under the Contract;
- c. The Contractor becomes subject to exclusion from participation in the Medicaid program or Medicare program pursuant to any federal or state administrative, civil, or criminal actions;
- d. The Contractor or any subcontractor provides fraudulent, misleading, or misrepresentative information to any Enrollee, potential enrollees, the Division or other representative of the State, or to the Secretary of the Department of Health and Human Services or his/her representative;
- e. Gratuities of any kind were offered to or received by any public official, employee or agent of the State from the Contractor, its agents, employees, subcontractors or suppliers, in violation of terms in this contract;
- f. Either of the sources of reimbursement for Medical Assistance, state and federal appropriations, no longer exists, or in the event that the sum of all obligations of the Division incurred pursuant to this contract and all other contracts entered into by the Division, including without limitation, all Statements of Participation entered into pursuant to the State Contractor, equals or exceeds the balance of such sources available to the Division for "Medical Assistance Benefits" for the fiscal year in which this Contract is effective less One Hundred Dollars (\$100.00), then this contract shall immediately terminate without further obligation of the Division as of that moment;
- g. Imposes premiums or charges in excess of those permitted by the Division;

- h. Discriminates on the basis of Enrollee health status or requirements for health care services, including expulsion or refusal to re-enroll an individual, except as permitted by the Division or engaging in any discouraging enrollment based on medical condition or history; or
- i. Distributes directly or indirectly marketing material in violation of provisions relating to such materials.

The findings by the Executive Director of the Division of the occurrence of any of the events stated above shall be conclusive. The Division will attempt to provide the Contractor with ten (10) days notice of the possible occurrence of events as described in this contract.

Upon termination of the Contract for any reason except as described in Subsection F, the Division will provide the Contractor with a pre-termination conference. The Division will give the Contractor written notice of its intent to terminate, the reason for termination, and the time and place of the conference. After the conference, the Division will give the Contractor written notice of the decision. If the decision is to affirm the termination, the notice will provide the effective date of the termination. The Division is required to notify Enrollees of the Division's intent to terminate the Contract and give Enrollees the opportunity to disenroll immediately from the Contractor without cause.

If the contract is terminated because the Contractor is not in compliance with terms of this contract and if directed by CMS, the Division cannot renew or otherwise extend this contract for the Contractor unless CMS determines that compelling reasons exist for doing so.

12.8 Temporary Management

The Division can require the appointment of temporary management upon the finding by the Division that there is continued egregious behavior or substantial risk to the health of Enrollees or to assure the health of Enrollees during a time or for an orderly termination or reorganization of the Contractor's Plan or until improvements are made to remedy Contract violations. Temporary management cannot be terminated until the Contractor has the capability to ensure violations will not recur. If the Contractor repeatedly fails to comply with Contract provisions, the Division may impose the sanction of temporary management and give Enrollees the right to terminate enrollment with the Contractor's Plan.

12.9 Obligations Upon Termination

Upon termination of this contract, the Contractor shall be solely responsible for the provision and payment for all Covered Services for all Enrollees for the remainder of any

month for which the Division has paid the monthly capitation rate. Upon final notice of termination, on the date, and to the extent specified in the notice of termination, the Contractor shall:

- a. Continue providing Covered Services to all Enrollees until midnight on the last day of the calendar month for which a capitation rate payment has been made by the Division;
- b. Continue providing all Covered Services to all infants of female Enrollees who have not been discharged from the hospital following birth, until each infant is discharged;
- c. Continue providing Covered Services to any Enrollees who are hospitalized on the termination date, until each Enrollee is discharged;
- d. Arrange for the transfer of patients and medical records to other appropriate providers as directed by the Division;
- e. Supply to the Division such information as it may request respecting any unpaid claims submitted by Outside Providers and arrange for the payment of such claims within the time periods provided herein;
- f. Take such action as may be necessary, or as the Division may direct, for the protection of property related to this contract, which is in the possession of the Contractor and in which the Division has or may acquire an interest; and
- g. Provide for the maintenance of all records for audit and inspection by the Division, CMS and other authorized government officials; the transfer of all data and records to the Division or its agents as may be requested by the Division; and the preparation and delivery of any reports, forms or other documents to the Division as may be required pursuant to this contract or any applicable policies and procedures of the Division.

The covenants set forth in this Section shall survive the termination of this contract and shall remain fully enforceable by the Division against the Contractor. In the event that the Contractor fails to fulfill each covenant set forth in this section, the Division 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 the Contractor and the Contractor shall refund to the Division all sums expended by the Division in so doing.

12.10 Liquidated Damages

The Contractor acknowledges and agrees that the Division 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 Medicaid Management Information System (MMIS) operated by the Division. The 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 the Contractor or due to the Contractor's failure to fully comply with the terms and conditions of this contract, the Division will incur substantial additional expense in processing the disenrollment of all Enrollees and mass MMIS changes, in effecting additional staffing changes, in procuring alternate health care arrangements for Enrollees and in modifying any Enrollee service materials identifying the Contractor; and that such expense is difficult or impossible of accurate estimation. Based upon the foregoing, the Contractor and the Division have agreed to provide for the payment by the Contractor to the Division of liquidated damages equal to Ten Thousand Dollars (\$10,000) 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) days following the date of the notice of termination. The Division and the Contractor agree that the sum set forth herein as liquidated damages is a reasonable estimate of the probable loss which will be incurred by the Division in the event this contract is terminated prior to the end of the Contract term or any renewal term due to the actions of the Contractor or due to the Contractor's failure to comply fully with the terms and conditions of this contract. In addition, the contractor will reimburse the Division for any federal disallowances or sanctions imposed on the Division as a result of the Contractor's failure to abide by the terms of this contract.

SECTION 13 – FEDERAL, STATE, AND GENERAL REQUIREMENTS

13.1 HIPAA Compliance

The Contractor shall abide by the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996, including EDI, code sets, identifiers, security, and privacy provisions as may be applicable to the services under this contract.

To the extent that the Contractor uses one or more subcontractors or agents to provide services under this Contract, and such subcontractors or agents receive or have access to protected health information (PHI), each such subcontractor or agent shall sign an agreement with the Contractor that complies with HIPAA.

The Contractor shall ensure that any agents and subcontractors to whom it provides PHI received from the Division (or created or received by the Contractor on behalf of the Division) agree in writing to the same restrictions, terms, and conditions relating to PHI that apply to the Contractor in this Contract. The Division shall have the option to review and approve all such written agreements between the Contractor and its agents and subcontractors prior to their effectiveness.

13.2 Conflict of Interest

In accordance with 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers and employees of the Division 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. § 27) against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

No public official of the State of Mississippi and no official or employee of the Division, DHHS, 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 the Contractor. The Contractor hereby certifies that no officer, director, employee or agent of the Contractor, any subcontractor or supplier and person with an ownership or control interest in the Contractor, any subcontractor or supplier, is also employed by the State of Mississippi or any of its agencies, its fiscal agent or any other agents of the Division, or by DHHS, CMS or any agents of DHHS or CMS or is a public official of the State of Mississippi. This contract will be terminated by the Division if it is determined that a conflict of interest exists.

13.3 Offer of Gratuities

The Contractor certifies that no Enrollee of Congress, nor any elected or appointed official, employee or agent of the State of Mississippi, DHHS, CMS, or any other federal agency, has or will benefit financially or materially from this contract. This Contract will be terminated by the Division if it is determined that gratuities of any kind were offered to or received by any of the aforementioned officials or employees from the Contractor, its agents, employees, subcontractors or suppliers.

13.4 Independent Contractor

It is expressly agreed that the Contractor and any subcontractors and agents, officers, and employees of the Contractor or any subcontractors shall act in an independent capacity in the performance of this Contract and not as officers or employees of the Division or the State of Mississippi. It is further expressly agreed that this Contract shall not be

construed as a partnership or joint venture between the Contractor or any subcontractor and the Division or the State of Mississippi. As an independent contractor, the Contractor is responsible for any taxes, deductions, or other withholdings as may be applicable.

13.5 Debarment, Suspension, or Exclusion

The Contractor may not knowingly have a relationship with the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities.
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

13.6 Provider Exclusions

The Division will not reimburse the Contractor for services rendered by any provider that is excluded from participation by Medicare, Medicaid, including any other states' Medicaid program, or SCHIP, including any other states' or SCHIP program, except for emergency services.

13.7 Compliance with Federal Laws

The Contractor and its subcontractors shall comply with all applicable standards, orders or requirements issued under Section 306 for the Clean Air Act (42 USC § 1857(h)), Section 508 of the Clean Water Act (33 USC § 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 CFR Part 15).

The Contractor and its subcontractors shall abide by mandatory standards and policies relating to energy efficiency which are contained in the State energy conservation Contractor issued in compliance with the Energy Policy and Conservation Act. (Pub. L. 94-165)

13.8 Assignment

This contract and any payments which may become due hereunder, shall not be assignable by the Contractor except with the prior written approval of the Division. The transfer of five percent (5%) or more of the beneficial ownership in the Contractor at any time during the term of this Contract shall be deemed an assignment of this contract. The Division shall be entitled to assign this Contract to any other agency of the State which

may assume the duties or responsibilities of the Division relating to this contract. The Division shall provide written notice of any such assignment to the Contractor, whereupon the Division shall be discharged from any further obligation or liability under this Contract arising on or after the date of such assignment.

13.9 No Waiver

No covenant, condition, duty, obligation, or undertaking contained in or made a part of this contract may be waived except by written agreement of the parties. The forbearance or indulgence in any form or manner by either party shall not constitute a waiver of any covenant, condition, duty, obligation, or undertaking to be kept, performed, or discharged by the party to which the same may apply. Until complete performance or satisfaction of all such covenants, conditions, duties, obligations, or undertakings, the other party shall have the right to invoke any remedy available under law or equity, notwithstanding any such forbearance or indulgence.

13.10 Severability

In the event that any provision of this contract (including items incorporated by reference) is found to be unlawful or unenforceable, then both the Division and the Contractor shall be relieved of all obligations arising under such provision. If the remainder of this contract is capable of performance, then this contract shall continue in full force and effect, and all remaining provisions shall be binding upon each party to this contract. 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 the Division and the Contractor, then both the Division and the Contractor shall be discharged from any further obligations created under the terms of this contract.

13.11 Force Majeure

Neither party to this contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts shall include natural disasters, strikes, riots, acts of war and similar events.

13.12 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 Deputy Administrator of Health Services. Such decision shall be in writing and mailed or otherwise furnished to the Contractor. The decision of the Deputy shall be final and conclusive, unless within ten (10) days following the date of such decision the Contractor mails or otherwise furnishes a written appeal to the Division'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, subject only to a decision by a court of competent jurisdiction. The Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. The Contractor shall proceed diligently with the performance of this Contract in accordance with the decision rendered by the Deputy Administrator of Health Services until a final decision is rendered by the Executive Director or his or her representative.

13.13 State Ownership

Ownership of all information and data developed, derived, documented, or furnished by the contractor resulting from this contract resides with the Division, State of Mississippi. The Division shall have unlimited use of this information to disclose, duplicate or utilize for any purposes whatsoever.

13.14 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 contracts, 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.

13.15 Entire Agreement

This Contract, together with all attachments (including the RFP, the proposals, and the responses to the letter inquiries), represents the entire agreement between the Contractor and the Division 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 the Contractor and the Division 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.

Any provision of this Contract which is in conflict with Federal and State Medicaid 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.

13.16 Compliance with Mississippi Employment Protection Act (MEPA)

Contractor/Seller represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et seq of the Mississippi Code Annotated (Supp 2008), and will register and participate in the status verification system for all newly hired employees. The term “employee” as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, “status verification system” means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Contractor/Seller agrees to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Contractor/Seller further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Contractor/Seller understands and agrees that any breach of these warranties may subject Contractor/Seller to the following: (a) termination of this Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Contractor/Seller by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both. In the event of such termination/cancellation, Contractor/Seller would also be liable for any additional costs incurred by the State due to contract cancellation or loss of license or permit.

SECTION 14 – REQUIRED SAVINGS

14.1 Financial Payment Structure and Provisions

DOM will pay the CCO monthly Capitation Payments based on the number of eligible and enrolled Members. DOM will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly capitation Rate by Member Rate Cell. The CCO must provide the Services and Deliverables, including Covered Services to Members, described in the Contract for monthly capitation Payments to be paid by DOM. The CCO 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. The CCO 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 the CCO to withhold Services or Deliverables due under the contract.

14.2 Required CCO Inpatient Savings Guarantee Program

Hospital inpatient services will not be included in the capitated CCO contract for MississippiCAN so that the services can be included in DOM's hospital upper payment limit (UPL) calculation. Hospital inpatient services will be paid on a FFS basis as they are today.

DOM designed a savings guarantee program that will provide a financial incentive for the CCOs to reduce FFS hospital inpatient costs compared to a FFS delivery system. The design of the program is summarized below:

- a. DOM will calculate an estimate of FFS hospital inpatient costs for each rate cell during the contract year (the inpatient FFS cost target).
- b. DOM will pay the CCOs an administrative fee of \$10.00 PMPM to coordinate the hospital inpatient care of CCO enrollees.
- c. The CCOs will guarantee that DOM will save at least 10% of the inpatient FFS cost target, net of the \$10.00 PMPM administrative fee.
 - i. If the FFS inpatient cost PMPM of a CCO's enrollees plus the \$10.00 PMPM administrative fee is greater than 90% of the inpatient FFS cost target, the CCO will pay a penalty equal to the difference so that DOM attains the 10% savings guarantee.
 - ii. If the FFS inpatient cost PMPM of a CCO's enrollees plus the \$10.00 PMPM administrative fee is less than 90% of the inpatient FFS cost target, the CCO will earn an incentive payment equal to 20% of the difference. CMS limits this incentive payment to 5% of the non-inpatient capitation rate.
- d. At the end of the contract year, actual FFS hospital inpatient costs for MississippiCAN enrollees will be compared to the inpatient FFS cost targets to determine if the CCOs attained the inpatient cost savings guarantees. This comparison will be risk adjusted using CDPS + Rx so that population acuity differences can be reflected in the comparison. The CDPS + Rx weights will be specific to inpatient services calculated using Mississippi FFS data.

- i. An interim settlement will occur three months after the close of the contract year. DOM will include estimates of IBNR and TPL recoveries for the FFS inpatient claims.
- ii. The final settlement will occur one year after the close of the contract year. DOM will include estimates of IBNR and TPL recoveries for the FFS inpatient claims.

Hospital inpatient FFS cost targets were developed for each rate cell as shown in the table below.

**MississippiCAN Inpatient FFS Targets and Savings Guarantees
Per Member Per Month (PMPM)
Effective January 1, 2011 – December 31, 2011
Subject to Risk Adjustment**

Rate Cell	FFS Inpatient Cost Target	10% Minimum Savings Guarantee
SSI / Disabled		
North	\$204.14	\$20.41
Central	\$234.57	\$23.46
South	\$227.68	\$22.77
Foster Care		
North	\$101.72	\$10.17
Central	\$116.89	\$11.69
South	\$113.46	\$11.35
Breast / Cervical Cancer		
North	\$233.68	\$23.37
Central	\$268.52	\$26.85
South	\$260.64	\$26.06

Note that the inpatient FFS cost targets reflect DOM's current per diem reimbursement structure. If the proposed APR-DRG reimbursement structure is implemented during the contract year, the FFS cost targets will be adjusted to reflect the new reimbursement structure

14.3 Repayment to the Division

The CCO is expected to achieve the target savings amount for each category of member eligibility and its corresponding target savings category. Upon demand by the Division,

the CCO will remit payment to the Division for the difference between actual savings realized by the CCO and the target program savings amounts described in 14.2.

SECTION 15 – CENTERS FOR MEDICARE AND MEDICAID SERVICES

15.1 Review and Approval

This agreement is subject to review and approval by the Centers for Medicare and Medicaid Services (CMS) prior to payment for services and may be modified as required and/or suggested by CMS. Any modifications to this agreement may be enacted pursuant to the provisions described in the RFP and this agreement.

IN WITNESS WHEREOF, the parties have caused this Contract to be executed by their duly authorized representatives.

DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
STATE OF MISSISSIPPI

BY:
ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

CONTRACTOR:

BY:

TITLE:

STATE OF MISSISSIPPI

COUNTY OF HINDS

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, ROBERT L. ROBINSON, 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 authorized by said Division that he signed and delivered the above and foregoing written Contract for and on behalf of said Division, 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 _____ day of _____ A.D., 2010.

NOTARY PUBLIC

My Commission Expires:

STATE OF

COUNTY OF

THIS DAY personally came and appeared before me, the undersigned authority, in and for the aforesaid jurisdiction, the within named, _____, in his/her official capacity as _____, who acknowledged to me, being first authorized by said corporation that he/she signed and delivered the above and foregoing written Contract for and on behalf of said corporation, and as his/her official act and deed on the day and year therein mentioned.

GIVEN under my hand and official seal of office on this the _____ day of _____, A.D., 2010.

NOTARY PUBLIC

My Commission Expires: