CONTRACT BETWEEN

THE STATE OF MISSISSIPPI DIVISION OF MEDICAID OFFICE OF THE GOVERNOR

AND

Contractor

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

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

AND _____

This Contract is entered into this ____ day of _____, 201_ 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 C.F.R. § 438.6(b) and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 C.F.R. § 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); and

WHEREAS, the Division contracted with a Contractor 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

A. Term

The Contract period begins July 1, 2017 and shall terminate on June 30, 2020. The Division may have, under the same terms and conditions as the existing Contract, an option for two (2) one-year extensions.

B. Definitions and Construction

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

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

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

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

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

The Division reserves the right to review the existing contract as needed to address contract and/or program vulnerabilities and discrepancies. No modification or change of any provision in the Contract shall be made, or construed to have been made, unless such modification or change is mutually agreed upon in writing by the Contractor and the Division. The agreed upon modification or change will be incorporated as a written Contract amendment and processed through the Division for approval prior to the effective date of

such modification or change. In some instances, the Contract amendment must be approved by the Centers for Medicare & Medicaid Services (CMS) before the change becomes effective.

The only representatives authorized to modify this Contract on behalf of the Division and the Contractor are shown below:

Contractor: Person(s) designated by the Contractor
Division of Medicaid: Executive Director

C. Applicable Law

At all times during the term of this Contract and in the performance of every aspect of this Contract, the Contract shall be governed by and construed in accordance with the laws of the State of Mississippi, excluding its conflict of law provisions, and any litigation with respect thereto shall be brought in the courts of the State of Mississippi.

The Contractor shall comply with all applicable Federal, State, and local laws and regulations and standards, as have been or may hereinafter be established, including but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care ACT (PPACA); the Health Care and Education Reconciliation Act of 2010 (HCERA); and other laws and regulations, specifically including without limitation, privacy and confidentiality rules and 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.

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

D. Representatives for the Division and Contractor

The Executive Director, or their designee, 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 Executive Director, or their designee. The Executive Director, or their designee, 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 Division will make the final decision.

The Chief Executive Officer or a comparable representative shall serve as Contract Officer for the Contractor, with full decision-making authority for the Contractor, and will be required to be physically located in the State of Mississippi. Each Contract Officer reserves the right to delegate such duties as may be appropriate to others in the Officer's employment or under the Officer's supervision.

E. Notices

Whenever, under this Contract or associated RFP, one party is required to give notice to the other, except for purposes of Notice of Termination under Section 16.K, Procedure on Termination, of this Contract, such notice shall be deemed given upon delivery, if delivered by hand, or upon the date of receipt or refusal, if sent by registered or certified mail, return receipt requested or by other carriers that require signature upon receipt. Notice may be delivered by electronic mail or facsimile transmission, with original to follow by certified mail, return receipt requested, or by other carriers that require signature upon receipt, and shall be deemed given upon transmission or facsimile confirmation that it has been received. Notices shall be addressed as follows:

In case of notice to the Division:

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

In case of notice to the Contractor:

Contractor Designee
Contractor
Street Address
City, State Zip Code

F. Contractor Representations

The Contractor hereby represents and warrants to the Division that:

1. The Contractor has at least three (3) years of experience with contractual services described here in this Contract;

2. The Contractor is licensed in the State of Mississippi by the Department of Insurance; or is in the process of obtaining license in Mississippi to be effective prior to the Enrollment of beneficiaries;

3. All information and statements contained in the Mississippi Coordinated Access Network (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;

4. A copy of the Contractor's 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;

5. 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;

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

7. The Contractor has experience in contractual services providing the types of services described in the RFP and this Contract; and

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

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

G. Assignment of the Contract

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

H. 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:

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

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

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

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

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

6. The conviction of any person who has an ownership or control interest in 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 XIX of the Social Security Act; and

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

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

I. 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 is required to obtain all relevant ownership and financial disclosure information from their own employees, Subcontractors, and network Providers.

The Contractor shall not knowingly have persons, managing employee, agent 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 five percent (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, in accordance with 42 C.F.R. § 438.610.

1. Disclosures

   The Contractor must disclose all information in accordance with 42 C.F.R. § 455.104(b) that shall include:

   a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business

location, and P.O. Box address;

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

Other tax identification number (in the case of a corporation) with an ownership or control interest in the Contractor or in any Subcontractor in which the Contractor (or Division's Agent or managed care entity) has a five percent (5%) or more interest;

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

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

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

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

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

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

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

In accordance with 42 C.F.R. § 455.104(d), all disclosures must be provided to the Division, the State's designated Medicaid agency.

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

a. Contractor is controlled by a sanctioned individual;

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

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

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

a. The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the twelve (12)-month period ending on the date of the request; and

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

Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information listed above to State survey agency at the time it is surveyed.

A managed care entity that is not subject to periodic survey and certification and has not supplied the information specified above to the Secretary within the prior twelve (12)-month period, must submit the information to the Division before entering into a contract or agreement to participate in the program.

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

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

At the time of Contract execution and Contract renewal, the Contractor must submit information for any person who has ownership and control interest of each Network Provider entity or who is an agent or managing employee of the Provider (as defined by 42 C.F.R. § 455.101) and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XIX services program since the inception of those programs, as required in 42 C.F.R. § 455.106. The Contractor shall also make this information available to the Division upon request within thirty-five (35) calendar days. The Division may refuse to enter into or may terminate this agreement if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106.

The Contractor must fully disclose all information in accordance with 42 C.F.R. § 1002.3.

The Division may refuse to enter into, or terminate, this Contract if it determines that the Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 1002.3(a). 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 R
Services Act, § 1903(m)(2)(A)(viii) and 1903(m) (4), which are defined as:

a. Any director, officer, partner, employee, or assignee responsible for management or administration of the Contractor; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the Contractor; 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 Contractor; or in the case of a Contractor organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;

b. Any organization in which a person is a director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the Contractor; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the Contractor;

c. Any person directly or indirectly controlling, controlled by, or under common control with the Contractor; or

d. Any spouse, child, parent, or authorized agent of an individual described in subsections a, b, or c.

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.

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 C.F.R. § 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 C.F.R. § 455.104 and 42 C.F.R. § 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.

2. Change of Ownership

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

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 Contractor.

Should the Contractor undergo a change of direct ownership, the Contractor 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 Members will be notified. Any change of ownership does not relieve the previous owner of liability under the previous Contract.

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

3. Prohibited Affiliations

Contractor shall not knowingly have a prohibited affiliation with the following:

a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; and

b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in subparagraph 3.1 of this Section.

Prohibited affiliations are defined as follows:

a. A director, officer, or partner of Contractor;

b. A Subcontractor of Contractor as governed by 42 C.F.R. § 438.230;

c. A person with beneficial ownership of 5 percent or more of the Contractor's equity; and,

d. A network provider or person with an employment, consulting, or other arrangement with Contractor for the provision of items and services that are significant and material to Contractor's obligations under this Contract.

e. Contractor may not have a relationship with an individual or entity that is excluded from participation in any Federal healthcare program under Section 1128 or 1128A of the Act.

If the Division finds that Contractor is not in compliance with the provisions of this Section, the Division:

a. Must notify the HHS Secretary of Contractor's non-compliance;

b. May continue this Contract with Contractor unless the Secretary directs otherwise; or

c. May not renew or otherwise extend this Contract unless the Secretary provides to the State of Mississippi and to Congress a written statement describing compelling reasons that exist for renewing or extending this

Contract despite the prohibited affiliations.

d. Nothing in this section must be construed to limit or otherwise affect other remedies available to the United States under Sections 1128, 1128A, or 1128B of the Act.

e. Any action by the Secretary described herein is taken in consultation with the Inspector General.

J. Responsiveness to Division Requests

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.

The Contractor shall acknowledge receipt of the Division's written, electronic, or oral requests for assistance no later than one (1) business day from receipt of the request from the Division, and the request shall be completed by Contractor to the satisfaction of the Division within five (5) business days from the date of receipt unless another time frame is specified by the Division. Requests by Contractor for extension of the time frame may be granted by the Division in its discretion. If the request is urgent, Contractor shall immediately, without unreasonable delay, acknowledge the Division's urgent requests for assistance and shall give such requests priority. Urgent requests shall be completed by Contractor to the satisfaction of the Division within the time frame specified by the Division. If no timeframe is specified, urgent requests shall be completed within five (5) business days from the date of receipt. Such urgent requests include, but are not limited to, issues involving legislators, legislative committees (e.g., Joint Committee on Performance Evaluation and Expenditure Review), other governmental bodies, and Care Management evaluation requests involving Members or Providers requiring an expeditious response based on the Member's health condition. Executive requests, program requests, and Medicaid Investigated Grievances shall be considered urgent.

The Contractor's acknowledgement of Division requests for assistance must include the required date of resolution, as described above. If the request is received from the Division in writing or electronically, the Contractor shall acknowledge receipt in the same manner the request was received, either in writing or electronically. If the request was received from the Division orally, the Contractor shall acknowledge receipt of the request orally and immediately follow-up with a written or electronic acknowledgement. Upon completion of the request, the Contractor shall submit to the Division, on or before the required date of completion, a detailed completion summary advising the Division of the Contractor's action and resolution. The completion summary shall contain all information necessary for the Division to adequately determine whether a request has been completed, and shall conform to specifications requested by the Division concerning form, format, or content of the summary, if any. Division requests shall not be considered completed if Contractor fails to submit the completion summary, and completion will not be considered timely if Contractor fails to submit the summary on or before the required completion date. Submission of the completion

summary in and of itself does not constitute completion of the Division request.

The Contractor may be subject to Liquidated Damages or other available remedies in accordance with Section 16, Default and Termination, of this Contract if the Contractor is in violation of this section.

K. Division Policies and Procedures

The Contractor shall comply with all applicable policies and procedures of the Division, such as Mississippi Administrative Code, Title 23, 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. Changes in applicable policies and procedures can be made via updates to the Administrative Code, Provider Reference Guide, State Plan, or through written communication from the Division to the Contractor.

If the Contractor elects not to reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the Contractor must furnish information about the services it does not cover in accordance with 42 C.F.R. § 438.102(b):

1. To the Division with its application for a Medicaid contract and whenever the Contractor adopts the policy during the term of the Contract;

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

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

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

L. Data Exchange Requirements

The Contractor shall be able to receive, maintain and utilize data extracts from the Division and/or its contractors, e.g., pharmacy data from the Division or its PBM. These data extract files will be used for obtaining necessary information to properly identify members, reimburse providers for services rendered, and/or to reconcile records accordingly.

The Contractor shall systematically update its database within five (5) calendar days of receipt of the files, and shall ensure that their Subcontractors update within five (5) calendar days of receipt of the files. The Contractor must notify the Division when unable to comply

with this requirement with reason and proposed resolution. Any data file unable to systematically update must be manually updated within one (1) calendar day of receipt. Data extract files include but are not limited to the following:

1. Daily Active Provider Extract;
2. Weekly Provider Affiliation Details Extract;
3. 834 Enrollment Files;
4. 835 Claims Payment Remittance Advice Transaction;
5. 277 Claims Acknowledgement;
6. NCPDP Formulary;
7. NCPDP Response File;
8. TPL Resource/Policy Information File, etc.;
9. Claims History Extracts; and
10. Prior Authorization Extracts.

The Division may impose liquidated damages under Section 15, Default and Termination, of this Contract for non-compliance with these requirements.

M. <u>Administration, Management, Facilities and Resources</u>

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 Members, as specified in this Contract, RFP, the Contractor's 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 Contractor 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.

The Contractor shall have, at a minimum, the following key management personnel or persons with comparable qualifications, as listed below, employed during the term of this Contract.

Executive Positions:

1. Chief Executive Officer (CEO): A full-time designated CEO (Contract Officer), with decision-making authority, to administer the day-to-day business activities conducted pursuant to this Contract located in Mississippi; The Mississippi CEO 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.

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

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

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

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

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

Administrative Positions:

1. Provider Services Manager: A dedicated, full-time professional located in Mississippi to be responsible for Provider Services and network development.

2. Member Services Manager: A dedicated, full-time professional located in Mississippi to be responsible for Member Services functions.

3. Quality Management Director: A designated health care practitioner to oversee quality management and improvement activities.

4. Utilization Management Coordinator: A designated health care practitioner to be

responsible for utilization management functions.

5. Complaint/Grievance Coordinator: A dedicated person for the processing and resolution of Complaints, Grievances, and Appeals.

6. Claims Administrator: A dedicated professional to oversee claims administration.

7. Other key personnel as identified by the Contractor.

The Division must approve key personnel required to be located in Mississippi 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) calendar days. The Contractor must notify the Division within five (5) business days of learning that any key position is vacant or anticipated to be vacant within the next thirty (30) calendar days.

The Division may impose liquidated damages, or other available remedies, if any key management personnel positions remain vacant for greater than ninety (90) calendar days in accordance with Section 16.E, Liquidated Damages. Contractor must submit to the Division for prior approval the proposed replacement for key positions at least fifteen (15) calendar days before hire. If the position is filled without Division approval, the Division may impose liquidated damages or other available remedies in accordance with Section 16.E, Liquidated Damages, of this Contract.

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

1. A designated person to be responsible for data processing and the provision of accurate and timely reports and Member Encounter Data to the Division;

2. Designated staff to be responsible for ensuring that all Network Providers, and all Out-of-network Providers to whom Members may be referred, are properly licensed in accordance with Federal and State law and regulations;

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

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

5. Sufficient medical management staffing to perform all necessary medical assessments and to meet all MississippiCAN Members' Care Management needs at all times; and

6. A designee who can respond to issues involving systems and reporting, Member Encounter Data, Appeals and Grievances, quality assessment, Member services, Provider services, EPSDT services management, pharmacy management, medical management, and Care Management.

N. Base of Operations

The Contractor shall not be located outside of the United States.

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 and that space must include, at a minimum, the following:

1. A private office with a door that locks;
2. A desk and desk chair;
3. A computer with a printer;
4. Equipment to send and receive facsimile transmissions;
5. A telephone;
6. A bookcase;
7. A file cabinet that locks;
8. Internet access; and
9. Standard office supplies.

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

Contractor shall ensure that no claims paid by Contractor to a network provider, out of network provider, Subcontractor, or financial institution located outside of the United States are considered in the development of actuarially sound capitation rates.

O. Cultural Competency

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

The Contractor must promote access and delivery of services, in a culturally competent manner to all Medicaid beneficiaries and Members including, but not limited, to those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of race, color, religion, national origin, sex, sexual orientation, gender, or gender identity. The Contractor must ensure that beneficiaries have access to covered services that are delivered in a manner that meets their unique needs.

P. Representatives for the Division and Contractor

At its discretion, the Division may rely on contracted Agents to perform selected activities under the direction of the Division. Some of these Agents may include but are not limited to the (1) Utilization Management Contractor(s), who will perform designated Prior Authorization, data analyses, and related functions, (2) the Fiscal Agent that will process Contractor Member Encounter Data and provide Enrollment assistance to Members, and (3) the External Quality Review Organization.

Q. Risk Management

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

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

1. Workers' Compensation

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

2. Liability

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

   The Contractor shall obtain, purchase and maintain, during the Contract period general liability insurance against bodily injury or death in an amount commensurate

with the responsibilities and liabilities under the terms of this Contractor; and insurance against property damage and fire insurance including contents coverage for all records maintained pursuant to this Contract in an amount commensurate with the responsibilities and liabilities under the terms of this Contract. The Contractor shall furnish to the Division certificates evidencing such insurance is in effect after award of contract is accepted and annually thereafter.

R. Readiness Reviews

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

SECTION 2 – DEFINITIONS

A. Definitions

1. **Abuse**: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of healthcare. It also includes Member practices that result in unnecessary cost to the Medicaid program.

2. **Administrative Service:** Administrative Service means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of, the delivery of, and payment for Covered Services, including but not limited to network utilization, clinical or quality management, service authorization, claims processing, management information systems operation, reporting, and infrastructure development for, preparation of, and delivery of, all required Deliverables under the Contract.

3. **Adverse Benefit Determination:** The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division; the failure of the Contractor to act within the timeframes provided in 42 C.F.R. § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; for residents in a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 C.F.R. § 438.52(b)(2)(ii); the denial of an enrollee's request to dispute a financial liability,

including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; and determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of Section 1919(e)(7) of the Act, if applicable.

4. **Actuary:** An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

5. **Agent:** An authorized entity that acts on behalf of the Division of Medicaid.

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

7. **Authorized Representative:** A person or entity acting on behalf of a Member with the Member's written consent or through the appointment by a court, legal guardian or other body holding legal standing to act on behalf of the Member.

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

9. **Behavioral/ Mental Health/Substance Use Disorder Services: Behavioral/**Mental health and/or substance and alcohol use disorder treatment services that are provided by the county mental health/intellectual disability/developmental disability programs, the single county authority administrators, or other appropriately licensed health care practitioners.

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

11. **Capitation Payments:** A payment the Division makes periodically to the Contractor on behalf of each Member enrolled under this Contract and based on the actuarially sound capitation rate developed as defined in 42 C.F.R. § 438.4 for the provision of services under the State plan. The Division makes the payment regardless of whether the particular Member receives services during the period covered by the payment.

12. **Choice Counseling:** The provision of information and services designed to assist Members in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among Contractors and Primary Care Providers. Choice counseling does not include making recommendations for or against enrollment into a specific Contractor.

13. **Clean Claim:** As defined by Miss. Code Ann. § 83-9-5, a Clean Claim refers to a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the Contractor.

14. **Closed Panel:** Providers who are no longer accepting new patients for the Contractor as part of the MississippiCAN Program have a Closed Panel.

15. **Complaint:** An expression of dissatisfaction, regardless of whether identified by the Provider as a "Complaint", received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

16. **Continued Stay Reviews:** Continued stay reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate.

17. **Contract Officer:** A representative of the entity entering into the Contract, with full decision-making authority for the entity, who reserves the right to delegate such duties as may be appropriate to others in the Officer's employment or under the Officer's supervision.

18. **Contractor:** Per 42 C.F.R. Part 438, a managed care Contractor providing services through various delivery systems may be a Managed Care Organization (MCO) as authorized under 1932(a)(1)(A) of the Social Security Act.

19. **Coordinated Care Organization:** An organization that meets the requirements for participation as a Contractor in the MississippiCAN Program and manages the purchase and provision of health care services under the MississippiCAN Program.

20. **Covered Service:** All health care services and benefits the Contractor must arrange to provide to Members, including all services required by the Contract and state and federal law, and all other services negotiated by the Parties.

21. **Credibility Adjustment:** An adjustment to the Medical Loss Ratio (MLR) provided by the Contractor in accordance with 42 C.F.R. § 438.8 to account for a difference between the actual and target MLR that may be due to random statistical variation.

22. **Credible Allegation of Fraud:** An allegation of fraud, which has been verified by the State (Division) and the Contractor, from any source, including but not limited to

the following:

a. Fraud hotline Complaints;

b. Claims data mining;

c. Patterns identified through provider audits, civil false claims cases and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

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

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

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

26. **Division:** The Division of Medicaid, Office of the Governor, State of Mississippi.

27. **Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Services:** As defined by Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and Federal regulations at 42 C.F.R. Part 441 Subpart B and in Mississippi State Plan, Administrative Code, and written communication to the Contractor. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for EPSDT eligible Members who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, behavioral/mental health, substance use, developmental, and specialty services.

28. **Emergency Care:** Covered inpatient or outpatient hospital services for an emergency medical condition which means the sudden onset of 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 placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child):

a. In serious jeopardy;

b. Serious impairment of bodily functions; or

c. Serious dysfunction of any bodily organ or part.

29. **Emergency Medical Condition:** 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.

30. **Emergency Services:** Covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a provider that is qualified to furnish these services under Medicaid and needed to evaluate or stabilize an Emergency Medical Condition. This in accordance with 42 C.F.R. § 438.114.

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

32. **Enrollment:** Adverse Benefit Determination taken by the Division to add a Member's name to the Contractor's monthly Member Listing report following the receipt and approval by the Division of an Enrollment application from an eligible Member who selects a Contractor or upon Auto enrollment of a Member to a Contractor.

33. **Expedited Resolution:** An expedited review by the Contractor of a Contractor Adverse Benefit Determination.

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

35. **External Quality Review:** The analysis and evaluation by an EQRO, or aggregated information in quality timeliness, and access to the health care services that the Contractor, or their contractors furnish to Medicaid beneficiaries.

36. **External Quality Review Organization:** An organization that meets the competence and independence requirements set forth in § 438.354, and performs external quality review, other EQR-related activities as set forth in § 438.358, or both.

37. **Federally Qualified Health Centers:** All organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or

population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

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

39. **Financial Relationship:** A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how may levels removed from a direct interest; or a compensation arrangement with an entity.

40. **Fraud:** The intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

41. **Grievance:** An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance", received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

42. **Grievance and Appeal System:** The processes the Contractor implements to handle Appeals of an Adverse Benefit Determination and Grievances, as well as the processes to collect and track information about them.

43. **Health Care Services:** All Medicaid services provided by a Contractor under contract with the State Medicaid agency in any setting, including but not limited to medical care, behavioral health care, and supports.

44. **Indian:** Any individual defined at 25 U.S.C. 1603(13), 1603(28), 1679(a), or who has been determined eligible as Indian, under 42 C.F.R. § 136.12.

45. **Indian Health Care Provider:** A health care program operated by the Indian Health Service (HIS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

46. **Insolvency:** The inability of the Contractor to pay its obligations when they are due,

or when its admitted assets do not exceed its liabilities plus the greater of: (i) any capital and surplus required by law for its organization; or (ii) the total par or stated value of its authorized and issued capital stock. "Liabilities" shall include, but not be limited to, reserves required by the Department of Insurance pursuant to Miss. Code Ann. § 83-41-329 (1972 as amended).

47. **Marketing:** Any communication from the Contractor to a Medicaid beneficiary who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the beneficiary to enroll in that particular Contractor or either to not enroll in or to disenroll from another Contractor. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 C.F.R. § 155.20, about the qualified health plan.

48. **Material Adjustment:** An adjustment that, using reasonable actuarial judgment, has a significant impact on the development of the capitation payment such that its omission or misstatement could impact a determination whether the development of the capitation rate is consistent with generally accepted actuarial principles and practices.

49. **Maternity "Kick" Payment:** A case rate payment to the Contractor for hospital inpatient physician and facility maternity delivery services. The Maternity "Kick" Payment will be paid to the Contractor when the Division determines a Member delivers a live baby or stillborn baby. The Maternity "Kick" Payment is paid to the Contractor in addition to the monthly full risk, prepaid capitation rate for the rate cells of Pregnant Women and MA Adult Females.

50. **Medicaid Investigated Grievance:** A Member or Provider Grievance made to the Division consisting of complaints or disputes expressing dissatisfaction with any aspect of the operations, activities, or behavior of the Contractor, or its Providers, that is in violation of the terms of this Contract and/or state or federal law and that has the potential to cause material harm to the complainant regardless of whether remedial Adverse Benefit Determination is requested, and that is not resolved by the Contractor within thirty (30) calendar days from the date of notice by the Division.

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

52. **Medical Loss Ratio (MLR):** The proportion of premium revenues spent on clinical services and quality improvement by the Contractor as calculated in accordance with the requirements of 42 C.F.R. § 438.8.

53. **Medical Loss Ratio Reporting (MLR) Year:** A twelve (12) month period consistent with the Rating Period (e.g., July 1 through June 30) during which benefits and services are provided to Members through contract with the Division.

54. **Medical Record:** A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Member including inpatient, outpatient, referral services and emergency medical services whether provided by Network Providers or Out-of-network Providers.

55. **Medically Necessary Services:** As defined by the Social Security Act, Section 1905 (42 USC 1396d(a)), the State Plan, and Administrative Code, Medically Necessary Services are also the most appropriate services that help achieve age-appropriate growth and development and will allow a Member to attain, maintain, or regain capacity. Medically Necessary Services may also be those services for Members that are necessary to correct or ameliorate disorders and physical and behavioral/mental illnesses and conditions, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

56. **Member:** An individual who meets all of the eligibility requirements for Mississippi Medicaid and enrolls with a Contractor under the MississippiCAN Program.

57. **Member Encounter Data:** The information relating to the receipt of any item(s) or service(s) by a Member under this Contract and is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818.

58. **Member Encounter Record:** A single electronic record of Claims for any item(s) or service(s) adjudicated by the Contractor, or by its Subcontractors, to Providers that have provided services to Members that is subject to the requirements of 42 C.F.R. §§ 438.242 and 438.818. An Encounter Record captures and reports information about each specific service provided each time a Member visits a Provider, regardless of the contractual relationship between the Contractor and Provider or Subcontractor and Provider.

59. **Member Encounter Record Denied:** Claims/lines are deemed as able to be processed and are given a final disposition of “no payment” within the claims adjudication processing system.

60. **Member Encounter Record Rejected:** Claims/lines are deemed as unable to be processed at any stage in the claims intake system.

61. **Member Months**: The number of months a Member or group of Members is covered by Contractor during the Medical Loss Ratio Reporting (MLR) Year.

62. **Mississippi Coordinated Access Network (MississippiCAN) Program:** Mississippi Medicaid’s coordinated care program for eligible Members that enroll with a Contractor, which are reimbursed with actuarially sound prepaid Capitation Payment rates.

63. **Network Provider:** Any provider, group of providers, or entity that is credentialed and has a valid network provider agreement with the Contractor, or a Subcontractor,

and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with the Contractor. A network provider is not a Subcontractor by virtue of the network provider agreement.

64. **Never Events:** Adverse events that are serious, largely preventable, and of concern to both the public and health care Providers for the purpose of public accountability as defined by the National Coverage Determinations (NCD) or the Division. The Never Events as defined in the NCD or the Division include ambulatory surgical centers (ASC) and practitioners as listed in the Mississippi State Plan.

65. **Non-claims Costs**: Those expenses for administrative services that are not: Incurred claims (as defined in paragraph (e)(2) of 42 C.F.R. § 438.8); expenditures on activities that improve health care quality (as defined in paragraph (e)(3) of 42 C.F.R. § 438.8); or licensing and regulatory fees, or Federal and State taxes (as defined in paragraph (f)(2) of 42 C.F.R. § 438.8).

66. **Non-Emergency Transportation:** Transportation for Members to receive medically necessary services on a non-emergency basis.

67. **Non-Emergency Admission Reviews:** Non-emergency inpatient admissions are admissions for planned or elective admissions and the Member has not been hospitalized.

68. **Open Panel:** Providers who are accepting new patients for the Contractor as part of the MississippiCAN Program.

69. **Overpayment:** Any payment made to a network provider by the Contractor to which the network provider is not entitled to under Title XIX of the Act or any payment to the Contractor by the Division to which the Contractor is not entitled under Title XIX of the Act.

70. **Out-of-network Provider:** A health care Provider who has not been credentialed by, does not hold current credentialed status, and/or does not have a signed Provider agreement with the Contractor.

71. **Outcomes:** Changes in member health, functional status, satisfaction or goal achievement that result from health care or supportive services.

72. **Panel:** Listing and number of Members that Network Providers have agreed to provide services for in accordance with this Contract.

73. **Partial Credibility:** A standard for which the experience of a Contractor is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target medical loss ratios is statistically significant. A Contractor that is assigned partial credibility (or is partially credible) will receive a credibility adjustment to its MLR.

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

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

76. **Pharmacy Benefit Manager (PBM):** A business that administers the prescription drug portion of covered services on behalf of the Contractor and/or the Division, in accordance with Miss. Code Ann. § 73-21-179.

77. **Physician-Administered Drugs and Implantable Drug System Devices:** Drugs, other than vaccines, diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, biological or implantable drug system device covered under the Social Security Act § 1927(k)(2) that:

    a. Are administered by a medical professional in a physician's office or other outpatient clinical setting;

    b. Are incident to physician services that are separately billed to the Division of Medicaid;

    c. Qualifies for rebate in accordance with 42 U.S.C. § 1396r-8;

    d. Are Food and Drug Administration (FDA) approved or follows medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by CMS; and

    e. Are not considered cosmetic, investigational, experimental or unproven.

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

79. **Potential Enrollee:** A Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given Contractor but is not yet Member of a specific Contractor.

80. **Preferred Drug List (PDL):** A medication list recommended to the Division of Medicaid by the Pharmacy & Therapeutics Committee and approved by the Executive Director of the Division of Medicaid for use in the Fee-for-Service delivery system and the MississippiCAN Program. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. The Contractor is required to follow the guidance provided in the PDL.

81. **Premium Revenue:** Includes the following for the MLR Reporting Year:

    a. Capitation Payments, developed in accordance with 42 C.F.R. § 438.4, to the Contractor, for all Members under a risk contract approved under 42 C.F.R. § 438.3(a), excluding payments made under to 42 C.F.R. § 438.6(d).

    b. State-developed one time payments, for specific life events of Members.

    c. Other payments to the Contractor approved under 42 C.F.R. § 438.6(b)(3).

    d. Unpaid cost-sharing amounts that the Contractor could have collected from Members under the contract, except those amounts the Contractor can show it made a reasonable, but unsuccessful, effort to collect.

    e. All changes to unearned premium reserves.

    f. Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 C.F.R. §§ 438.5 or 438.6.

82. **Primary Care Provider (PCP):** Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Physician Assistant, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology. For purposes of enhanced PCP payments authorized by Mississippi Code § 43-13-117 (A) (6), PCP is defined in State Plan Attachment 4.19-B.

83. **Prior Authorization:** A determination to authorize a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

84. **Provider:** Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

85. **Provider Network:** The Panel of health service Providers with which the Contractor contracts for the provision of covered services to Members and Out-of-network Providers administering services to Members.

86. **Provider-Preventable Conditions:** A condition that meets the definition of a "health care-acquired condition" or an "other Provider-preventable condition" as defined by

42 C.F.R. § 447.26.

87. **Quality:** As it pertains to external quality review, means the degree to which a Contractor entity increases the likelihood of desired outcomes of its enrollees through (1) Its structural and operational characteristics (2) The provision of services that are consistent with current professional, evidence-based-knowledge (3) Interventions for performance improvement.

88. **Rate Cell:** A set of mutually exclusive categories of Members that is defined by one or more characteristics for the purpose of determining the capitation rate and making a Capitation Payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each Member should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under this Contract.

89. **Rating Period**: A period of twelve (12) months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 C.F.R. § 438.7(a). The Rating Period shall be July 1 to June 30 consistent with the State fiscal year.

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

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

85. **Reserve Account:** An account established pursuant to Section 13.A, Capitation Payments, of this Contract into which a portion of the payments made by the Division are deposited and held as security for any refund or liquidated damages due the Division.

86. **Retroactive Eligibility Review:** A review that is conducted after services are provided to a Member and the Member is retroactively determined to be eligible for Medicaid. The Division provides retroactive Medicaid eligibility for a Member that was not eligible for Medicaid benefits at the time of hospitalization. The Division will only retroactively enroll newborns in the categories of eligibility containing children under the age of one (1).

87. **Retrospective Inpatient Hospital Review:** A review that is conducted for inpatient hospital services after the services are provided to a Member. Retrospective Inpatient Hospital Reviews include those admissions where the Member was admitted and discharged and certification was not obtained while the Member was hospitalized.

88. **Retrospective Review:** A review that is conducted after services are provided to a Member.

89. **Risk Adjustment**: A methodology to account for the health status of Members via relative risk factors when predicting or explaining costs of services covered under the contract for defined populations or for evaluating retrospectively the experience of Contractor. Must be developed in a budget neutral manner consistent with generally accepted actuarial principles and practices.

90. **Rural Health Clinics:** The Rural Health Clinics (RHCs) program is intended to increase primary care services for Medicaid and Medicare members in rural communities. RHCs can be public, private, or non-profit. RHCs receive enhanced reimbursement rates for providing Medicaid and Medicare services in rural areas. RHCs must be located in rural, underserved areas and must use midlevel practitioners.

91. **Service Authorization:** A managed care Member's request for the provision of services

92. **State Administrative Hearing:** A hearing conducted by the Division or its Subcontractor. Any Provider Appeal of an Adverse Benefit Determination that is not resolved wholly in favor of the Provider by the Contractor may be Appealed by the Provider or the Provider's authorized representative to the Division for a State Administrative Hearing once the Provider is deemed to have exhausted the Contractor's appeals process.

93. **State Fair Hearing:** A hearing conducted by the Division or its Agent in accordance with 42 C.F.R. § 431 Subpart E for applicants, Members or beneficiaries.

94. **State Issue:** A verbal or written request, point of discussion, or expression of dissatisfaction received from a Medicaid Member, Member's representative or Medicaid Provider that may include benefits, services, reimbursement, enrollment, utilization management, or other concerns related to service delivery. The Division forwards this concern to the Contractor for response and resolution to ensure that the Contractor is in compliance with the goals of the MississippiCAN program.

95. **State Medicaid Fraud Control Unit:** A Unit of the Mississippi Attorney General's office. This Unit has the mission of investigating and prosecuting criminal cases of Fraud in the Mississippi Medicaid program.

96. **Subcontract:** An agreement between the Contractor and any individual firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, or any other entity to perform part or all of the Contractor's responsibilities under this Contract. Subcontracts must be approved in writing by the Division prior to the start date of the agreement.

97. **Subcontractor:** An entity with which the Contractor enters into an agreement to provide contractually required services. An individual or entity, including delegated

vendors, that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this Contract. A network provider is not a Subcontractor by virtue of the network provider agreement with the Contractor.

98. **Substance Use Disorder:** Also known as drug/alcohol use disorder, is a condition in which the use of one or more substances leads to a clinically significant impairment or distress.

99. **Substance Use Disorder Benefits:** benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

100. **Third Party Liability/Resource:** Any resource available to a Member for the payment of medical expenses associated with the provision of covered services, other than those which are exempt under Title XIX of the Act, including but not limited to, insurers and workers' compensation plan.

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

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

103. **Urgent Care:** Urgent care services are utilized because the Members primary care physician is not available. An urgent condition isn't life threatening but may need prompt attention. Urgent care services are for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care. Urgent care centers can typically treat things including, but not limited to, sprains, strains, minor broken bones.

104. **Urgent care and emergency care reviews:** A review of the urgent care services or emergency care services that is conducted after services are provided to a Member.

105. **Validation:** The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

106. **Weekend and Holiday Admission Reviews:** Weekend admissions are those admissions where the Member was admitted on a weekend (Friday, Saturday, or

Sunday). Holiday admissions are defined as those admissions where a Member is admitted on a state-observed holiday.

B. Acronyms

1. ABN – Advance Beneficiary Notification
2. ACIP – Advisory Committee on Immunization Practices
3. CAHPS® – Consumer Assessment of Healthcare Providers and Systems
4. CAP – Corrective Action Plan
5. CEO – Chief Executive Officer
6. CLIA – Clinical Laboratory Improvement Amendments
7. CMS – Centers for Medicare and Medicaid Services
8. COE – Category of Eligibility
9. CPS – Child Protection Services
10. CST – Central Standard Time
11. DHHS – Department of Health and Human Services
12. DOI – Department of Insurance
13. ECM – Electronic Claims Management
14. EIN – Employer Identification Number
15. EHR – Electronic Health Record
16. EPSDT – Early and Periodic Screening, Diagnosis and Treatment
17. EQR – External Quality Review
18. EQRO – External Quality Review Organization
19. FFS – Fee-for-Service
20. FQHC – Federally Qualified Health Center
21. GAAP – Generally Accepted Accounting Principles
22. HEDIS® – Healthcare Effectiveness Data and Information Set
23. HHS – United States Department of Health and Human Services
24. HIPAA – Health Insurance Portability and Accountability Act
25. ICF/IID – Intermediate Care Facility for Individuals with Intellectual Disabilities
26. I/T/U – Indian Tribe, Tribal Organization, or Urban Indian Organization
27. MDHS – Mississippi Department of Human Services
28. MEPA – Mississippi Employment Protection Act
29. MES – Medicaid Enterprise System
30. MLR – Medical Loss Ratio
31. MMIS – Medicaid Management Information System
32. MS HIN – Mississippi Health Information Network
33. MississippiCAN – Mississippi Coordinated Access Network
34. MSDH – Mississippi State Department of Health
35. NAIC – National Association of Insurance Commissioners
36. NCCI – The National Correct Coding Initiative
37. NET – Non-Emergency Transportation
38. NCQA – National Committee for Quality Assurance
39. NPI – National Provider Identifier
40. OIG – Office of Inspector General
41. PBM – Pharmacy Benefits Manager

42. PCP – Primary Care Provider
43. PDL – Preferred Drug List
44. PHRM/ISS – Perinatal High Risk Management/Infant Services System
45. PHI – Protected Health Information
46. PI – Program Integrity
47. PII – Personal Identification Information
48. PIP – Performance Improvement Project
49. PMPM – Per Member Per Month
50. PRTF – Psychiatric Residential Treatment Facility
51. QI – Quality Improvement
52. QM – Quality Management
53. RAC – Recovery Audit Contractor
54. RHC – Rural Health Clinic
55. TANF – Temporary Assistance for Needy Families
56. TIN – Tax Identification Number
57. TPL – Third Party Liability
58. TTY/TTD – Text Telephones/Telecommunications Device for the Deaf
59. VP – Video Phones

SECTION 3 – MEMBER ELIGIBILITY

A. General Requirements

Eligibility criteria for the MississippiCAN Program will be the same as the eligibility criteria for Mississippi Medicaid. MississippiCAN Members must also meet additional requirements for Enrollment as described below.

The Program will operate on a statewide basis. The Program will include both (1) Members who have the option to disenroll and receive services through the Fee-for- Service delivery system, and (2) Members who may not disenroll depending on Member's category of eligibility. Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in 42 C.F.R. § 438.50(a).

The Division reserves the right to assign a Member to a specific health plan.

B. Populations Who Have the Option to Enroll in the MississippiCAN Program

Table 1 specifies Medicaid populations that may voluntarily enroll in MississippiCAN. The Division will enroll eligible Members within these categories into MississippiCAN, and Members will have the option to disenroll once within ninety (90) days of initial Enrollment and thereafter during annual open enrollment periods. Members that disenroll will be served through the Medicaid fee-for-service system.

Table 1. Populations Who Have the Option to Enroll

Populations Who Have the Option to Enroll	Age Categories*

Populations Who Have the Option to Enroll	Age Categories*
SSI	0-19
Disabled Child Living at Home	0-19
DHS-Foster Care Children	0-19
DHS-Foster Care Children (Adoption Assistance)	0-19
Indians	0-65
*The hyphen denotes "up to" the age listed.	

C. Populations Who May Not Disenroll from the MississippiCAN Program

Table 2 specifies Medicaid populations that the Division will enroll into the MississippiCAN Program on a mandatory basis. These Members may voluntarily select or be automatically enrolled with a Contractor, but may not opt out of the MississippiCAN Program. Members may change Contractor selection once within the first ninety (90) days of Enrollment and thereafter during open enrollment periods.

Table 2. Populations Who May Not Disenroll

Population Who May Not Disenroll	Age Categories*
SSI	19-65
Working Disabled	19-65
Breast and Cervical Cancer	19-65
Pregnant Women	8-65
Parent/Caretakers	19-65
Medical Assistance Children (Populations other than those listed in Table 1)	0-19
*The hyphen denotes "up to" the age listed.	

D. Coordination with the Division's Agent

The Contractor must develop and maintain written policies and procedures for coordinating Enrollment information with the Division or its contracted Agent. The Contractor must receive advance written approval from the Division prior to use of these policies and procedures.

SECTION 4 – MISSISSIPPICAN ENROLLMENT AND DISENROLLMENT

The Division or its Agent shall send written notification to the Member to inform the Member of Enrollment into the MississippiCAN Program and to select a Contractor and PCP. The Division and its Agent will be responsible for Choice Counseling for the Member.

A. Enrollment of Members with a Contractor

A Member shall have thirty (30) Calendar Days to select a Contractor and a PCP. Members who fail to make a voluntary Contractor selection within thirty (30) calendar days of their Enrollment will be auto enrolled to a Contractor by the Division. Auto-assignment rules will

include provisions to:

1. Determine whether the Member was previously enrolled with a Contractor within the previous sixty (60) calendar days; and assign Member to that Contractor;

2. Determine whether an immediate family member is assigned to a Contractor and assign the Member to that Contractor;

3. Review paid claims data within the past six (6) months and assign Member to the Contractor that has a contract with a PCP with whom the Member has a history in the last six (6) months; and

4. If no previous assignment within sixty (60) days; and no immediate family members already enrolled, of if the Member does not have a prior history with a PCP, then assign the Member to Contractor with a PCP closest to Member's home address.

5. If multiple Contractors meet this standard, then assignment will occur using a random process.

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

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

Beneficiaries already enrolled with a Contractor are given priority to continue that enrollment if the Contractor entity does not have the capacity to accept all those seeking enrollment under the program.

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

B. <u>Choice of a Network Provider</u>

The Contractor shall offer each Member the opportunity to choose from at least two (2) network Primary Care Providers (PCPs). If the Member does not voluntarily choose a PCP, the Contractor may assign the Member a PCP. A Member who has received Prior Authorization from the Contractor for referral to a specialist or from the Division's vendor for inpatient care shall be allowed to choose from among all the available specialists and

hospitals within the Contractor's network to the extent possible, reasonable, and appropriate.

The Contractor is responsible for assigning Members to PCPs to serve as Medical Homes and must have written policies and procedures for assigning Members to PCPs. The Contractor must submit PCP assignment policies and procedures to the Division for review and approval upon contract award and must also submit any updates. 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:

1. **Providers Qualifying as Primary Care Providers (PCP):** The following types of specialty Providers may perform as Primary Care Providers:

    a. Pediatricians;

    b. Family and General Practitioners;

    c. Internists;

    d. Obstetrician/Gynecologists;

    e. Nurse Practitioners (contracted nurse practitioners acting as PCPs must have a formal, written collaborative/consultative relationship with a licensed physician with admitting privileges at an inpatient hospital facility or have a written agreement with a physician who has admitting privileges at a hospital appropriate for the patient needing admission);

    f. Physician Assistants;

    g. Specialists who perform primary care functions upon request; or

    h. Other Providers approved by the Division. (e.g., surgeons, clinics, including but not limited to Federally Qualified Health Centers, Rural Health Clinics, Health Departments, and other similar community clinics).

    i. If applicable, for Members who qualify under the rural resident exception, (under which the Division may limit a rural area resident to a single Contractor), the limitation on the Member's freedom to change between Primary Care Providers can only be as restrictive as the limitations on Member-requested Disenrollment.

2. **Default Assignment of PCP**: If the Member does not request an available PCP within thirty (30) days of Enrollment with the Contractor, then the Contractor must assign the new Member to a network PCP within sixty (60) days of Enrollment,

taking into consideration such known factors as current Provider relationships, language needs (to the extent they are known), age and sex, enrollment of family members (e.g., siblings), and area of residence. The Contractor's policies and procedures must include a documented process for ensuring that the PCP is willing to accept assignment of a Member prior to assigning the Member to the PCP.

3. **Change of PCP**: The Contractor must allow Members to select or be assigned to a new PCP when requested by the Member, 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.

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

C. Enrollment Period

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

The Division shall provide Members with open enrollment periods in accordance with program enrollment requirements and the length of Member enrollment. The first ninety (90) days following a Member's initial Enrollment will be an open Enrollment period during which the Member can enroll once with a different Contractor without cause. Members subject to either mandatory or optional Enrollment into MississippiCAN are subject to the enrollment requirements as outlined below:

1. **Enrollment of Populations with the Option to Disenroll:** The Division will enroll newly eligible Medicaid beneficiaries into MississippiCAN. Beneficiaries who are in eligibility categories that may voluntarily participate in MississippiCAN will have the option to disenroll from the MississippiCAN Program without cause or change Contractors without cause during the ninety (90) day period following the date the Division sends the Member notice of Enrollment or the date of the Member'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 Member to miss the annual Disenrollment opportunity; or when the Division imposes an intermediate sanction on the Contractor as specified in this Contract in Section 16, Default and Termination, of this Contract.

2. **Enrollment of Populations Who May Not Disenroll:** Members who are mandated

into the Program may change Contractors without cause during the ninety (90) day period following the date the Division sends the Member notice of Enrollment or the date of the Member's initial Enrollment, whichever is later. After the Member's initial Enrollment, the Member may change Contractors without cause during the annual open Enrollment period.

The Division or its Agent will notify Members at least once every twelve (12) months, and at least sixty (60) Calendar Days prior to the date upon which the Enrollment period ends that they have the opportunity to switch Contractors or to change their program selection if the Member has the option to disenroll from MississippiCAN. Members who do not make a choice will be deemed to have chosen to remain with their current Contractor.

D. Member Information Packet

The Contractor shall provide each Member, prior to the first day of the month in which their Enrollment starts, an information packet indicating the Member's first effective date of Enrollment. The Contractor must ensure the information is provided no later than fourteen (14) Calendar Days after the Contractor receives notice of the Member's Enrollment. The Contractor shall utilize at least standard mail, in envelopes marked with the phrase "Return Services Requested" as the medium for providing the Member identification cards. The Division must receive a copy of this packet on an annual basis for review and approval, or at any point when changes are made to the packet. At a minimum, the Member information packet shall include:

1. An introduction letter;
2. A MississippiCAN Program identification card;
3. Information about how to obtain a copy of a Provider Directory in compliance with 42 C.F.R. § 438.10(f)(6)(h) at a minimum; and
4. A Member Handbook.

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

E. Health Risk Screening

The Contractor shall complete a brief five (5) question Health Risk Screening for all Members to identify Members who may require assignment into medium or high risk levels for Care Management. The Health Risk Screening may be conducted via telephone, via mail, via secure email if the Member designates an email address and chooses it for communication, or via secure web portal. Communications with Members must be clear and

understandable. The Contractor shall complete the Health Risk Screening within the following time frames:

1. Within ninety (90) Calendar Days for all Members upon contract implementation; and

2. Within thirty (30) calendar days from the effective date of Enrollment for newly enrolled Members after contract operations begin.

Please refer to Section 8, Care Management, of this Contract for additional requirements related to Care Management.

F. Enrollment Verification

The Division, or its Agent, shall provide the Contractor on a monthly basis a listing of all MississippiCAN Program Members who have selected or been assigned to the Contractor.

The Contractor must ensure that Out-of-network Providers can verify Member Enrollment in the Contractor's plan prior to treating a patient for non-Emergency Services. Within five (5) business days of the date on which the Contractor receives the Member Listing Report from the Division, the Contractor must provide Network Providers and Out-of-network Providers the ability to verify Enrollment by telephone or by another timely mechanism. The Division may impose liquidated damages or other available remedies in accordance with Section 16, Default and Termination, of this Contract if the Contractor is in violation of this section.

G. Disenrollment

A Member must be disenrolled from the Contractor if the Member:

1. No longer resides in the State of Mississippi;

2. Is deceased;

3. No longer qualifies for medical assistance under one of the Medicaid eligibility categories in the eligible population;

4. Becomes a nursing home resident. For the purposes of determining eligibility for MississippiCAN, PRTFs and ICF/IIDs shall not be considered a long term care facility;

5. Becomes enrolled in a waiver program;

6. Becomes eligible for Medicare coverage; or

7. Is diagnosed with hemophilia.

The Contractor may request Disenrollment of a Member at any time based upon one or more of the reasons listed herein. The Contractor must notify the Division within three (3) calendar days of receipt of the Member Listing Report of their request that a Member be disenrolled and provide written documentation of the reason for the Disenrollment request. The Division will make a final determination regarding Disenrollment. Approved Disenrollment shall be effective on the first (1st) day of the calendar month for which the Disenrollment appears on the Member Listing Report. If the Division fails to make a Disenrollment determination by the first day of the second month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the Division, the Disenrollment is considered approved.

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

Additionally, any Member may request Disenrollment from the Contractor for cause if:

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

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

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

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

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

Member 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 (1st) day of the second (2nd) month following the month in which the Member or the Contractor files the request with the Division.

H. Disenrollment of Nursing Home Residents

Members who become Nursing Home, or ICF/IID, Residents must be disenrolled from the Contractor. Once the Medicaid office has completed the nursing home, or ICF/IID, application process, and the long-term care segment has been entered, the Member will automatically be closed out of MississippiCAN Enrollment, with a closure date of one (1) day prior to the admission date.

For Members who become Nursing Home, or ICF/IID, Residents before the fifteenth (15th) day of a month, the Contractor will be required to refund the monthly capitation payment for

that Member to the Division. For Members who become Nursing Home, or ICF/IID, Residents on or after the fifteenth (15th) day of a month, the Contractor will be allowed to keep the monthly capitation payment for that Member.

For the purposes of determining eligibility for MississippiCAN, PRTFs shall not be considered a long term care facility.

I. Disenrollment of Medicare Recipients

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

The Contractor will be required to render services for the months of capitation payment from the Division for that Member.

J. Re-Enrollment and Retroactive Eligibility

The Division or its Agent will automatically re-assign a Member into the Contractor in which he or she was most recently assigned if the Member has a temporary loss of eligibility, defined as less than sixty (60) Calendar Days. The Division will only retroactively enroll newborns in the categories of eligibility containing children under one (1).

When Retroactive Eligibility and Retrospective Reviews requests are necessitated, the Contractor shall not deny payment for medically necessary covered services for lack of prior authorization or lack of referral. The Contractor shall not deny a claim on the basis of the provider's failure to file the claim within a specified time period after the date of service when the provider could not have reasonably known which Contractor the Member was in during the timely filing period.

K. Member Listing Report

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

The Member Listing Report shall be provided to the Contractor sufficiently in advance of the

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

L. Enrollment of Children in Foster Care

If the Contractor is responsible for the provision of services to children in foster care, the Contractor shall comply with policies for the relevant state agencies, such as DHS, CPS, or the Division, related to this population and associated state and federal requirements.

M. Enrollment Discrimination

The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract.

Contractor shall not discriminate against individuals eligible to enroll on the basis of health status or need for health care services.

The Contractor shall not discriminate against individuals eligible to enroll or on the basis of race, color, religion, sex, sexual orientation, gender identity, disability, 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, religion, national origin, sex, sexual orientation, gender identity, disability, limited English proficiency, marital status, political affiliation, or level of income.

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

The Division may impose liquidated damages or other available remedies in accordance with Section 16, Default and Termination, of this Contract if the Contractor is in violation of this section.

N. Special Rules for Indians

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

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

SECTION 5 – COVERED SERVICES AND BENEFITS

The Contractor must ensure that all services provided are Medically Necessary. The Contractor must submit reports related to covered services and benefits in accordance with Section 11, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract.

A. Covered Services

The Contractor shall provide all Medically Necessary covered services allowed under the MississippiCAN Program. The Contractor shall ensure that all covered services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee for service Medicaid as set forth in 42 C.F.R. § 440.230 and that no incentive is provided, monetary or otherwise, to Providers for withholding from Members' 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.

The Contractor shall comply with Medicaid NCCI guidelines. The Contractor shall have policies, approved by the Division, that address manually priced claims.

Contractor must have policies and procedures in place to deal with states of emergency. The Division may lift service limits for beneficiaries during states of emergency, and Contractor's must provide, at minimum, coverage for the same level of services being covered by the Division during the state of emergency.

B. Emergency Services

The Contractor shall provide all inpatient and outpatient Emergency Services in accordance with 42 C.F.R. § 438.114. The Contractor shall cover and pay for emergency medical services, including but not limited to dialysis and dialysis access services, regardless of whether the Provider that furnishes the services has a contract with the Contractor. The Contractor shall have policies that address emergency use of services in an inpatient and outpatient emergency setting.

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

1. A Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would 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.

2. The Contractor, or the member's Primary Care Provider (PCP), instructed the Member to seek Emergency Services.

The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms, inclusive of dialysis services, or refuse to cover Emergency Services based on the emergency room provider or hospital not notifying the Member's Primary Care Provider or Contractor of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

Coverage of Emergency Services is not subject to Prior Authorization requirements, but Contractor may include a requirement in its provider agreements that notice be given to Contractor regarding the use of Out-of-network Providers for Emergency Services.

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

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

C. Post-Stabilization Care Services

The Contractor shall cover and pay for Post-Stabilization Care Services in accordance with the provisions of 42 C.F.R. § 438.114(c).

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

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

2. The Contractor cannot be contacted; or

3. The Contractor representative and the treating physician cannot reach an agreement concerning the Member's care and a Contractor physician is not available for consultation. In this situation, the Contractor must give the treating physician the

opportunity to consult with a Contractor physician and the treating physician may continue with care of the patient until a Contractor physician is reached or one of the criteria of 42 C.F.R. § 438.114 is met.

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

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

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

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

4 The Member is discharged.

D. EPSDT Services

The Contractor shall comply with Sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and Federal regulations at 42 C.F.R. Part 441 Subpart B that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services.

The Contractor must have written policies and procedures, approved by the Division, related to the provision of 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 immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures of all EPSDT eligible Members, in accordance with the Periodicity Schedule established by the Division for EPSDT services, including periodic examinations for vision, dental, and hearing and all medically necessary services. The Contractor shall identify all EPSDT eligible Members whose Medical Records do not indicate up-to-date immunizations and shall ensure that these Members receive necessary immunizations.

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 work to improve the percentage of Members receiving appropriate screenings.

EPSDT wellness (screening) services shall be administered in accordance with Mississippi Administrative Code, State Plan and written communication from the Division to the Contractor. For CMS mandatory reporting purposes, including but not limited to CMS 416 reporting, EPSDT wellness (screening) services must be provided by enrolled Medicaid providers, including, but not limited to, the Mississippi State Department of Health, other

public and private agencies, private physicians, Rural Health Clinics, comprehensive health clinics, public schools and/or public school districts certified by the Mississippi Department of Education and similar agencies which provide various components of the EPSDT services, that have signed an EPSDT specific provider agreement. with the Division. The Division will provide the Contractor with a list of qualified EPSDT providers on a monthly basis. EPSDT providers who have not signed an EPSDT specific agreement with the Division shall not submit claims with preventive Medicine CPT codes. The Division will provide the Contractor with a list of qualified EPSDT providers on a monthly basis.

Enrolled Medicaid providers who have not signed an EPSDT specific provider agreement with the Division may render EPSDT wellness (screening) services. The Contractor shall not include wellness services rendered by providers who have not signed an EPSDT specific provider agreement with the Division in the Contractors' reports to the Division.

The Contractor must require that EPSDT providers, as defined by the Division, render age appropriate assessment screening services including components defined by the Division. If a suspected problem is detected by a screening examination, the Member must be evaluated as necessary for further diagnosis with referral, if indicated. This diagnosis is used to determine treatment needs.

The Contractor must establish a tracking system that provides information on compliance with EPSDT service provision requirements in the following areas:

1. Initial visit for newborns;

2. EPSDT screenings and reporting of all screening results; and

3. Diagnosis, treatment and/or referral for Member.

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

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

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

3. If requested, any necessary assistance with arranging for transportation to ensure that Members obtain necessary EPSDT screening services. This assistance must be offered at least three days prior to each due date of a child's periodic examination;

4. Protocols for conducting outreach with non-compliant Members, including home visits, as appropriate;

5. A process for outreach and follow-up to EPSDT eligible Members with special health

care needs; and;

6. For children in foster care only, a process for outreach and follow-up with County Department of Human Services Agencies to assure that they are notified of all EPSDT eligible members who are under their supervision and who are due to receive EPSDT screens and follow-up treatment.

7. The Contractor may develop alternate processes for follow-up and outreach subject to prior written approval from the Division.

E. Behavioral Health/Substance Use Disorder

The Contractor shall provide Behavioral Health/Substance Use Disorder Services to Members in the MississippiCAN Program in accordance with42 C.F.R. § 438.3 and the Mental Health Parity and Addiction Equity Act (MHPAEA). The Contractor shall comply with all requirements related to Care Management, access and availability with respect to Behavioral Health/Substance Use Disorder Services. All Behavioral Health/Substance Use Disorder Services covered by the Division for enrolled populations that are medically necessary must be covered. The Contractor's provision of Behavioral Health/Substance Use Disorder services shall fully comply with the requirements set forth in 42 C.F.R. §§ 438.900 through 438.930.

All Contract requirements herein shall apply to the provision of Behavioral Health/Substance Use Disorder Services unless specified.

Division policy regarding Behavioral Health/Substance Use Disorder Services is referenced in the Mississippi Administrative Code, Title 23, Part 206, but other sections of the code may also reference Behavioral Health/Substance Use Disorder Services.

F. Prescription Drugs, Physician-Administered Drugs and Implantable Drug System Devices

The Contractor shall comply with all requirements found in the Social Security Act section 1927 and all changes made to the Covered Outpatient Drug Section of the Patient Protection and Affordable Care Act (PPACA) found in 42 C.F.R. Part 447 [CMS 2345-FC].

The Contractor shall provide pharmacy services to Members enrolled in the MississippiCAN Program. The Contractor shall comply with the Mississippi Pharmacy Practice Act and the Mississippi Board of Pharmacy rules and regulations.

The Contractor is restricted from requiring Members to utilize a pharmacy that ships, mails, or delivers prescription drugs or devices. However, the Contractor may implement a mail-order pharmacy program in accordance with State and Federal law.

The Contractor shall provide Physician-Administered Drugs and Implantable Drug System Devices to Members enrolled in the MississippiCAN Program as defined in the Mississippi

Administrative Code, Title 23, Part 203.

The Contractor must use the most current version of the MS DOM Universal Preferred Drug List (PDL), which is subject to periodic changes. The Contractor must use the Medicaid PDL developed by the Division or its Agent and may not develop and use its own PDL. The Contractor will be provided opportunities to offer feedback on the PDL to the Division. A pharmacy representative from the plan shall attend the P&T committee meetings as a guest and will be offered the opportunity to contribute in an evaluative and educational capacity in post P&T committee meetings. The Executive Director of the Division has final authority on drugs with preferred and non-preferred status on the PDL. The Contractor shall follow the same PA criteria of that of FFS for drugs requiring PA on the PDL.

The Contractor must refer to the Pharmacy Services page on the Division's website for a current listing of prescription drugs on the PDL to ensure continuity of care for Members. Pursuant to 438.10(i), MCOs must make available in paper and electronic form the following Preferred Drug List information: which medications are covered (generic and name brand), what tier each medication is on, if applicable, and the information must be made available on the MCOs website.

The Contractor may require Prior Authorization in accordance with Section 5.J of this Contract for drugs outside the PDL. The Contractor must cover and pay for a minimum of a three (3)-day emergency supply of prior authorized drugs until authorization is completed.

The Contractor shall ensure that prescription drugs, Physician-Administered Drugs and implantable Drug System Devices are prescribed and dispensed in accordance with medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS). No payment may be made for services, procedures, devices, supplies or drugs which are still in clinical trials and/or investigative or experimental, cosmetic, or unproven in nature. The Contractor may consider exceptions to the criteria if there is sufficient documentation of stable therapy as reflected in ninety (90) calendar days of paid Medicaid claims.

The Contractor is not authorized to negotiate rebates for preferred products. The Division or its Agent will negotiate rebate agreements. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer, all Medicaid outpatient drug claims, including Provider-administered drugs, must be exempt from such rebate agreements. Covered outpatient drugs dispensed to Members eligible for medical assistance who are enrolled with the Contractor shall be subject to the same rebate requirements as the Division is subject under Section 1927 of the Act and the Division shall collect such rebates from manufacturers.

The Contractor shall not keep a spread between what the Contractor and its Pharmacy Benefit Manager (PBM) pay and what any participating pharmacy receives on any prescription drug claim dispensed to a Member.

The Contractor's reimbursement methodology for the PBM must be based on the actual

amount paid by the PBM to a pharmacy for dispensing and ingredient costs. However, this prohibition on the industry practice known as "spread pricing" is not intended to prohibit the Contractor from paying the PBM reasonable administrative and transactional costs for services.

The Contractor must ensure its subcontracted PBM does not directly or indirectly charge or hold a pharmacist or pharmacy responsible for a fee for any step of or component or mechanism related to the claim adjudication process, including the development or management of a claim processing or adjudication network, or participation in a claim processing or adjudication network.

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

The Contractor shall provide coverage of covered outpatient drugs as defined in section 1927(k)(2) of the Act, that meets the standards for such coverage imposed by section 1927 of the Act.

The Contractor shall report drug utilization data that is necessary for the Division to bill manufacturers for rebates in accordance with section 1927(b)(1)(A) of the Act no later than thirty (30) calendar days after the end of each quarterly rebate period. Such utilization information must include, at a minimum, information on the total number of units of each dosage form, strength, the billing provider's NPI number and package size by National Drug Code of each covered outpatient drug dispensed or covered by the Contractor.

The Contractor shall have established procedures to identify utilization data for covered outpatient drugs that are subject to discounts under the 340B drug pricing program from such reports. Contractor must adopt the Division's billing requirements for 340B claim submissions billed by registered 340B covered entities.

The Contractor shall operate a drug utilization review program that complies with the requirements described in section 1927(g) of the Act and 42 C.F.R. part 456, subpart K. The Contractor shall provide a detailed description of its drug utilization review program activities to the Division on an annual basis.

The Division shall oversee one common drug utilization review board for MississippiCAN and FFS beneficiaries. The Division requires the Contractor's pharmacy account managers to attend all drug utilization review board meetings and to participate with the Division in implementing drug utilization review board initiatives for MississippiCAN members. The Division shall submit one (1) drug utilization review annual report to CMS inclusive of MississippiCAN and FFS data.

The Contractor must conduct a prior authorization program that complies with the requirements of section 1927(d)(5) of the Act.

Please refer to Mississippi Administrative Code, Title 23, Part 203. The Contractor shall

report information specified by the Division to enable the collection of rebates by the Division, as described in Section 11, Reporting Requirements, of this Contract.

G. Non-Emergency Transportation

The Contractor shall provide Non-Emergency Transportation for its Members to access Medically Necessary Services, in compliance with minimum Federal requirements for the provision of transportation services and according to Division policies, which are outlined in Mississippi Administrative Code, Title 23, Part 201. Non-Emergency Transportation shall be provided to Members who require transportation to and from medically necessary Medicaid covered non-Emergency Services.

See Exhibit E, Non-Emergency Transportation, of this Contract for additional requirements of the Contractor.

H. Non-Covered Services

The Contractor shall refer Members to Providers enrolled in the Medicaid Fee-for- Service delivery system for all Medically Necessary Services not covered by the Contractor under the MississippiCAN Program. The Contractor shall have written policies and procedures for the referral of Members for non-covered services, which shall provide for the smooth transition to Out-of-network Providers and assistance to Members in obtaining a new PCP, if appropriate. These procedures shall be applicable to the referral of Members to Out-of-network Providers, as necessary, upon Disenrollment, regardless of the reasons for Disenrollment.

I. Enhanced Services

The Contractor may provide enhanced services that exceed the benefits or services provided under the Mississippi Fee-for-Service delivery system, subject to advance written approval by the Division. Any enhanced services must fully comply with the provisions of 42 C.F.R. § 438.3(e). Enhanced services are generally considered to have a direct relationship to the maintenance or enhancement of a Member's health status. Examples of potentially approvable services include various seminars and educational programs promoting healthy living or illness prevention, memberships in health clubs and/or facilities promoting physical fitness and expanded eyeglass or eye care benefits. These services must be generally available to all Members, and may not be tied to specific Member performance without Division prior approval. The Division may grant exceptions in areas where it believes that such tie-ins shall produce significant health improvements for Members.

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

written materials describing its covered benefits or Provider Network.

If the Contractor elects to provide enhanced services, it shall submit a statement annually as to the value of these services within thirty (30) calendar days of request from the Division or its Agent in a format to be specified by the Division. The utilization and actual cost of enhanced services are taken into account in developing the component of the capitation rates that represents the covered State plan services.

J. Prior Authorizations

1. General Requirements

The Contractor must have written policies and procedures, approved by the Division, for the Prior Authorization of services, which must comply with this Contract and Mississippi Administrative Code. The Division must receive Prior Authorization criteria and associated policies and procedures for advanced written approval forty-five (45) calendar days prior to implementation of the criteria, process, or procedure.

The Contractor shall have procedures for processing requests for initial and continuing authorizations of services. Decisions to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a physician pursuant to Miss. Code Ann. § 41-83-31.

The Contractor shall use a mechanism to ensure consistent application of review criteria for authorization decisions that includes consultation with the requesting Provider when appropriate. The Contractor shall determine the medical necessity for non-inpatient hospital medical services authorizations, Retroactive Eligibility Reviews and Retrospective Reviews to eligible Mississippi Medicaid beneficiaries utilizing the Division's approved criteria and policies.

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

The Contractor shall comply with 42 C.F.R. § 438.210 (b)(3), which requires that any decision to deny a Service Authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, or long-term services and supports needs.

The Contractor shall have the capability and established procedures to receive Retrospective Review requests within sixty (60) days of the service date and conduct prepayment reviews. The Contractor shall ensure determinations for Retrospective Reviews are completed ninety-eight percent (98%) of the time within twenty (20) business days of receipt.

2. Medical and Surgical Services

The Contractor shall determine the medical necessity for emergency and non-emergency inpatient hospital admission prior authorizations, continued stays, Retroactive Eligibility Reviews and Retrospective Reviews for inpatient medical/surgical services to eligible Mississippi Medicaid beneficiaries utilizing the Division's approved criteria and policies.

a. Emergency Admission Reviews: The Contractor shall have the capability and established procedures to receive Emergency Admission Reviews post-admission for admissions that are not planned or elective and conduct prior authorizations when the Member has not been discharged. The Contractor shall ensure determinations for Emergency Admission Reviews are completed ninety-eight percent (98%) of the time within twenty-four (24) hours (one workday) of receipt.

b. Non-Emergency Admission Reviews: The Contractor shall have the capability and established procedures to receive Non-Emergency Admission Reviews requests and conduct prior authorizations prior to the planned date of admission. The Contractor shall ensure determinations for Non-Emergency Admission Reviews are completed ninety-eight percent (98%) of the time within twenty-four (24) hours (one workday) of receipt.

c. Weekend and Holiday Admission Reviews: The Contractor shall have the capability and established procedures to receive Weekend and Holiday Admission Reviews requests and conduct prior authorizations post-admission when the Member has not been discharged. The Contractor shall ensure determinations for Weekend and Holiday Admission Reviews are completed ninety-eight percent (98%) of the time within twenty-four (24) hours (one workday) of receipt.

d. Continued Stay Reviews: The Contractor shall have the capability and established procedures to receive Continued Stay Reviews requests for additional inpatient days of care for admissions previously certified and conduct prior authorizations on or before the next review point (i.e. the last certified day). The Contractor shall ensure determinations for Continued Stay Reviews are completed ninety-eight percent (98%) of the time within twenty-four (24) hours (one workday) of receipt when Members remain hospitalized and within twenty-four (24) hours (one workday) when Members have been discharged.

e. Retroactive Eligibility Reviews: The Contractor shall have the capability and established procedures to receive Retroactive Eligibility Review requests. The Contractor shall ensure determinations for Retroactive Eligibility Reviews are completed ninety-eight percent (98%) of the time within twenty (20) business days of receipt.

f. Retrospective Inpatient Hospital Reviews: The Contractor shall have the capability and established procedures to receive Retrospective review request for Inpatient and Outpatient services within sixty (60) days of the service date and conduct prepayment reviews. The Contractor shall ensure determinations for Retrospective Reviews are completed ninety-eight percent (98%) of the time within twenty (20) business days of receipt.

The Contractor shall develop and maintain a Web-based, electronic review request system for Prior Authorization and prepayment review of inpatient medical/surgical services that allows for data input by the submitting providers. The Contractor's system shall have the capability for automated criteria/rules-based certification system. The Contractor shall manually review each Prior Authorization and prepayment review request received that is not certified by the Contractor's rules-based system, along with any required supporting documentation to support the need for inpatient medical/surgical services.

a. The Contractor shall have the capability and established procedures for verbal consultation by the physician reviewer with the attending physician to obtain additional information when the documentation submitted does not clearly support medical necessity.

b. The Contractor shall ensure that all cases (including reductions) not meeting medical necessity criteria for inpatient medical/surgical services are reviewed by medical directors duly licensed in Mississippi and in compliance with Miss. Code Ann. § 41-83-31. At any point after an initial denial a physician who has had a denial may request a review by a reviewer of the same specialty for the case in question.

The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a pended review and for informing the provider of the information needed along with a time frame for submission.

The Contractor shall have the capability and established procedures for verbal and written notification to the requesting provider of a suspended review. Notification to providers of suspended reviews shall not exceed the following:

Table 3: Notification of Suspended Reviews for Inpatient Medical/Surgical Services

Review Type	Contractor Action	Time Standard
Emergency Admission Reviews	Verbal Notification to Provider	Within four (4) hours past due date for requested information
Non-Emergency Admission Reviews	Written Notification to Provider	Within one (1) business day past due date for requested

Weekend and Holiday Admission Reviews Continued Stay Reviews		information
Retrospective Inpatient Hospital Reviews	Written Notification to Provider	Within three (3) business days past due date for requested information
Retroactive Eligibility Reviews	Written Notification to Provider	Within three (3) business days past due date for requested information

The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss inpatient medical/surgical services cases that have been denied, modified, or considered for denial.

The Contractor shall notify providers and Members or legal guardians/representatives of review determinations for inpatient medical/surgical services requests.

a. The Contractor shall notify the requesting provider of the approval by telephone, fax, or secure e-mail.

b. The Contractor shall notify the requesting provider of the denial orally.

c. Written or electronic notice of the denial will be issued to the attending physician, facility, and Member or, if a child, the legal guardian/representative.

d. Time frames for notification to providers and Members of review outcomes for Prior Authorization and prepayment review of inpatient medical/surgical services shall not exceed the following standards:

Table 4: Notification of Review Outcomes for Inpatient Medical/Surgical Services

Review Type	Contractor Action	Time Standard
Emergency Admission Reviews	Verbal Approval to Provider	Within 24 hours from review determination
Non-Emergency Admission Reviews	Written Approval to Provider	Within one (1) business day from review determination
Weekend and Holiday Admission Reviews	Verbal Denial to Provider	Within 24 hours from review determination

Continued Stay Reviews	Written Denial to Provider	Within one (1) business day from review determination
	Written Denial to Member/ Parent/Representative	Within one (1) business day from review determination
Retrospective Inpatient Hospital Reviews	Written Approval to Provider	Within three (3) business days from review determination
Retroactive Eligibility Reviews	Written Denial to Provider	Within three (3) business days from review determination
	Written Denial to Member/ Parent/Representative	Within three (3) business days from review determination

3. Organ Transplant Services

   The Contractor shall develop, implement, and maintain a utilization management program, which includes Prior Authorization and Retrospective Review of application requests for organ transplant services.

   The Contractor shall determine the medical necessity of transplant applications and requests for extension of benefits for eligible Mississippi Medicaid beneficiaries utilizing the Contractor's criteria and policies that have been approved by the Division. The Contractor shall ensure determinations transplant applications and requests for extensions of benefits are completed ninety-eight percent (98%) of the time within three (3) business days of receipt. The Contractor shall ensure determinations for Retrospective Reviews are completed ninety-eight percent (98%) of the time within twenty (20) business days of receipt.

   The Contractor shall establish and maintain a procedure for the attending physician to contact the Contractor's Medical Director to discuss transplant cases that have been denied, modified, or considered for denial.

   The Contractor shall issue notifications of approvals and denials to the requesting provider, facility, Division and Member or, if a child, the legal guardian/representative.

4. Pharmacy

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

a. Member experiences an adverse event(s) or reaction(s) to preferred medications; or

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

c. The Contractor must establish criteria and coverage policies for drugs not listed on the PDL, which must be approved by the Division. The Contractor must ensure that decisions regarding policies and procedures for prescription drugs are made in a clinically sound manner.

5. Web-based Prior Authorization System

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

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

The Contractor shall have the ability to communicate through the MS HIN Health Information Exchange in the future.

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

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

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

The Contractor shall create a "smart" electronic authorization request form, customized for each service that requires certification. The form must be standardized for all Contractors and must be prior approved by the Division. The Contractor shall design this form so that it reduces the chances of technical denials due to incorrect or missing information.

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

6. Time Frames for Non-Inpatient Hospital Medical Services

The Contractor must notify the requesting Provider and the Member 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 by the treating Provider and/or Member. The notice must meet the requirements specified in 42 C.F.R. § 438.404.

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

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

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

K. Advance Directives

The Contractor shall develop, document, and maintain advance directive policies that comply with 42 C.F.R. § 422.128 and with the State's Uniform Health Care Decisions Act. Contractor is responsible for educating and training staff, individuals, and the community on policies and procedures as it relates to advance directives. Additionally, the Contractor shall provide adult Members with written information on its advance directives policies. The Contractor shall inform the Members 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) calendar days after the effective date of change. The Contractor must also inform Members that Complaints and Grievances concerning non-compliance with the advance directive requirements may be filed with the State Survey and Certification Division of the State Department of Health. The Contractor shall have policies that include written information concerning the individual's rights to make decisions concerning medical care, to refuse or accept medical or surgical treatment, and to formulate advance directives; and provision for individual and community education about advance directives. The Contractor is prohibited from conditioning the provision of care or otherwise discriminating against an individual based on whether or not the individual has executed an advance directive.

The Contractor must maintain written policies and procedures on advance directives for adults receiving medical care by or through the PAHP if the Contractor's Provider Network

includes: home health agencies, home health care providers, personal care providers, or hospice providers.

L. Member Notification

The Contractor shall provide Members written notice of an Adverse Benefit Determination in writing consistent with 42 C.F.R Part 438.404 and 438.10. The notice must explain the following:

1. The Adverse Benefit Determination the Contractor has made or intends to make;

2. The reasons for the Adverse Benefit Determination, including the right of the Member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;

3. The Member's right to request an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal described at § 438.402(b) and the right to request a State Fair Hearing;

4. The procedures for exercising the rights specified in this subsection;

5. The circumstances under which an appeal process can be expedited and how to request an expedited appeal; and

6. The Member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services.

The notice(s) as described within this subsection must be mailed within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days prior to the date of the Adverse Benefit Determination;

2. For denial of payment, including denial of payment that may result in Member financial liability, at the time of any action affecting the claim;

3. For standard service authorization decisions that deny or limit services, within ten (10) calendar days of the date of the Adverse Benefit Determination.

M. Services for Foster Care Children

The Contractor will coordinate closely with the Mississippi Department of Child Protection

Services (CPS) and the Division through regular meetings of a task force. The Contractor shall comply with relevant Contract requirements that impact the provision of services. The Contractor shall also provide data and reports required by the Mississippi Department of Child Protection Services and the Division to demonstrate compliance.

SECTION 6 – MEMBER SERVICES

The Contractor must submit reports related to Member Services in accordance with Section 11, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract.

A. Member Services Call Center

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

1. Hours of Operation

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

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

2. Functions

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

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

   b. Assisting Members with making appointments and obtaining services;

   c. Assisting with arranging transportation for Members;

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

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

3. Customer Care

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

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

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

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

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

4. Staff Training

The Contractor's Member services call center staff must receive trainings at least quarterly. Trainings must include education about Medicaid, the MississippiCAN Program, appropriate instances for transferring a Member to a Care Manager, and customer service. Staff must receive updates about continued Medicaid changes and

requirements, including "Late Breaking News" articles, Provider Bulletins, State Plan Amendments, Administrative Code Filings, the Division's Provider Reference Guide and MississippiCAN Program updates. The Contractor will submit quarterly reports detailing the trainings conducted, topics covered, and the number and positions of staff completing the trainings.

5. Performance

   The Contractor shall maintain sufficient equipment and call center staff to ensure that the abandonment rate for any month is not greater than five percent (5%). The Contractor will be subject to liquidated damages if the abandonment rate exceeds this target, in accordance with Section 16.E, Liquidated Damages, of this Contract.

B. Member Education

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

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

The Contractor shall also conduct, in collaboration with the Division, a minimum of ten (10) MississippiCAN Workshops annually targeting Members. The Division will notify the Contractor of the dates, times, and locations for Workshops. The Division will determine the topics to be covered during each workshop and the Contractor shall assist in the presentation of the content.

C. Member Identification Card

The Contractor shall provide each Member an identification card that is recognizable and acceptable to the Contractor's network Providers. The Contractor may only issue one (1) identification card for all covered benefits. The Contractor's identification card will include, at a minimum, the name of the Member, the Mississippi Medicaid identification number, the name and address of the Contractor, the name of the Member's PCP, if PCP name available, a telephone number to be used to access after-hours non-emergency care, instructions on what to do in an emergency, the Member Services Call Center phone number, and a Contractor identification number, if applicable. The Contractor must submit and receive approval of the identification card from the Division fifteen (15) calendar days prior to

production of the cards.

The Contractor shall provide each Member an identification card, prior to the first day of the month in which their Enrollment starts. The Contractor must mail all Member identification cards, utilizing at least standard mail, in envelopes marked with the phrase "Return Services Requested

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

In cases of returned Member identification cards, the Contractor must attempt to contact the Member to verify the Member's address. The Contractor shall be innovative and employ creative techniques to contact Members with returned Member identification cards and identify valid addresses for these Members.

D. Member Handbook

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

The Contractor shall submit a copy of the Member Handbook to the Division for approval thirty (30) to sixty (60) calendar days prior to distribution and as part of the readiness review process. The Contractor must update the Member Handbook at minimum, annually, addressing changes in policies through submission of a cover letter identifying sections that have changed and/or an electronic redlined handbook showing before and after language. The Contractor shall submit a copy of any changes to the Member Handbook to the Division for approval no fewer than thirty (30) calendar days prior to distribution. Upon receipt of any changes to the initial handbook, the Division will work to review and approve any changes within thirty (30) calendar days. 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 Contractor shall give each of its Members thirty (30) calendar days' written notice of any material change to the MississippiCAN Program before its intended effective date.

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

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

1. Table of Contents;

2. Description of populations who are eligible for the MississippiCAN Program, including information about which populations have the option to disenroll and which may not disenroll as well as a description of populations that are excluded from program participation;

3. Terms and conditions under which Member eligibility and coverage for Medicaid and the MississippiCAN Program may be terminated;

4. Procedures to be followed if Member wishes to change Contractors;

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

6. Information about choosing and changing PCPs;

7. Making appointments and accessing care:

    a. Appointment-making procedures and appointment access standards;

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

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

    d. The extent to which, and how, Members may obtain benefits, including information about receiving care from Out-of-network Providers; and

    e. Information about family planning services, including explanation that there are no restrictions on the choice of Provider from whom the Member may receive family planning services and supplies and that each Member is free from coercion or mental pressure and free to choose the method of family planning to be used, in accordance with 42 C.F.R. § 441.20. The MCO must comply with section 42 C.F.R 438.10(g)(2)(vii), which specifies that members cannot be required to obtain a referral prior to choosing a family planning provider;

    f. The Member Handbook shall contain the list of services not covered by the MCOs because of moral or religious objections and how to obtain information from the State about how to access those services not covered.

8. Member Services:

    a. Instructions on how to contact the Member Services Call Center and a description of the functions of Member Services;

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

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

d. A description of EPSDT screenings and services and instructions advising Members about how to access such services;

e. A description of all available covered services, including inpatient services, behavioral health/substance use disorder, Non-Emergency Transportation, dental, maternity, pharmacy, and preventive services, services available to children in foster care, if applicable, and an explanation of any service limitations, referral and Prior Authorization requirements. This description should include that the Member may receive a minimum of a three (3)-day emergency supply for prior authorized drugs until authorization is completed;

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

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

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

i. A description of the Contractor's confidentiality policies;

j. An explanation of any service limitations or exclusions from coverage; including limitations that may apply to services obtained from Out-of-network Providers;

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

l. Circumstances under which an eligible Member may disenroll or be involuntarily disenrolled from the Contractor and/or MississippiCAN Program;

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

10. Member Complaints, Grievances, and Appeals:

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

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

ii. Information on filing Complaints, Grievances, and State Fair Hearing procedures as specified in 42 C.F.R. § 438.400 through 438.424;

iii. Time frames to register and receive a response regarding a Complaint, Grievance, or Appeal with the Contractor and/or the Division as described in this Contract;

iv. The availability of assistance in the filing process, including making available reasonable assistance in completing forms and taking other procedural steps, which includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;

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

vi. A description of the continuation of benefits process required by 42 C.F.R. § 438.420 and information describing how the Member may request continuation of benefits, as well as information on how the Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member. In accordance with 42 C.F.R. § 438.420, the Contractor must continue the enrollee's benefits if all of the following occur:

a) The enrollee files the request for an appeal timely in accordance with § 438.402(c)(1)(ii) and (c)(2)(ii);

b) The appeal involves the termination, suspension, or reduction of previously authorized services;

c) The services were ordered by an authorized provider;

d) The period covered by the original authorization has not expired; and

e) The enrollee timely files for continuation of benefits.

11. Emergency Medical Care:

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

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

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

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

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

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

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

12. Member Identification Cards;

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

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

13. Interpretation and Translation Services:

a. Information on how to access verbal interpretation services, free of charge, for any non-English language spoken [42 C.F.R. § 438.10(d)];

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

c. Information on how to access the handbook in an alternative format for

special needs individuals including, for example, individuals with visual impairments [42 C.F.R. § 438.10(d)];

14. Member Rights:

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

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

    c. Information about the Contractor's privacy policies;

15. Member Responsibilities:

    a. A description of procedures to follow if:

        i. The Member's family size changes;

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

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

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

    c. Information about the process that Members and Providers must follow when requesting inpatient Prior Authorization;

    d. Information about advance directives such as living wills or durable power of attorney, in accordance with 42 C.F.R. § 489.100 and 42 C.F.R. § 438.3(j); and

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

16. Contractor Responsibilities:

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

b. Additional information about physician incentive plans as set forth in 42 C.F.R. § 438.3(i); and

c. Notification to the Member that the Division should be notified if the Member has another health insurance policy and that the Contractor will coordinate the payment of claims between the two (2) insurance plans.

E. Provider Directory

The Contractor shall develop, regularly maintain and make available Provider Directories that include information for all types of Providers in the Contractor's network, including, but not limited to PCPs, hospitals, specialists, Providers of ancillary services, behavioral health/substance use disorder facilities, and pharmacies. In accordance with 42 C.F.R. § 438.10(h), the Provider Directory shall include, but is not limited to, the following information for physicians (including, but limited to, specialists), hospitals, pharmacies, and behavioral health providers:

1. Provider's name as well as any group affiliation;

2. Street address(es);

3. Telephone number(s);

4. Web site URL, as appropriate;

5. Whether the provider will accept new enrollees;

6. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;

7. Whether the provider's office/facility has accommodations for people with physical disabilities including offices, exam room(s) and equipment;

8. Identification of PCPs and PCP groups, specialists, hospitals, facilities, and FQHCs and RHCs by area of the State;

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

10. Identification of Closed Panels (web-based version only); and

11. Identification of hours of operation including identification of Providers with non-traditional hours (before 8 a.m. or after 5 p.m. CST or any weekend/holiday hours).

The Contractor shall make available hard copy Provider directories in State Medicaid Regional Offices, the Contractors' offices, WIC offices, upon Member request, and other areas as directed by the Division.

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

The Contractor must submit its Provider Directory template to the Division for advance written approval prior to use and before distribution to its Members if there are significant format changes to the directory template.

F. Communication Standards

All written material provided to Members or potential Members, including, but not limited to, all Marketing materials, plan booklets, descriptions and information, instructional materials, policies and procedures disclosures, notices and handbooks must meet requirements specified under 42 C.F.R. § 438.10, 45 C.F.R. Part 92, and the following requirements:

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

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

3. Documents contain font size no smaller than 12 point.

4. Documents can be easily made available in alternative formats and electronically by the Contractor and are available upon request and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited, in accordance with 42 C.F.R. § 438.10(d)(6)(iii).

5. Documents include large print taglines and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

6. Significant publications and communications, including small-sized significant

publications and communications, shall contain the notices and taglines required by 45 C.F.R. § 92.8.

Member information required under 42 C.F.R. § 438.10 may be provided electronically by the Contractor provided that all of the conditions established by 42 C.F.R. § 438.10(c)(6) are met.

All Enrollment, Disenrollment and educational documents and materials made available to Members by the Contractor must be submitted to the Division for review and approval thirty (30) calendar days prior to release, unless specified elsewhere in this Contract. The Contractor must review all materials on an annual basis and provide a list of these materials to the Division annually indicating the review date. If the Contractor revises these materials, the Contractor will submit the updated materials to the Division for review and approval highlighting and using a redlined format for changes. The Contractor must meet the Division's required time frames for the submission of Deliverables in the event that requested Deliverables do not have a submission time frame specified, in accordance with Section 11.X, Deliverables, of this Contract. In such cases, the Division will specify the time frame for submission of Deliverables. The Division will notify the Contractor of the time frame it will require for review of Deliverables.

The Contractor shall also make verbal interpretation services available free of charge to each Member for all non-English languages and shall institute a mechanism for all Members who do not speak English to communicate effectively with their PCP and with Contractor staff and Subcontractors. Verbal interpretation services must be available to ensure effective communication regarding treatment, medical history, or health education [42 C.F.R. § 438.10(d)]. The Contractor must provide auxiliary aids such as Teletypewriter (TTY), Telecommunications Device for the Deaf (TDD), or Video Phones (VP) for the hearing impaired. Trained professionals shall be used when needed where technical, medical, or treatment information is to be discussed with the Member, family member of the Member, or a friend of the Member.

The Contractor shall notify Members that verbal interpretation services and interpretation services for the hearing impaired and vision-impaired are available and how to access those services.

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

G. Additional Requirements for Communication with Contractor's Members

The Contractor shall submit all communication materials with its Members to the Division thirty (30) business days prior to the planned distribution and the Division must approve these materials before they are released.

Communication activities must comply with all relevant Federal and State laws, including,

when applicable, the Health Insurance Portability and Accountability Act, the anti- kickback statute, and civil monetary penalties prohibiting inducements to Members. The Contractor may be subject to sanctions if it offers or gives something of value to a Member that the Contractor knows or should know is likely to influence the Member's selection of a particular Provider, practitioner, or supplier of any item or service for which payment may be made, in whole or in part, by Medicaid. Additionally, the Contractor is prohibited from offering rebates or other cash inducements of any sort to its Members, without prior written approval from the Division. The Contractor may be subject to liquidated damages, a fine, and/ or sanctions if it conducts any communication activity that is not approved in writing by the Division.

1. Allowable Contractor Communication Activities

   The Contractor may engage in the following activities with prior Division approval:

   a. Distribution of communication materials to Members pre-approved by the Division; and

   b. The Contractor is allowed to offer non-cash incentives to its Members for the purposes of rewarding for compliance in immunizations, prenatal visits, participating in Care Management, or other behaviors as pre-approved by the Division. On a case by case basis, the Division may approve cash-value incentives upon request by the Contractor, and if adequately justified. The Contractor shall analyze Member data to identify gaps in care and areas to improve outcomes. The Contractor must provide to the Division for approval information about the interventions the Contractor will employ to improve upon those gaps, including Member incentives the Contractor will provide to Members, and the expected impact of the incentives, along with a plan to evaluate the impact of those incentives. 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. The Contractor must submit all incentive award packages to the Division for written approval at least thirty (30) calendar days prior to planned implementation.

2. Prohibited Communication Activities

   The following are prohibited communication activities targeting Members under this Contract:

   a. Engaging in any informational activities which could mislead, confuse, or defraud Contractor's Members or misrepresent the Division;

   b. No assertion or statement (whether written or verbal) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity.

H. Internet Presence/Website

The Contractor shall develop, host and maintain a website specific to the MississippiCAN Program on a unique, secure URL specific to the program. The Contractor shall provide MississippiCAN specific, up-to-date information about the Contractor's programs, Provider Network, customer services, and Member and Provider Grievance and Appeals systems on a non-secure section of the website. The Contractor shall maintain coverage guidelines and billing instructions specific to the MississippiCAN Program only on a non-secure section of the website in an easily identifiable location. PHI shall be accessible through a secure section of the website.

The website must comply with the Marketing and communication policies and procedures, and requirements for written materials described in this Contract, and must be consistent with applicable State and Federal laws. The website must take into consideration the Americans with Disabilities Act Standards for Accessible Design, Plain Language Guidelines, and Section 508 of the Rehabilitation Act of 1973, as amended by the Workforce Investment Act of 1998, and include a translation tool. The website shall also contain all notices required by law, including but not limited to the notice and tagline requirements of 45 C.F.R. § 92.8.

The website must support the current version and immediate prior version of, at minimum, the following web browsers: Internet Explorer, Mozilla FireFox, Google Chrome, and Safari.

The website must include a tool to measure web portal analytics and statistics, including, but not limited to, website visits, unique visitors, visitor information, browser, devices, and page views. A comprehensive web portal usage report must be sent to the Office of Communications on a monthly basis, and as requested.

The website design must be responsive to and accommodate for devices such as a mobile phone and tablet, and the website design and organization must be refreshed and updated upon the implementation of the Contract, and periodically thereafter, and upon request by the Division.

The website must have a news section or an area to post important notices targeted for beneficiaries and providers, on their respective web portal homepage. The Contractor must post information provided by Division to the news section within one (1) business day upon request, and provide confirmation to the Division within three (3) business days of publication by providing in writing proof of the update, including the URL of the news post, if applicable.

The Contractor shall submit website screenshots to the Division for review and approval prior to making the website available and as updated. Additionally, a live demonstration of the web portal is required prior to activation.

1. Member Portal

The Contractor shall also include a copy of the Member Handbook, information about Member rights and responsibilities and the Complaints, Grievances, and Appeals process on the Member portal. PHI shall be accessible through a secure section of the website.

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

Contractor shall submit proposed final web content pertinent to the MississippiCAN program to the Division for review and approval forty-five (45) calendar days prior to making the content available and as updated.

2. Provider Portal

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

a. Ability to submit inquiries and receive responses;

b. Access to a copy of the Provider Manual;

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

d. Access to a searchable Provider Directory;

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

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

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

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

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

I. Marketing

All Marketing activities by the Contractor including, but not limited to, the Contractor's development of Marketing materials such as written brochures and fact sheets, shall be in

accordance with 42 C.F.R. § 438.104.

Marketing plans and materials must be distributed to the Contractor's entire service area as indicated in this Contract. Marketing plans and materials shall not mislead, confuse, or defraud the Members or the Division. Specifically, the Contractor cannot make any assertion or statement, whether written or verbal, that the Member must enroll in the Contractor in order to obtain benefits or 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 thirty (30) business days prior to the planned distribution and the Division must approve these materials before they are released.

The Contractor shall 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 Subcontractors. These procedures shall contain a provision that a Contractor employee outside the Marketing department resolve or be involved in the resolution of Marketing/customer service Complaints. Marketing Complaints that cannot be satisfactorily resolved between the Contractor and the complainant must be forwarded to the Division for further investigation and resolution. Regardless of the resolution status of the Marketing Complaint, the Contractor must also submit the Marketing Complaint tracking log to the Division on a quarterly basis.

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

1. Marketing Services

   The Contractor shall:

   a. Submit to the Division for prior written approval a work plan of planned Marketing activities annually;

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

   c. Submit all new and/or revised Marketing and informational materials or proposed changes to the Marketing work plan to the Division before their planned distribution or implementation (42 C.F.R. § 438.104). Upon receipt, the Division will specify the time frame for completing review. The Contractor may distribute Marketing materials to Medicaid beneficiaries where the Member is currently enrolled with the Contractor, assuming that the

Division has approved the Marketing materials for distribution to Members;

d. Coordinate and submit to the Division all schedules, plans, and informational materials for community education, networking and outreach programs. The Contractor shall submit the schedule to the Division at least two (2) weeks prior to any event and must be approved by the Division;

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

f. Be subject to liquidated damages, a fine, and/or sanctions if it conducts any Marketing activity that is not approved in writing by the Division (42 C.F.R. § 438.700).

2. Allowable Contractor Marketing Activities

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

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

b. Distribution of promotional materials pre-approved by the Division;

c. Pre-approved informational materials for media outlets including, but not limited to, television, radio, social media channels and newspaper dissemination;

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

e. 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 Contractor 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; and

3. Prohibited Marketing and Outreach Activities

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

a. Engaging in any informational or Marketing activities which could mislead, confuse, or defraud Members or misrepresent the Division (42 C.F.R. §

438.104);

b. Directly or indirectly, conducting door-to-door, telephonic, email, texting, or other "cold call" Marketing of Enrollment at residences and Provider sites, and events or venues of outreach targeting beneficiaries (42 C.F.R. § 438.104);

c. Sending direct mailing;

d. Making home visits for Marketing or Enrollment;

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

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

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

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

i. Contacting Members who disenroll from the Contractor 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;

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

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

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

m. No assertion or statement (whether written or verbal) that the Contractor is endorsed by the Centers for Medicare and Medicaid Services (CMS); Federal or State government; or similar entity (42 C.F.R. § 438.104); and

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

J. Member Rights and Responsibilities

In accordance with 42 C.F.R. § 438.100, the Contractor shall have written policies and procedures regarding Member rights and shall ensure compliance of its staff and affiliated Providers with any applicable Federal and State laws that pertain to Member rights. Policies and procedures shall include compliance with:

1. Member Rights

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

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

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

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

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

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

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

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

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

The written policies and procedures shall also address the responsibility of Members

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

2. Member Protections

The Contractor agrees to protect Members from certain payment liabilities and not hold Members 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 service(s), 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 Member 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 Members against balance billing by Subcontractors.

K. Member Complaint, Grievance, Appeal and State Fair Hearing Process

The Contractor shall draft and disseminate to Members, Providers, and Subcontractors, a system and procedure, which has the prior written approval of the Division for the receipt and adjudication of Complaints, Grievances, and Appeals or requests for a State Fair Hearing by Members. The Complaint, Grievance, and Appeal policies and procedures shall be in accordance with 42 C.F.R. Part 438, Subpart F and the State's Quality Strategy, with the modifications that are incorporated in the Contract and Exhibit D, Member Complaint, Grievance, Appeal, and State Fair Hearing Process, of this Contract. The Contractor shall not modify the Complaint, Grievance, and Appeal procedure without the prior approval of the Division, and shall provide the Division with a copy of the modification.

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

The Division shall have the right to intercede on a Member's behalf at any time during the Contractor's Complaint, Grievance, and/or Appeal process whenever there is an indication from the Member, or, where applicable, authorized person, that a serious quality of care issue is not being addressed timely or appropriately. Additionally, the Member may be accompanied by a representative of the Member's choice to any proceedings.

The Contractor shall provide Members as a part of the Member handbook, information on how they or their representative(s) can submit a Complaint or file a Grievance or an Appeal, and the resolution process. The Member information shall also advise Members of their right to file a request for a State Fair Hearing with the Division of Medicaid, upon notification of a Contractor Adverse Benefit Determination, subsequent to an Appeal of the Contractor Adverse Benefit Determination. The Member must exhaust all Contractor level Appeal procedures prior to requesting a State Fair Hearing with the Division. The member may make written request for continuation of benefits within ten (10) calendar days of notice of Adverse Benefit Determination, pending the determination of a State Fair Hearing.

Should a State Fair Hearing result in the reversal of an Adverse Benefit Determination made by the Contractor, the Contractor shall bear all costs associated with the hearing. These costs may include, but are not limited to, medical appropriateness reviews by the Division contracted Independent Physician Reviewers, hearing officer's fees, attorney's fees, and court reporter's fees.

The Contractor shall use the definitions for Complaints, Grievances, and Appeals as set forth in this section and adhere to time frames required by this Contract and Federal.

Table 5 below and Exhibit D, Member Complaint, Grievance, Appeal, and State Fair Hearing Process, of this Contract outline additional specific requirements pertaining to Complaints, Grievances, and Appeals.

Table 5. Summary of Member Complaints, Grievances, and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Complaint: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Complaint", received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Complaint not resolved within one (1) calendar day shall be treated as a Grievance. A Complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.			

Party	Action	Time Frame	Extensions Available
Member, Provider on behalf of a Member, or Authorized Representative	Submit a Complaint	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Resolve a Complaint	Within one (1) calendar day	
Grievance: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance", received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this **Contract**. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the Contractor, PIHP or PAHP to make an authorization			
Member, Provider on behalf of a Member, or Authorized Representative	File a Grievance	At any time after the Grievance has occurred.	
Contractor	Confirm receipt of Grievance and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance or as expeditiously as the Member's health condition requires	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
Appeal: A request for review to be performed by the Contractor of a Contractor's Adverse Benefit Determination related to a member. In the case of a Member, the Contractor Adverse Benefit Determination may include determinations on the health care services a Member believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Member).			

Party	Action	Time Frame	Extensions Available
Member or Authorized Representative	File an Appeal	Within sixty (60) calendar days from the date on the Contractor's Adverse Benefit Determination	
Contractor	Confirm receipt of the Appeal and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires. No longer than 72 hours after the Contractor receives the request for an Expedited Resolution of an Appeal.	Contractor may extend time frames by up to fourteen (14) calendar days in accordance with 42 C.F.R. § 438.408(c)
State Fair Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. § 431 Subpart E. Any **Adverse Benefit Determination** or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. § 431 Subpart E.			
Member or Authorized Representative	File a request for a State Fair Hearing	Within one hundred and twenty (120) calendar days from the date of the Contractor's notice of resolution.	

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

SECTION 7 – PROVIDER NETWORK

The Contractor must submit reports related to Provider Networks in accordance with Section 11, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract.

A. General Requirements

The Contractor and its Subcontractor or delegated vendors shall recruit and maintain a Provider Network, using Provider contracts as approved by the Division. The Contractor must comply with federal regulations regarding Provider Network adequacy as stated in 42 C.F.R. §§ 438.68, 438.206, 438.207; and must comply with state regulations regarding reconsideration of inclusion per Miss. Code Ann. § 83-41-409 (e).

The Contractor is solely responsible for providing a network of physicians, pharmacies, facilities, and other health care Providers through whom it provides the items and services included in covered services. In establishing its Provider Network, the Contractor shall contract with FQHCs and RHCs. The Contractor must contract with as many FQHCs and RHCs as necessary to permit Member access to participating FQHCs and RHCs without having to travel a significantly greater distance than the location of a non-participating FQHC or RHC. If the Contractor cannot satisfy this standard for FQHC and RHC access at any time, the Contractor must allow its Medicaid Members to seek care from non-contracting FQHCs and RHCs and must reimburse these Providers at Medicaid fees.

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

The Contractor shall ensure that its network of Providers is adequate to assure access to all covered services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services. The Contractor may not close their Provider Network for any Provider type without prior approval from the Division.

B. Provider Network Requirements

1. Geographic Access Standards

   In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members, the Contractor shall meet the geographic access standards for all Members set forth in Table 6.

Table 6. Geographic Access Standards

Provider Type	Urban	Rural
PCPs- Adult and Pediatric	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists Adult and Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers Adult and Pediatric	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
OB/GYN	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
PCPs	Two (2) within fifteen (15) miles	Two (2) within thirty (30) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles
Emergency Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	One (1) within thirty (30) minutes or thirty (30) miles
Urgent Care Providers	One (1) within thirty (30) minutes or thirty (30) miles	Not Applicable
Behavioral Health Providers (Mental Health Providers and Substance Use Disorder) (Adult and Pediatric)	One (1) within thirty (30) minutes or thirty (30) miles	One within sixty (60) minutes or sixty (60) miles

Provider Type	Urban	Rural
Durable Medical Equipment Providers	One (1) within thirty (30) minutes or thirty (30) miles	One with sixty (60) minutes or sixty (60) miles
Pharmacies	One (1) open twenty-four (24) hours a day, seven (7) days a week within thirty (30) minutes or thirty (30) miles	One (1) open twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within sixty (60) minutes or sixty (60) miles
Dialysis Providers	One (1) within sixty (60) minutes or sixty (60) miles	One within ninety (90) minutes or ninety (90) miles

The Division shall specify the urban and rural designation of counties within Mississippi. All travel times are maximums for the amount of time it takes a Member, using usual travel means in a direct route to travel from their home to the Provider. The Division recognizes that Non-Emergency Transportation Providers may not always follow direct routes due to multiple passengers.

If the Contractor is unable to identify a sufficient number of Providers located within an area to meet the geographic access standards, or is unable to identify a sufficient number of Providers within a Provider type or specialty, the Contractor will submit documentation to the Division verifying the lack of Providers. The Division may approve exceptions to the geographic access standards in such cases. The Division may impose liquidated damages under Section 16, Default and Termination, of this Contract if the Contractor fails to meet Provider Network access standards.

The Contractor must pay for services covered under the Contract on an out-of-network basis for the Member if the Contractor's Provider Network is unable to provide such services within the geographic access standards. Services must be provided and paid for in an adequate and timely manner, as defined by the Division, and for as long as the Contractor is unable to provide them.

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

2. Accessibility

The Contractor shall have in its network the capacity to ensure that the appointment scheduling does not exceed those set forth in Table 7.

Table 7. Appointment Scheduling Time Frames

Type	Appointment Scheduling Timeframes
PCP (Well Care Visit)	Not to exceed thirty (30) calendar days
PCP (Routine Sick visit)	Not to exceed seven (7) calendar days
PCP (Urgent Care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health/Substance Use Disorder Providers (routine visit)	Not to exceed twenty-one (21) calendar days
Behavioral Health/Substance Use Disorder Providers (urgent visit)	Not to exceed twenty-four (24) hours
Behavioral Health/Substance Use Disorder Providers (post- discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

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

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

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 Member access to services.

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

3. Direct Access

   The Contractor must provide female Members 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 Member's designated source of primary care if that source is not a women's health specialist.

4. Second Opinions

   Upon request, the Contractor must provide for a second opinion from a Network Provider, or arrange for the Member to obtain one outside the network from an Out-of-network Provider, at no cost to the Member.

5. Patient-Centered Medical Homes

   The Contractor shall encourage the development of NCQA-recognized Patient-Centered Medical Homes and coordinate with any Division-level initiatives related to the development and NCQA recognition of Patient-Centered Medical Homes, as defined by the Division. Based on the collaboration with the Division, the Division will define specific reporting requirements which may change as the initiative is implemented. The Division will notify the Contractor of the reporting requirements in writing at least sixty (60) days before the report containing the required information is due.

6. EPSDT Providers

   EPSDT wellness (screening) services shall be administered in accordance with Mississippi Administrative Code, State Plan and written communication from the Division to the Contractor. For CMS mandatory reporting purposes, including but not limited to CMS 416 reporting, EPSDT wellness (screening) services must be provided by enrolled Medicaid providers, including, but not limited to, the Mississippi State Department of Health, other public and private agencies, private physicians, Rural Health Clinics, comprehensive health clinics, public schools and/or public school districts certified by the Mississippi Department of Education and similar agencies which provide various components of the EPSDT services, that have signed an EPSDT specific provider agreement. with the Division. The Division will provide the Contractor with a list of qualified EPSDT providers on a monthly basis.

7. Family Planning

   The Contractor shall demonstrate that its network includes sufficient family planning providers to ensure timely access to covered services.

8. Accessibility Considerations

   The Contractor must ensure that Network Providers provide physical access,

reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

9. Additional Requirements

The Contractor's Provider Network shall reflect, to the extent possible, the diversity of cultural and ethnic backgrounds of the population served, including those with limited English proficiency. The Contractor must also consider the expected utilization of services, given the characteristics and health care needs of the population.

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

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

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

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

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

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

C. PCP Responsibilities

The Contractor shall require PCPs to meet the following requirements:

1. PCPs who serve EPSDT eligible Members, and are qualified EPSDT providers in accordance with Section 5.D, EPSDT Services, of this Contract, are responsible for conducting EPSDT screens for all EPSDT eligible Members on their Panel. Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Member's PCP Medical Record.

2. PCPs currently enrolled as a Mississippi Medicaid provider who have signed an

EPSDT specific provider agreement and serve EPSDT eligible Members report Member Encounter Data associated with EPSDT screens, using a format approved by the Division, to the Contractor within ninety (90) calendar days from the date of service.

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

    a. Contact Members identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children;

    b. Identify to the Contractor any such Members who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by the Contractor; and

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

4. Specialists as PCPs

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

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

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

D. <u>Provider Terminations</u>

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

1. Termination by the Contractor

   The Contractor must notify the Division in writing of its intent to terminate a Network Provider and services provided by a Network Provider (which includes but is not limited to a specialty unit within a facility and/or a large Provider group) sixty (60) calendar days prior to the effective date of the termination. The Contractor must submit a Provider termination work plan and supporting documentation within ten (10) business days of the Contractor's notification to the Division of the termination and must provide weekly updates to this information. This work plan shall document work steps and due dates and shall include, but is not limited to the submission of:

   a. Provider Impact and Analysis;

   b. Updated Provider Network and/or Provider Affiliation File;

   c. Provider Notification of the Termination;

   d. Member Impact and Analysis;

   e. Member Notification of the Termination;

   f. Member Transition and Continuity of Care;

   g. Systems Changes;

   h. Provider Directory Updates for the Division's Agent (include date when all updates will appear on Provider files);

   i. Contractor Online Directory Updates;

   j. Submission of Required Documents to the Division (Member notices for prior approval);

   k. Submission of Final Member Notices to the Division;

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

   m. Termination Retraction Plan, if necessary.

   The Division may also request additional background information regarding the Provider termination, including but not limited to a summary of the issues, reasons for the termination, any other requirement of 42 C.F.R. § 438.404, and information on negotiations or outreach between the Contractor and Provider.

   The Contractor must deny or revoke a Provider Agreement for cause for any reasons set forth in 42 C.F.R. §§ 455.416, 455.420, 1001.1001 and Miss. Code Ann. § 43-13-

121(7).

Unless the Provider is being terminated for cause, the Contractor must allow a Member to continue an ongoing course of treatment from the Provider for up to sixty (60) calendar days from the date the Member is notified by the Contractor of the termination or pending termination of the Provider, or for up to sixty (60) calendar days from the date of Provider termination, whichever is greater. A Member is considered to be receiving an ongoing course of treatment from a Provider under the following circumstances:

a. During the previous twelve (12) months the Member was treated by the Provider for a condition that requires follow-up care or additional treatment or the services have been prior authorized;

b. An adult Member with a previously scheduled appointment shall be determined to be in receipt of an ongoing course of treatment from the Provider, unless the appointment is for a well adult check-up;

c. Any EPSDT eligible member with a previously scheduled appointment, including an appointment for well child care, shall be determined to be in receipt of an ongoing course of treatment from the Provider; or

d. A Member who is pregnant may continue to receive care from the Provider that is being terminated through the completion of the Member's postpartum care.

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

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

2. Termination by the Provider

If the Contractor is informed by a Provider that the Provider intends to no longer participate in the Contractor's Network, the Contractor must notify the Division in writing sixty (60) calendar days prior to the date the Provider will no longer participate in the Contractor's network. If the Contractor receives less than sixty (60) calendar days' notice that a Provider will no longer participate in the Contractor's

Network, the Contractor must notify the Division within two (2) business days after receiving notice from the Provider.

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

3. Termination for Cause

The Contractor must terminate any provider (any individual or entity furnishing services to Medicaid beneficiaries under fee-for-service or managed care arrangements) from participation in the managed care program that has been terminated for cause upon notification from the Division. For cause may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. A termination for cause occurs when action has been taken to revoke a provider's billing privileges, a provider has exhausted all applicable appeal rights or timeline for appeal has expired, and there is no expectation on the part of the provider or the Division that the revocation is temporary.

The Contractor must notify the provider of its termination in writing. The notice must state the reason(s) for termination and the effective date. The Contractor must submit to the Division a copy of the provider's notification within forty-eight (48) hours of the termination.

4. Member Notification

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

E. <u>Provider Credentialing and Qualifications</u>

The Contractor must prepare, submit to the Division for approval, and follow a documented process for credentialing and recredentialing of Providers who have signed contracts or participation agreements with the Contractor, in accordance with 42 C.F.R. § 438.214 and Mississippi Department of Insurance Regulation 98-1. The Contractor shall maintain a Credentialing Committee and the Contractor's Medical Director shall have overall responsibility for the committee's activities. The Contractor must utilize a universal application, credentialing, and contracting process for MississippiCAN Providers as established or approved by the Division. The Contractor must conduct Provider credentialing simultaneously with Provider contracting to ensure timely processing; however, credentialing

must be completed before final execution of the contract with the Provider.

The Contractor's credentialing and recredentialing policies and procedures must meet the requirements within 42 C.F.R.§ 438.12 and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Contractor may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

The Contractor shall use credentialing and recredentialing standards set forth by the National Committee for Quality Assurance (NCQA) and EQRO recommendations. The Contractor must follow the most current version of the credentialing organization's credentialing requirements from year to year. Also, the Contractor must ensure that delegated credentialing providers and vendors adhere to the same standards of this Contract.

The Contractor shall verify and certify to the Division that all Network Providers and any Out-of-network Providers to whom Members 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 must ensure that all Network Providers are enrolled with the State as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 C.F.R. part 455, subparts B and E. This provision does not require the Network Provider to render services to fee-for-service beneficiaries. All Contractor Network Providers must also be enrolled in the Mississippi Medicaid program using the same National Provider Identifier (NPI) numbers and Mississippi Medicaid Provider Numbers with active enrollment segments. Additionally, all Contractor Network Providers must be enrolled as Group or Individual providers consistent with enrollment with the Division. Contracted nurse practitioners acting as PCPs shall be held to the same requirements and standards as physicians acting at PCPs. The Contractor may execute Network Provider agreements pending the outcome of the process in § 438.602 (b)(1) of up to one hundred and twenty (120) days, but must terminate a Network Provider immediately upon notification from the State that the Network Provider cannot be enrolled, or the expiration of one (1) one hundred and twenty (120) day period without enrollment of the provider, and notify affected enrollees.

In contracting with Providers, the Contractor will be responsible for obtaining all disclosure information from all Network Providers and Out-of-network Providers and abide by all applicable Federal regulations, including 42 C.F.R. §§ 455.104 and 455.106. during the credentialing and recredentialing process.

The Contractor shall maintain a file for each Provider containing a complete Provider application including a signed attestation statement, a copy of the Provider's current license issued by the State, a valid DEA or Controlled Dangerous Substances certificate, proof cover page of malpractice insurance (copy of certificates or cover pages), and such additional information as may be specified by the Division.

In contracting with laboratory Providers and or any Provider who bills for laboratory

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

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

1. The verification of the existence and maintenance of credentials, licenses, malpractice claims history, certificates, and insurance coverage of each admitting Provider from a primary source, site assessment, hospital admitting privileges or admitting plan. Proof of this verification must be maintained within each provider file;

2. A methodology and process for recredentialing Providers every 3 years;

3. A description of site assessment including:

    a. The initial site assessment, prior to the completion of the initial credentialing process, of private practitioner offices and other patient care settings conducted in-person during the Provider office visit;

    b. A site reassessment if the provider location has changed since the previous credentialing activity;

    c. A site reassessment of private practitioner offices and other patient care settings, conducted in-person, when a complaint has been lodged against the specific provider. This reassessment must be completed within 60 calendar days of the complaint.

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

5. Procedures for practitioners to correct erroneous information;

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

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

8. Procedures for verifying the inclusion of Providers including but not limited to the following databases: HHS-OIG's List of Excluded Individuals and Entities (LEIE), System of Award Management (SAM), CMS' Medicare Exclusion Databank (MED), State Board of Examiners, National Practitioner Data Bank (NPDB), Health Integrity and Protection Databank (HIPDB), and any State listings of excluded Providers. Copies or prints of all queries shall be included in Provider credentialing files.

9. Receipt of all elements contained within the credentialing file prior to the credentialing and recredentialing decision with no element older than 180 days.

10. The Contractor maintains a Credentialing Committee:

    a. That meets at regular intervals;

    b. Is chaired by the Contractor's Medical Director;

    c. Membership includes a variety of participating practitioners;

    d. Reviews credentialing files for practitioner who do not meet the established criteria;

    e. Credentialing files that meet criteria are reviewed and approved by the Medial Director or designated physician;

    f. Ensure the date of the Credentialing Committee decisions is included in each credentialing file.

11. Specific provisions that address acute, primary, behavioral, substance use disorders, and LTSS providers, as appropriate.

    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 notify a practitioner within five (5) business days of any missing or invalid information that would impede completion of credentialing and/or contracting.

    The Contractor shall credential all completed application packets within ninety (90) calendar days of receipt. In cases of network inadequacy, the Contractor shall credential all completed application packets within forty-five (45) calendar days of receipt.

    The Contractor shall notify the Division within ten (10) calendar days of the

Contractor's denial of a Provider credentialing or recredentialing application either for program integrity-related reasons, due to limitations placed on the Provider's ability to participate for program integrity-related reasons, or the Contractor's decisions not to allow a Provider to participate in the network.

Contractor will load Provider information into its claims processing system within thirty (30) calendar days of provider contract approval.

The Contractor must submit reports in accordance with Section 11.E, Provider Services Reports, of this Contract.

F. Provider Agreements

The Contractor must have written agreements with a sufficient number of Providers to ensure Member access to all Medically Necessary Services covered by the MississippiCAN Program.

Contractor must ensure that all Members receiving inpatient and PRTF services are provided with a transitional care plan that includes outpatient follow-up and/or continuing treatment prior to discharge from the inpatient setting or PRTF. All new or renewal provider agreements entered into after the effective date of this Contract Amendment must include provisions to this effect.

In all Provider agreements, the Contractor must comply with the requirements specified in 42 C.F.R. § 438.214 and Miss. Code Ann. § 83.41.409 (e). The Contractor's Provider agreements must include at least the following provisions:

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

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

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

4. A requirement that the Contractor cannot prohibit or restrict a Provider acting within

the lawful scope of practice from providing information the Member needs in order to decide among all relevant treatment options and the risks, benefits, and consequences of treatment or non-treatment.

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

6. A requirement securing cooperation with the QM and UM Program standards outlined in Section 10, Quality Management, of this Contract.

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

8. A requirement that the Contractor include in all capitated Provider agreements a clause which requires that should the Provider terminate its agreement with the Contractor, for any reason, the Provider will provide services to the Members assigned to the Provider under the Contract up to the end of the month in which the effective date of termination falls.

9. A requirement that the Provider must comply with all applicable laws and regulations pertaining to the confidentiality of Member Medical Records, including obtaining any required written Member consents to disclose confidential Medical Records.

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

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

12. A requirement that, effective July 1, 2014, the Provider must submit claims within one hundred eighty (180) calendar days from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial.

The Contractor may not enter into a Provider agreement that prohibits the Provider from contracting with another Contractor or that prohibits or penalizes the Contractor for contracting with other Providers. The Contractor may not require Providers who agree to participate in the MississippiCAN Program to contract with the Contractor's other lines of business.

G. Mainstreaming

The Contractor must ensure that network Providers do not intentionally segregate their Members in any way from other persons receiving services.

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

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

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

3. The assignment of times or places for the provision of services on the basis of the race, color, national origin, sex, sexual orientation, gender identity, disability, creed, religion, age, ancestry, marital status, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the Members to be served.

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

H. Provider Services

The Contractor must submit reports in accordance with Section 11.E, Provider Services Reports, of this Contract.

1. Provider Services Call Center

   The Contractor must operate Provider services call center functions at a minimum during regular business hours (8:00 a.m. to 5:00 p.m. CST, Monday through Friday). Provider services functions include, but are not limited to, the following:

   a. Assisting Providers with questions concerning Member eligibility status;

   b. Assisting Providers with Contractor Prior Authorization and referral procedures;

c. Assisting Providers with claims payment procedures and handling Provider disputes and issues. An issue that is not resolved within thirty (30) calendar days of notice by the Division, unless another timeframe is agreed upon by the Division and Contractor may be defined as Medicaid Investigated Grievances

d. Facilitating transfer of Member Medical Records among medical Providers, as necessary;

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

f. Referring Providers to the Fraud and Abuse Hotline;

g. Developing a process to respond to Provider inquiries regarding current enrollment; and

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

The Contractor must develop appropriate, interactive scripts for call center staff to use when making outbound calls to Providers and to respond to Providers calls. The Contractor must develop special scripts for emergency and unusual situations, as requested by the Division. All scripts must be clear and easily understood. All scripts shall promote the use of the Contractor's web-based Provider portal. The Contractor must review the scripts annually to determine any necessary revisions. The Division reserves the right to request and review call center scripts at any time.

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

The Contractor shall maintain sufficient equipment and call center staff for Provider services call center to ensure that the average abandonment rate for any month is not greater than five percent (5%). The Contractor will be subject to sanctions if the abandonment rate exceeds this target, in accordance with Section 16, Default and Termination, of this Contract.

2. Provider Manual

The Contractor shall develop and maintain a Provider manual for network Providers. Copies of the Provider manual must be distributed in a manner that makes them easily accessible to all participating Providers, including provision of an electronic version

through the web portal. The Provider manual must be submitted to the Division for approval thirty (30) calendar days prior to implementation and must be approved by the Division prior to use.

The Provider manual must be updated annually and approved by the Division prior to use. The Division may grant an exception to this annual requirement upon written request from the Contractor provided there are no major changes to the manual.

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

a. Description of the Care Management system and protocols;

b. Description of the role of a PCP;

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

d. Contact information including: telephone number; email address; and websites

e. Contact follow-up responsibilities for missed appointments;

f. Information regarding written translation and verbal interpretation services for Members with Limited English Proficiency and alternate methods of communication for those requesting communication in alternate formats;

g. Information about filing Provider disputes;

h. Prior authorization review and reconsideration, Complaint, Grievance, Appeal, and State Fair Hearing information;

i. Prior authorization clinical and technical criteria guidelines for all services requiring prior authorization;

j. Billing instructions, including claims submission time frame requirements and manual or invoice pricing requirements;

k. Provider performance expectations, including disclosure of quality management and utilization management criteria and processes;

l. Information about EPSDT screening requirements and EPSDT services;

m. Provider responsibility to follow up with Members who are not in compliance with the EPSDT screening requirements and EPSDT services;

n. A definition of “medically necessary” consistent with the language in this Contract;

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

p. Information about Member confidentiality requirements;

q. Information about the process for communicating with the Contractor on limitations on Panel size

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

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

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

3. Provider Education and Training

The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members, including EPSDT services. The Contractor shall conduct initial training within thirty (30) calendar days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or the Division or as requested by the Provider to ensure compliance with program standards and the Contract. The Contractor shall employ personnel for the purpose of serving as provider representatives. Provider representatives will partner with Network Providers to assist in delivering high-quality, cost-effective health care services for members. These provider representatives will communicate with providers on behalf of the Contractor and shall be trained in, and capable of performing the following duties:

a. Build strong working relationships with Providers;

b. Assist in the resolution of operational issues;

c. Share and disseminate best practices; and

d. Promote mutual values and goals.

The Contractor shall employ sufficient representatives as a proportion of contracted providers to address all provider inquiries within a reasonable time frame. Provider

representatives shall be allocated by the Contractor based on provider density within network areas and shall be reallocated based on provider density changes. Unless otherwise approved by the Division, Contractor shall employ a minimum of eight (8) provider representatives with two (2) additional representatives designated for out of state providers. The Division shall reserve the right to modify or change the provider representative requirements during the term of the Contract.

The Contractor shall develop and submit a Provider Training Manual and prospective Training Plan to the Division for review and approval initially and as updated prior to use. The Contractor will submit quarterly reports on the trainings conducted, topics covered, the number and positions of staff completing the trainings, and trainings planned in the subsequent quarter.

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

I. Provider Complaint, Grievance, Appeal and State Administrative Hearing Process

The Contractor shall draft and disseminate to Providers and Subcontractors, a system and procedure, which has the prior written approval of the Division for the receipt and adjudication of Complaints, Grievances, and Appeals by Providers. The Grievance and Appeal policies and procedures shall be in accordance with the State's Quality Strategy, with the modifications that are incorporated in the Contract. The Contractor shall not modify the Grievance and Appeal procedure without the prior approval of the Division, and shall provide the Division with a copy of the modification.

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

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

The Contractor shall provide Providers as a part of the Provider Manual, information on how they or their representative(s) can file a Grievance or an Appeal, and the resolution process. The information shall also advise Providers of their right to file a request for a State Administrative Hearing with the Division of Medicaid, upon notification of a Contractor Adverse Benefit Determination, subsequent to an Appeal of the Contractor. Adverse Benefit Determination. The Provider must exhaust all Contractor level Appeal procedures prior to requesting a State Administrative Hearing with the Division.

Should a State Administrative Hearing result in the reversal of an Adverse Benefit Determination made by the Contractor, the Contractor shall bear all costs associated with the

hearing. These costs may include, but are not limited to, medical appropriateness reviews by the Division contracted Independent Physician Reviewers, hearing officer's fees, attorney's fees, and court reporter's fees.

The Contractor shall use the definitions for Complaints, Grievances, and Appeals as set forth in this section and adhere to time frames required by this Contract and Federal regulations. Table 8 below outlines additional specific requirements pertaining to Complaints, Grievances, and Appeals.

Table 8. Summary of Provider Complaints, Grievances, and Appeals Requirements

Party	Action	Time Frame	Extensions Available
Complaint: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Complaint", received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Complaint not resolved within one (1) calendar day shall be treated as a Grievance. A Complaint includes, but is not limited to inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.			
Provider	Submit a Complaint	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Resolve a Complaint	Within one (1) calendar day	
Grievance: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance", received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract.			
Provider	File a Grievance	Within thirty (30) calendar days of the date of the event causing the dissatisfaction	
Contractor	Confirm receipt of the Grievance and expected date of resolution	Within five (5) calendar days of receipt of the Grievance	
Contractor	Resolve a Grievance	Within thirty (30) calendar days of the date the Contractor receives the Grievance	Contractor may extend time frames up to fourteen (14) calendar days
Appeal: A request to be performed for review by the Contractor of a Contractor Adverse Benefit Determination related to a Provider. The Contractor Adverse Benefit Determination may include, but is not limited to, for cause termination by the Contractor, or delay or non-payment for covered services.			

Party	Action	Time Frame	Extensions Available
Provider	File an Appeal	Within thirty (30) calendar days of receiving the Contractor's notice of Adverse Benefit Determination	
Contractor	Confirm receipt of the Appeal and expected date of resolution	Within ten (10) calendar days of receipt of the Appeal	
Contractor	Resolve an Appeal	Within thirty (30) calendar days of the date the Contractor receives the Appeal or as expeditiously as the Member's health condition requires Within three (3) calendar days after the Contractor receives the request for an Expedited Resolution of an Appeal	Contractor may extend time frames by up to fourteen (14) calendar days
State Administrative Hearing: A hearing conducted by the Division of Medicaid or its Subcontractor. Appeal that is not resolved wholly in favor of the Provider by the Contractor may be appealed by the Provider or the Provider's authorized representative to the Division for a State Administrative Hearing.			
Provider	File a request for a State Administrative Hearing	Within thirty (30) calendar days of the final decision by the Contractor	
Division	Take final administrative Action	Within ninety (90) calendar days from the date the Provider filed for direct access to a State Administrative Hearing	

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

J. Reimbursement

The Contractor shall reimburse Out-of-network Providers for the following covered services and specialty care for which the Contractor has referred the Member to an Out-of-network Provider and out-of-area services provided to a Member in accordance with the Contractor's approved plan for out-of-network services.

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

The Contractor shall reimburse all Network Providers at a rate no less than the amount that the Division reimburses fee-for-service providers with the exception of capitation and other incentive arrangements under Section 7.K, Physician Incentive Plans, of this Contract and such innovative payment models authorized under Miss. Code Ann. § 43-13-117 (H). If the Contractor enters into a contract with a FQHC or a RHC, the Contractor shall provide payment that is not less than the level and amount of payment which the Contractor would make for the services if the services were furnished by a provider which is not a FQHC or RHC. The Contractor shall follow the Mississippi State Plan related to enhanced payment for primary care services.

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

The Contractor shall generate Explanations of Benefits, in a format approved by the Division and submit the policy and procedures for sampling for Explanation of Benefits for Division approval. The Contractor must send the Explanation of Benefits to Members within thirty (30) calendar days of adjudication.

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

See Section 18 for information regarding the Claims payment.

1. No Supplemental Payments

   The Division must ensure that no payment is made to a Network Provider other than by the Contractor covered under this Contract, except when these payments are specifically required to be made by the Division in Title XIX of the Act, in 42 C.F.R. chapter IV, or when the Division makes direct payments to Network Providers for graduate medical education costs approved under the State plan.

2. Payments for Provider-Preventable Conditions

   The Contractor may not make payments for Provider-preventable conditions as defined by the Federal regulations and the Mississippi State Plan in accordance with 42 C.F.R. § 438.3(g).

   In accordance with the Mississippi State Plan, the Contractor shall identify and deny Never Events, which are a type of Provider-preventable condition. The Contractor

shall track data and submit a report quarterly, in a format to be specified by the Division.

Section 2702(a) of the PPACA prohibits Federal financial participation (FFP) payments to States for any amounts expended for providing medical assistance for health care-acquired conditions (HCACs) and other Provider-Preventable Conditions (PPCs). PPCs are hospital-acquired conditions not present on hospital admission, the wrong procedure performed on a patient, and procedures performed on a wrong patient or body part. The Contractor may not make payments for PPCs as defined by the federal regulations in accordance with 42 C.F.R. § 438.3(g). The Contractor will track PPC data and make it available to the Division upon request.

3. Payments from Members

Members utilizing medical services which are not medically necessary or who obtain covered services from Out-of-network 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 Members for covered services under this Contract, nor shall the Contractor charge Members for missed appointments. Members with coverage from Third Party Liability/Resources shall not 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.

If applicable, any cost sharing imposed on Medicaid enrollees will be in accordance with Medicaid Fee-for-Service requirements at 42 C.F.R. § 447.50 through 42 C.F.R. § 447.60. Additionally, the Contractor must exempt from premiums any Indian who is eligible to receive, is currently receiving, or has received an item or service furnished by an Indian health care provider or through referral under contract health services, if applicable

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

K. Physician Incentive Plans

The Contractor may operate a physician incentive plan only if no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to a Member. Contracts must comply with the requirements set forth in 42 C.F.R. §§ 422.208 and 422.210.

The Contractor shall provide to the Division of Medicaid the following disclosure annually or at the request of the Division of Medicaid:

1. Whether services not furnished by physician/group are covered by incentive plan. If the physician incentive plan does not cover services furnished by physician/group, no further disclosure is required;

2. The type of incentive arrangement (included but not limited to, withhold, bonus, capitation, any other incentive arrangements that have the potential to hold a physician or a physician group liable for more than 25 percent of potential payments);

3. Percentage of withhold or bonus, if applicable;

4. Panel size, and if patients are pooled, the approved method used; and

5. 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.

L. <u>Provider Discrimination</u>

Neither 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.

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 based on 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 provide the affected Providers written notice of the reason for its decision. Denials of Provider enrollment due to excess network capacity must receive Division approval prior to Provider notification. Nothing in this provision, however, shall preclude the Contractor from using reimbursement amounts greater than the Division's Fee-for-Service fee schedule 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 Members. 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.

SECTION 8 – INDIAN HEALTH SERVICES/TRIBAL 638/URBAN INDIAN HEALTH

In addition to the network adequacy requirements described above, the Contractor must demonstrate that there are sufficient Indian Health Care Providers participating in the provider network of the Contractor to ensure timely access to services available under the Contract from such providers for Indian enrollees who are eligible to receive services. The Contractor shall pay Indian Health Care Providers for covered services provided to Indian Members who are eligible to receive services from such providers as described in 42 C.F.R. § 438.14(b)(2).

The Contractor shall permit any Indian who is enrolled in with the Contractor and who is eligible to receive services from an Indian Health Care Provider Primary Care Provider participating as a network provider, to choose that Indian Health Care Provider as his or her Primary Care Provider, as long as that provider has capacity to provide the services. Indian Members shall be permitted to obtain services covered under this Contract from out-of-network Indian Health Care Providers from whom the Member is otherwise eligible to receive such services.

If access to covered services cannot be ensured due to few or no Indian Health Care Providers, the Contractor will be considered to have met these requirements if:

1. Indian Members are permitted by the Contractor to access out-of-state Indian Health Care Providers; or

2. If this circumstance is deemed to be good cause for disenrollment from both the Contractor and the MississippiCAN program in accordance with 42 C.F.R. § 438.56(c).

The Contractor must permit an out-of-network Indian Health Care Provider to refer an Indian enrollee to a network provider. The Contractor shall comply with the following Indian Health Care Provider payment requirements of 42 C.F.R. § 438.14(c) including, but not limited to:

1. When an Indian Health Care Provider is enrolled in Medicaid as a FQHC but not a participating provider of the Contractor, it must be paid an amount equal to the amount the Contractor would pay an FQHC that is a network provider but is not an Indian Health Care Provider, including any supplemental payment from the State to make up the difference between the amount the Contractor pays and what the Indian Health Care Provider FQHC would have received under fee for service.

2. When an Indian Health Care Provider is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the Contractor's network or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's fee-for-service payment methodology.

SECTION 9 - CARE MANAGEMENT

A. <u>Care Management Responsibilities</u>

The Contractor is responsible for Care Management – a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Management includes but is not limited to Continuity of Care, Transition of Care, and Discharge Planning.

The Contractor shall develop and implement a Care Management system to ensure and promote timely access and delivery of health care and services required by Members, continuity of Members' care, and coordination and integration of Members' care, including physical and Behavioral Health/Substance Use Disorder Services, especially for those members with chronic and severe medical and behavioral conditions.

Within ninety (90) calendar days of contract award, the Contractor shall provide its overall approach to Care Management to the Division for review and approval. The Contractor shall revise its approach as requested by the Division, and will submit any subsequent updates to the Division for approval.

1. Assignment of Risk Levels

   The Contractor shall develop a Care Management program that addresses the varying needs and differing levels of Care Management needs for Members. Based on the Health Risk Screening, the Contractor's Care Management program must provide for the completion of a detailed health risk assessment for Members, which includes an assessment of and assignment to risk stratification levels (e.g., low, medium, rising, high) which determine the intensity of interventions and follow-up care that is required for each Member. The Contractor shall prioritize and assign Members to low, medium, or high levels based on the identified risk and level of need. Members who have high costs or potentially high costs or otherwise qualify, include but are not limited to Members with persistent and/or preventable inpatient readmissions, pregnant women under twenty-one (21), high risk pregnancies, serious and persistent behavioral health conditions, Substance Use Disorder, and infants and toddlers with established risk for developmental delays, shall be assigned to the medium or high risk level and receive Care Management services. Members being discharged from an acute inpatient psychiatric stay or PRTF shall be assigned to high risk level and receive Care Management services. Members with less intensive needs will be assigned to the low risk level and shall have access to Care Management teams.

   The Care Manager must contact the Member via telephone or face-to-face interview to assess the Member's Care Management needs. This detailed health risk assessment must evaluate the Member's medical condition(s), including physical, behavioral, social and psychological needs. The goal of this assessment is to confirm the Member's need for Care Management, identify the Member's existing and /or potential health care needs, determine the types of services needed by the Member and begin the development of the treatment plan. The Contractor will determine the need for an onsite visit at the Member's residence to complete this assessment. This detailed health risk assessment must occur within thirty (30) calendar days for

Members newly assigned to the High or Medium risk levels as a result of the Health Risk Screening, referral and/or predictive modeling.

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

a. Identification of the severity of the Member's conditions/disease state;

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

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

d. The Member's current treatment Providers and treatment plan, if available. The treatment plan for the Member must be completed within thirty (30) days of the completion of the detailed health risk assessment, if appropriate.

The Contractor shall conduct initial and ongoing predictive modeling to identify and evaluate the Member's risk level, which must incorporate the use of pharmacy utilization data. In addition, in consideration of the fact complete claims data may not be available for the MississippiCAN population, particularly for Members new to the program, the Contractor must propose other analyses used to identify and stratify Members who may be in need of Care Management services. Whenever available, the Contractor shall use findings from an initial Health Risk Screening for new Members. The Contractor shall report on the number of Members for whom they attempted to conduct a Health Risk Screening, the number of Members who could not be reached, and the findings from the Health Risk Screenings for those Members whom the Contractor was able to assess. The Contractor shall report this information as part of the Care Management Reports.

Additionally, Members may be considered for receiving Care Management services, through Provider referral, State Agency referral and Member self-referral. At a minimum, the Contractor shall provide Care Management services to all Members identified with the following chronic conditions: diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants.

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

The Contractor must receive Division approval for other analysis used to identify Member's risk level prior to use. The Contractor shall modify its approach upon Division request. Additionally, the Contractor shall provide alternate solutions if the implemented approach does not achieve the targeted outcomes and savings over time.

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

2. Care Management Services

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

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

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

b. Access to a Member services call center;

c. Assistance with care coordination and access to primary care, inpatient services, Behavioral Health/Substance Use Disorder Services, preventive and specialty care, as needed;

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

e. Coordination of discharge planning and follow-up to care post discharge from a PRTF;

f. Coordination with other health and social programs such as MSDH's PHRM/ISS Program, Individuals with Disabilities Education Act (IDEA),the Special Supplemental Food Program for Women, Infants, and Children (WIC); Head Start; school health services, and other programs for children with special health care needs, such as the Title V Maternal and Child Health Program, and the Department of Human Services; Developing, planning and assisting Members with information about community-based, free care initiatives and support groups;

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

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

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

services;

j. Working with Members, Providers, and other Contractors to ensure continuity of care; and

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

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

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

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

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

d. Procedures and criteria for making referrals to specialists and sub-specialists;

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

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

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

h. Ensuring that when a Provider is no longer available through the Contractor, the Contractor allows Members who are receiving an ongoing course of treatment to access services from Out-of-network Providers for sixty (60) calendar days.

Members identified as medium risk or high risk will be assigned a Care Manager. The Contractor shall provide Members assigned to the medium risk level all services included in the low risk level and the following services, at a minimum:

a. Facilitate relapse prevention plans for Members with substance use disorder, depression, and other high- risk behavioral health conditions and their PCPs/Community Mental Health Centers/Private Mental Health Centers (e.g., patient education, extra clinic visits, and follow-up phone calls);

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

c. Educate Provider office staff about symptoms of exacerbations and how to communicate with patient;

d. Develop speaking points and triggers for making emergency appointments; and

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

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

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

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

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

d. Educate staff about barriers Members experience in making and keeping appointments;

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

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

3. Perinatal High Risk Management/Infant Services System

The Contractor shall coordinate with the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will work with MSDH to identify Members who meet the Program criteria. MSDH will provide case management services to those Members, and the Contractor will coordinate with MSDH to confirm the case manager will support all of the Members' health care needs. Should the Members have additional needs; the Contractor will provide additional case management and coordinate with the MSDH case managers to create an individual medical treatment plan for the Members. Members shall have

freedom of choice regarding PHRM/ISS services provided by MSDH or the Contractor. Should the Member choose PHRM/ISS services through the MSDH, the Contractor will conduct health care assessments for pregnant women and offer the women the option of case management by either the Contractor or the Mississippi State Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS). The Contractor will coordinate with MSDH to confirm the case manager will support all of the Members' health care needs. The Contractor will coordinate with the MSDH, as specified by the Division.

4. Continuity of Care

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

5. Reporting

The Contractor will submit quarterly reports to the Division that include specified Care Management program data as described in Section 11, Reporting Requirements, and Exhibit H, Reporting Requirements, of this Contract. The Division will request cases to review for appropriateness in terms of assignments to risk levels, treatment plans, and discharge planning, at its discretion.

The Contractor shall submit a report on its activities related to coordinating with the MSDH on PHRM/ISS and providing additional case management to identified Members in a format to be specified by the Division.

B. <u>Transitional Care Management</u>

1. General Requirements

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

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

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

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

d. Notify PCP, Behavioral Health/Substance Use Disorder provider, or other specialist within fourteen (14) days of Member's discharge from inpatient setting to allow for follow-up appointments to be made;

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

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

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

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

2. Transitional Care Management Policies and Procedures

Contractor shall, initially, and as revised, submit to the Division for review and prior approval, Transitional Care Management policies and procedures and a staffing model designed to achieve a seamless, efficient transition with minimal impact to Member's care. The Division will work to complete the initial review within forty-five (45) calendar days and any subsequent updates within fifteen thirty (30) calendar days prior to implementation.

3. Transition of Care Team

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

4. Transition of Care Process

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

a. Identification of Members needing transition of care;

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

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

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

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

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

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

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

5. Transition of Care Contractor Requirements

The Contractor shall have a transition of care policy consistent with requirements of 42 C.F.R. § 438.62. The contractor must make its transition of care policy publicly available and provide instructions to Members and Potential Enrollees on how to access continued services upon transition. The transition of care policy must be explained to Members in the materials to Members and Potential Enrollees in accordance with § 438.10.

In the event a Member entering the Contractor, either as a new Member or transferring from another Contractor, is receiving medically necessary services in addition to or other prenatal services the day before enrollment, the Contractor shall be responsible for the costs of continuation of such medically necessary services, without any form of prior authorization and without regard to whether such services are being provided by a Network Provider or non-contract providers.

For medically necessary covered services, the Contractor shall provide continuation of such services for up to ninety (90) calendar days or until the Member may be reasonably transferred without disruption to a Network Provider, whichever is less. The Contractor may require prior authorization for continuation of services beyond thirty (30) calendar days; however, the Contractor is prohibited from denying authorization solely on the basis that the provider is a non-contract provider.

For medically necessary covered services being provided by a Network Provider, the

Contractor shall provide continuation of such services from that provider. Members who are transitioning to another provider when a provider currently treating their chronic or acute medical or behavioral health condition, or currently providing prenatal services has terminated participation with the Contractor, will receive continuation of coverage for such provider for up to ninety (90) calendar days or until the member may be reasonably transferred to another provider without disruption of care, whichever is less.

For members in their second or third trimester of pregnancy, the Contractor shall allow continued access to the Member's prenatal care provider and any provider currently treating the Members chronic, acute medical or behavioral health/substance use disorder through the postpartum period.

SECTION 10 – QUALITY MANAGEMENT

The Contractor must submit reports related to quality management in accordance with Section 11, Reporting Requirements, Exhibit G, Quality Management, and Exhibit H, Reporting Requirements, of this Contract.

A. General Requirements

The Contractor shall support and comply with the MississippiCAN Quality Strategy, including all reporting requirements in formats to be determined by the Division.

The Contractor shall comply with the MississippiCAN Quality Management (QM) requirements to improve the health outcomes for all Members. Improved health outcomes will be documented using established Performance Measures.

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

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

The Contractor shall cooperate with all of the Division's vendors including the Division's Utilization Management vendor and Quality Improvement Organization vendor for the completion of IV & V (Independent Verification & Validation) quality and clinical reviews and at the request of the Division.

The Contractor shall participate and shall recruit network Providers to participate in the MississippiCAN Quality Leadership Team as defined in Table 9 below.

Table 9. MississippiCAN Program Quality Committees

Quality Committee	Committee Membership
MississippiCAN Quality Leadership Team	Medical Directors of each of the Contractors Other Contractor Executives, as designated by the Division Other representatives, as determined by the Division At least two (2) network Providers from each Contractor who are actively involved in providing services to Members Members receiving MississippiCAN services, to be determined by the Contractor Division Staff
MississippiCAN Quality Task Force	MississippiCAN Contractors, including the Quality Managers and Health Services Managers Quality Managers and Health Services Managers from the behavioral health subsidiary Division Staff

B. Accreditation

The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) and provide to the Division, on an annual basis, any and all documents related to achieving such accreditation. The Division reserves the right to post accreditation status publicly on its website in accordance with 42 C.F.R. § 438.332. Accreditation status may also be posted to the related website operated by the Contractor.

C. External Quality Review

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

The Contractor shall address any deficiencies or contract variances identified by the External Quality Review Organization (EQRO) expediently, on a schedule to be determined by the Division. The Division may issue sanctions, liquidated damages, or pursue other available remedies for deficiencies or contract variances, which are not addressed to the satisfaction of the Division.

D. 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 C.F.R. § 438.330 which:

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

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

3. Provides for interpretation and dissemination of performance and outcome data to Network Providers and Out-of-network Providers approved for referrals for primary and specialty;

4. 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;

5. Provides for the maintenance of Member Encounter Data to identify each practitioner providing services to Members, specifically including the unique physician identifier for each physician; and

6. Complies with Miss. Code Ann. § 83-41-313 et seq. (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:

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

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

    a. Data collection and analysis;

    b. Evaluation and reporting of findings;

    c. Implementation of improvement actions where applicable; and

    d. Individual accountability for each activity.

3. Composition of the QM committee including a physical and behavioral health Provider.

4. Procedures for remedial action when deficiencies are identified.

5. Specific types of problems requiring corrective action.

6. Provisions for monitoring and evaluating corrective action to ensure that actions for improvement have been effective.

7. Procedures for Provider review and feedback on results.

8. Annual performance evaluation of the QM program as part of the Internal Audit that includes:

    a. Description of completed and ongoing QM activities including Care Management effectiveness evaluation;

    b. Identified issues, including tracking of issues over time;

    c. Trending of measures to assess performance in quality of clinical care and quality of service to Members; and

    d. An analysis of whether there have been demonstrated improvements in Members' health outcomes, the quality of clinical care and quality of service to Members; and overall effectiveness of the QM program (e.g., improved HEDIS® scores).

9. The Contractor must have in effect mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs. The assessment mechanism must use appropriate health care professionals.

10. The Contractor must address health care disparities.

The Contractor will submit a copy of Annual Program Description, Annual Program Evaluation and Annual Work Plan to the Division annually for review and approval. The QM program description, including the Annual Work Plan, will be submitted to the Division for written approval annually. The Contractor will also submit regular quarterly work plan updates to the Division. The Division reserves the right to expand the QM Program as needed to assure quality Member care.

The Annual Program Description and other information reported to the Division, including reporting on required standards, such as network adequacy, will be published on the Division website.

The Contractor will make available to its Members and Providers information about the QM program and a report on the Contractor's progress in meeting its goal annually. This information must be reviewed and approved by the Division prior to distribution.

E. Performance Measures

The Contractor shall comply with the Division's Quality Management requirements to improve the health outcomes for all Members. The Contractor shall meet specific performance targets, as outlined in Exhibit F, Performance Measures, of this Contract for each of the Performance Measures identified by the Division. The Contractor shall, on an annual basis, measure and report to the Division on its performance using the standard Performance Measures required by the Division and submit to the Division data, as specified by the Division, which enables the Division to calculate the Contractor's performance using the standard measures identified by the Division.

The Division may update performance targets, include additional Performance Measures or remove Performance Measures from the list of required Performance Measures and required targets at any time during the Contract period. The Division and the Contractor(s) shall have an ongoing collaborative process on the development, addition, and modification of Performance Measures and setting of performance targets to identify opportunities for improving health outcomes.

Many of the MississippiCAN Performance Measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®). The Contractor shall use the standardized methodology as outlined in Volume 2, HEDIS® Technical Specifications[1], to calculate its performance rates. The Contractor shall contract with a Certified HEDIS® Audit Firm to conduct a certified audit of its HEDIS® rates, and shall report the findings of that audit, including the actual report submitted by the auditor to NCQA, to the Division. The Contractor shall report rates for all Performance Measures to the Division, regardless of whether they are based on HEDIS® technical specifications.

While the Contractor must meet the Division Performance Measure Targets for each measure, it is equally important that the Contractor continually improve health outcomes from year to year. The Contractor shall strive to meet the Performance Measure targets established by the Division.

The Division reserves the right to make any HEDIS® and Performance Measures results public.

F. CAHPS® Member Satisfaction Survey

The Contractor shall contract with an NCQA certified survey vendor to administer an annual

[1]NCQA publishes the Technical Specifications annually to assist in the calculation of HEDIS® measures. Contractor shall use the version, which represents the reporting year for HEDIS® rates (e.g., health plans report calendar year 2013 rates in 2014 based on Volume 2-2014 Technical Specifications).

CAHPS® Member Survey. The results of the survey and action plans derived from these results must be filed with the Division at least ninety (90) calendar days following the Contractor's receipt of the survey findings from its certified survey vendor.

The Division reserves the right to make any CAHPS® Member Survey and results public.

G. Provider Satisfaction Survey

The Contractor shall conduct annual Provider satisfaction surveys. The Contractor must submit to the Division for review and approval, the survey questions and methodology by March 1 for the current calendar year. The results of the survey and action plans derived from these results must be filed with the Division at least ninety (90) calendar days following the completion of the survey and no later than December 1 for the current calendar year.

H. Value-Based Purchasing

At its option, the Division may implement a value-based purchasing model within the MississippiCAN Program. The Division reserves the right to phase in implementation of a value-based purchasing model beginning with a performance incentive program. Should the Division move forward with such an effort, the Division will provide operational protocols describing the process for selecting priority areas, measures, and targets, Contractor expectations, and Division responsibilities prior to implementation. If implemented, the value-based purchasing model will require the participation of key Contractor staff, including the Medical Director, in regular meetings with Division staff. The value-based purchasing model may lead to the creation of subcommittees to current MississippiCAN Program Quality Committees, referenced in Section 10.A, General Requirements, of this Contract.

The Contractor will have an opportunity to provide recommendations on selections for priority areas, measures, and targets based on the results of gaps analysis and root cause analyses performed by the Contractor. The Division will have final authority on the selection of priority areas, measures, and targets, which the Contractor will be required to comply.

I. Performance Improvement Projects

The Contractor shall also perform a minimum of four (4), either clinical or non-clinical Performance Improvement Projects (PIP) each year on topics prevalent and significant to the population served. PIPs shall meet all relevant CMS requirements and shall be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery. The Contractor shall:

1. Show that the selected area evaluation is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);

2. Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project;

3. Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;

4. Implement interventions to achieve improvement in the access to and quality of care;

5. Evaluate the effectiveness of the interventions;

6. Establish standardized Performance Measures (such as HEDIS® or another similarly standardized product);

7. Plan and initiate activities for increasing or sustaining improvement; and

8. Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

Due to the critical importance of the area of obesity to the 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 quality improvement activities. The Division will pre-approve all PIPs. The Division may require the Contractor to implement PIPs focusing on specified conditions. The Contractor will include study question and study indicators agreed upon by the Division and the Contractor.

The Contractor shall include information on PIPs in the Quality Management program description and work plan submitted to the Division.

In addition to those set forth herein, CMS, in consultation with the State, and other stakeholders, may specify additional Performance Measures and topics for PIPs to be undertaken by the Contractor.

J. Disenrollment Survey

The Contractor shall outreach to Members who disenroll from the Contractor to determine the reason for their Disenrollment. The Contractor must administer Disenrollment surveys to Members via phone or mail within five (5) business days of the Member disenrolling from the Contractor. The Contractor must submit to the Division for review and approval, the survey questions and methodology.

The Contractor shall report findings from the Disenrollment survey and a work plan for addressing results of the Disenrollment survey on a quarterly basis to the Division.

K. 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:

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

2. A designated health care practitioner, qualified by training and experience, to serve as the QM Director;

3. A committee which includes representatives from the Provider groups as well as clinical and non-clinical areas of the organization;

4. A senior executive who is responsible for program implementation;

5. Substantial involvement in QM activities by the Contractor's Medical Director;

6. QM activities must be distinctly separate from the Utilization Review activities and the distinction must be well defined;

7. The QM committee must meet regularly with specified frequency to oversee QM activities. This frequency will be sufficient to demonstrate that the committee is following up on all findings and required actions, but in no case are such meetings to be less frequent than quarterly;

8. Records that document the committee's activities, findings, recommendations, actions, and results; and

9. Accountability to the governing body of the organization to which it reports on activities, findings, recommendations, actions, and results on a scheduled basis.

L. 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.

M. Clinical Practice Guidelines

The Contractor shall develop and make available to Providers clinical practice guidelines consistent with national standards for disease and chronic illness management of Members. These clinical practice guidelines shall be based on reasonable scientific evidence, reasonable medical evidence, reviewed annually by Network Providers who can recommend adoption of clinical practice guidelines to the Contractor, and communicated to those whose performance will be measured against them. Clinical guidelines are provided by the Contractor to physicians and other Network Providers as appropriate. The Contractor reviews 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 the results of the study and a summary of any corrective actions taken to ensure compliance with the guidelines.

N. Utilization Review

The Contractor will provide for a system of utilization review consistent with the requirements of 42 C.F.R. Part 456 and in accordance with Miss. Code Ann. § 41-83-1 et seq. and other applicable sections (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:

1. Criteria and procedures for the evaluation of medical necessity of medical services for Members;

2. Criteria and procedures for pre-authorization and referral that include review, reconsideration, Appeal and Grievance mechanisms for Providers and Members;

3. Mechanisms to detect and document underutilization as well as over utilization of medical services;

4. Mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs;

5. Availability of utilization review criteria to Providers;

6. Involvement of actively practicing, board certified physicians in the program to supervise all review decisions and to review denials for medical appropriateness;

7. Availability of physician reviewer to discuss determinations by telephone with physicians who request such;

8. Evaluation of new medical technologies and new application of existing technologies and criteria for use by Network Providers;

9. Annual utilization review program review to determine effectiveness and need for changes;

10. Process for measuring Provider performance against at least two (2) of the clinical guidelines on an annual basis;

11. Process and procedure to address disparities in health care, which shall be in included in the Quality Improvement Work Plan;

12. A process for identifying clinical issues and analyzing the issues by appropriate clinicians and, when appropriate, developing corrective action taken to improve services;

13. Development of disease management programs that focus on diseases that are chronic or very high cost including but not limited to diabetes, asthma, hypertension, obesity, congestive heart disease, and organ transplants; and

14. A comprehensive health education program that will support the Care Management programs.

The Contractor shall annually evaluate its UM program and submit a copy of this evaluation to the Division annually. The UM program description will be submitted to the Division for written approval annually.

The Contractor shall provide utilization review criteria to Providers upon request.

O. Reporting Maternity Admissions for Delivery

Mississippi Medicaid covers maternity services including, but not limited to, delivery services, the care involved in the actual birth, and continued care for two (2) months following the birth of the newborn. Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, as required by the Division.

Medicaid policy exempts certain maternity admissions for delivery from the reporting requirement and providers are not required to submit reports for these situations. No report is required if the beneficiary has Medicare Part A and Part B coverage for the hospitalization time frame and the Medicare benefits are not exhausted. No review is required if the beneficiary's Medicaid eligibility is only for the Family Planning Waiver.

The Contractor shall develop, implement, and maintain a maternity admission for delivery reporting process.

The Contractor shall issue a written notification for issuance of a Prior Authorization Number to the requesting provider within two (2) business days from receipt of completed report.

P. Internal Audit and Report

The Contractor shall 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, Member utilization, access to covered services, and treatment outcomes. The Contractor shall submit a

report to the Division, detailing the annual review, completed activities and corrective actions, corrective actions which are recommended or in progress, and the results of all clinical, administrative and Member 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.

Q. Medical Audit

The Division may conduct 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 Members. 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 services.

R. EPSDT Audit

The Division will evaluate CMS 416 reports to determine compliance by the Contractor with the requirements of this Contract for provision of Division defined EPSDT Services to EPSDT eligible Members.

The Contractor must achieve the screening rates in Table 10 to comply with this Contract. The identified targets may be updated by the Division periodically.

Table 10. EPSDT Screening Rates

Measure	Screening Rate Targets
Screenings	Eighty-five percent (85%) of enrolled Members under age one (1) had required screenings; Seventy-five percent (75%) of enrolled Members between the ages of one (1) and twenty-one (21) had required screenings.
Immunizations	Eighty percent (80%) of enrolled EPSDT eligible Members required immunizations

The screening rate will be calculated using the reportable number for Line 7-Screening Ratio of the EPSDT 416 report. To calculate the screening rate, the Division shall divide the actual number of initial and periodic screening services received (line 6 of 416 report) by the expected number of initial and periodic screening services (line 5 of 416 report). This ratio indicates the extent to which EPSDT eligibles receive the number of initial and periodic screening services required by the State's periodicity schedule prorated by the portion of the year for which they are Medicaid eligible. For a child who has been enrolled from birth through twelve (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 Advisory Committee on Immunization Practices (ACIP) and

AAP Bright Futures immunization schedule.

The Contractor shall publish screening rates in required educational and Marketing presentations to potential Members.

The Contractor may be subject to Liquidated Damages or other available remedies if it does not achieve the targets specified in Table 10, in accordance with Section 16, Default and Termination, of this Contract.

S. Readiness Reviews

The Contractor shall comply with all requirements related to the assessment of the Contractor's performance prior to implementation, as required by the Request for Proposals. The Division will complete readiness reviews of the Contractor prior to implementation of MississippiCAN Program expansions and contract renewals at its discretion. This includes evaluation of all program components including information technology, administrative services, Provider Network management and medical management. The readiness reviews will include desk reviews of materials the Contractor must develop and onsite visits at the Contractor's administrative offices. The Division may also conduct onsite visits to any Subcontractor's offices.

1. Non-Emergency Transportation (NET) Services

   As part of the readiness review, the Contractor shall submit a final Quality Assurance Plan for NET services to the Division for its review and approval. The Quality Assurance Plan shall include at least the following:

   a. The Contractor's procedures for certification that all NET services paid for are properly authorized and actually rendered;

   b. The Contractor's plan to develop safeguards against Fraud or Abuse by NET Providers, Medical Providers, Members and Contractor staff and fulfill the Division's reporting requirements regarding such activity;

   c. The Contractor's agreement to indemnify the Division against any causes of actions or claims of payment brought by NET Providers or Members; and

   d. The Contractor's plan to ensure that NET Providers meet standards for vehicle maintenance, operation, and inspection; driver qualifications and training; Complaint resolution; and delivery of courteous, safe and timely NET services.

T. Medicaid Managed Care Quality Rating System

The Division reserves the right to develop and implement a Medicaid managed care quality rating system in accordance with 42 C.F.R. § 438.334. Upon development and

implementation of the quality rating system, the Division may issue an annual quality rating for each Contractor based on collected data and using the Medicaid managed care quality rating system adopted under this authority. The Division reserves the right to prominently display the quality rating given by the Division to the Contractor on its external website in a manner that complies with the standards in 42 C.F.R. § 438.10(d).

SECTION 11 – REPORTING REQUIREMENTS

The Division reserves the right to make operational reports, data, and information submitted by the Contractor public. The Division also reserves the right to perform audits, as appropriate, to verify and validate operational reports, data, and information submitted by the Contractor. See Exhibit H for a list of all reporting requirements included in this Contract. Additionally, the Division will provide the Contractor a Reporting Manual, which includes all reporting requirements and naming conventions for reports to be provided to the Division. The Division reserves the right to request additional information or reports, outside of those identified in the Reporting Manual, from the Contractor to assist in the determination of Contract compliance. Ad hoc reports requested by the Division, outside of those identified in the Reporting Manual, shall be named as instructed by the requestor.

A. Record System Requirements

The Contractor and any Subcontractor shall maintain detailed records evidencing all expenses incurred pursuant to this Contract; Member Enrollment status; provision of covered services; Complaints, Member grievance and appeal records in 42 C.F.R. § 438.416; base data in 42 C.F.R. § 438.5(c); MLR reports in 42 C.F.R. § 438.8(k); and all relevant medical information relating to individual Members, for the purpose of audit and evaluation by the Division and other Federal or State agencies. All records, including training records, pertaining to the Contract, including records of any Subcontractors and Subcontractors' contractors, shall be maintained and available for review by authorized Federal and State agencies, including, but not limited to, CMS, OIG, the Comptroller General, and their designees during the entire term of this Contract and for a period of ten (10) years thereafter, unless an audit, litigation, or other legal action is in progress. When an audit is in progress, audit findings are unresolved, or there is pending litigation that has not been completed, records shall be kept for a period of no less than ten (10) 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**.** If the Division, CMS, OIG or Comptroller General determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, OIG or the Comptroller General may inspect, evaluate, and audit any Subcontractor at any time.

All records, including training records, pertaining to the Contract must be readily retrievable within three (3) business days for review at the request of the Division and its authorized representatives at no cost to the Division or its authorized representatives.

Related to QM activities, the Contractor shall maintain and make available to the Division,

CMS, OIG, the State 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.

B. 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, and timetables for submission. The Division will also provide 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. The Division will provide the Contractor with written notice of such modifications. Modifications will be completed and effective within sixty (60) calendar days from the date on the written notice provided to the Contractor, unless otherwise approved by the Division.

The Contractor shall transmit and receive all transactions and code sets required by HIPAA regulations, as required by Section 17.A, HIPAA Compliance, of this Contract.

The Contractor shall submit to the Division copies of all reports submitted to the Mississippi Department of Insurance.

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 reports specified in Exhibit H, Reporting Requirements, of this Contract.

C. Enrollment Reports

The Contractor shall submit to the Division information about all new Enrollments, Disenrollments, reinstatements and circumstances affecting the Enrollment status of Members, as received by the Contractor, in a submission format approved by the Division. The Contractor shall review each Member 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 Member Listing Report is issued. Adjustments will be made to the next Member Listing Report to reflect corrections, and the Enrollment or Disenrollment of Members reported to 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.

D. Member Identification Card Reports

The Contractor shall submit a monthly report of returned identification cards. The report

must identify all returned cards, with the Member's Mississippi Medicaid identification number, first/last name, incorrect address, and correct address, if available.

E. Provider Services Reports

The Contractor shall submit a quarterly report providing information on general Provider services operations, including but not limited to Provider credentialing and recredentialing, Provider enrollment, Provider services call center, staff training, and Complaints, Grievances, and Appeals.

F. Pharmacy Lock-In Program

The Contractor shall submit a monthly report providing information on the Pharmacy Lock-In program in order to monitor services received and reduce unnecessary or inappropriate utilization.

G. EPSDT Reports

The Contractor shall comply with all requirements related to the submission of an EPSDT 416 report as required by the Federal government. The Contractor will have in place a periodic notification system that will facilitate compliance with the EPSDT periodicity schedule. This report must be submitted annually for the Division to comply with Federal requirements.

The Contractor shall submit quarterly reports with EPSDT 416 measures to the Division.

H. Medical Records

The Contractor shall ensure the maintenance of current, detailed, organized Medical Records by health care Providers for each Member sufficient to disclose the quality, quantity, appropriateness and timeliness of services performed pursuant to this Contract. As described in 42 C.F.R. Part 456, Subparts C and D, Medical Record content must include, at a minimum for hospitals and mental hospitals:

1. Identification of the Member;

2. Physician name;

3. Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care;

4. Initial and subsequent continued stay review dates;

5. Reasons and plan for continued stay if applicable;

6. Other supporting material the committee believes appropriate to include. For non-

mental hospitals only;

7. Date of operating room reservation; and

8. Justification of emergency admission if applicable.

Medical records shall be accessible and made available by Providers providing services to Members enrolled with the Contractor, and to the Division for purposes of Medical Record review. The Contractor shall follow applicable policies and procedures in accordance with Division Administrative Code.

I. Financial Reports

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.

The Contractor shall submit to the Division a copy of all quarterly and annual filings submitted to the Department of Insurance. 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 Department of Insurance 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.

Contractor must submit to the Division audited financial statements specific to this Contract on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. The Department of Insurance regulates the financial stability of all appropriately licensed Contractors in Mississippi. The Contractor agrees to comply with all DOI standards.

The Contractor shall file with the Division other financial reporting as required for the Capitation Payment development process.

J. Claims Denial Report

The Contractor shall submit to the Division on a monthly basis a listing of the denials processed during the previous month in all Contractor systems. This report should be submitted by the fifteenth (15th) calendar day of the following month. The report will be

prepared in accordance with the Division's format and include a breakdown of the denials by category to include, at a minimum, 1) prior-authorization, 2) claims completion errors, 3) duplicate claims, 4) services not covered or member is not eligible for services, 5) timely filing, and 6) any other denial categories utilized by Contractor.

The Contractor shall summarize the above denials, reported for the previous month, in a report as a percentage of total claims processed. A detailed explanation shall be provided for any percentage of denial in excess of two percent (2.0%) by individual denial category. Additionally, a detailed explanation shall be provided by the Contractor if the monthly aggregate denial rate exceeds six percent (6.0%). The Contractor may be placed on a Corrective Action Plan if a pattern of inappropriate denials or delays of provider payments is detected by the Division. The determination that a pattern of inappropriate denials or delays of provider payments exists is at the sole discretion of the Division. Failure to resolve the issues within the timeframe specified by the Division or as otherwise requested through the Corrective Action Plan may result in liquidated damages or other available remedies in accordance with Section 16, Default and Termination, of this Contract.

K. <u>Provider Statistical and Summary Report</u>

The Contractor shall follow all guidelines related to Provider Statistical and Summary Report (PS&R) production for each hospital, as requested on an ad hoc basis by hospitals and/or the Division. The Division will provide guidelines to the Contractor describing the reporting formats and Contractor report delivery deadlines. MississippiCAN PS&R's will be required separately for outpatient hospital and inpatient claims payment information. MississippiCAN PS&Rs should be validated for accuracy each time the report is modified and prior to distribution to hospitals and/or the Division.

L. <u>Hospice Reports</u>

The Contractor shall provide a monthly report addressing utilization of hospice services for monitoring purposes. This report should be submitted by the fifteenth (15th) calendar day of the second month following the reporting period. The report will be prepared in accordance with the Division's format and include, at a minimum, number of Members accessing hospice services, the length time spent in hospice, total Member discharges, Member discharge status, the total number of hospice prior authorization requests, and outcomes of hospice prior authorization requests.

M. <u>Third Party Liability Audit</u>

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

N. <u>Third Party Liability Reporting</u>

The Contractor shall provide a monthly report of Third Party Subrogation to the Division that

includes, at a minimum, the Member's name, Medicaid Identification Number, date of accident, lien amount and third party's name and contact information by the fifteenth (15th) of each month. Medicaid's third party unit will review the monthly report and inform the Contractor whether or not Medicaid has a claim for services relating to the date of accident. In such cases, the Contractor will work closely with the Division to coordinate efforts.

For cases identified by the Division as having a separate claim for medical services, the Division has the right to request the Contractor submit related information for the Division's review within three (3) business days of the request.

1. The Contractor shall submit monthly the following reports of Third Party Resources in the Division's required format: All newly identified TPL leads, which should include, at a minimum, the Member's name, Medicaid identification number, date of service, carrier name, carrier identification number, policy number and policy eligibility period. The TPL leads must be verified prior to submission to the Division;

2. A report showing the total amount of all claims that were denied (cost avoided) due to the existence of having a TPL on file; and

3. A report showing the total amount of all monies recovered from other insurance companies after Contractor had initially paid the claim as primary.

Additionally, the Contractor shall submit an annual report reconciling recovery amounts.

O. <u>Contractor Member Complaints, Grievances, and Appeal Reporting</u>

The Contractor shall maintain a health information system to track the receipt and resolution of verbal, in-person, and written Complaints, Grievances, and Appeals. The Contractor shall submit to the Division monthly and by the fifteenth (15th) business day after the close of the quarter, a mutually agreed upon summary report of all Provider and Member Complaints, Grievances, and Appeals as illustrated in this Contract. The system and the tracking logs shall be made accessible to the Division for review.

The Contractor shall also submit to the Division monthly and by the fifteenth (15th) business day after the close of the quarter a detailed log of all Member Complaints, Grievances and Appeals and all Provider Complaints, Grievances and Appeals made on behalf of a Member under this Contract.

1. Grievance and Complaint categories identified shall be organized or grouped by the following general guidelines:

    a. Transportation;

    b. Access to Services/Providers;

    c. Provider Care and Treatment;

d. Contractor Customer Service;

e. Payment and Reimbursement Issues; and

f. Administrative Issues.

2. Appeal categories identified shall be organized or grouped by the following general guidelines:

   a. Transportation;

   b. Contractor Administrative Issues; and

   c. Benefit Denial or Limitation.

3. The log shall contain the following information for each Complaint, Grievance, or Appeal:

   a. The date of the communication;

   b. The Member's Mississippi Medicaid identification number;

   c. Whether the Complaint, Grievance or Appeal was written or verbal;

   d. Indication of whether the dissatisfaction was a Complaint, Grievance or an Appeal;

   e. The category, specified in subsection 1, of each inquiry;

   f. A description of subcategories or specific reason codes for each Complaint, Grievance and Appeal;

   g. The resolution (detailed information about how the Complaint, Grievance or Appeal was resolved); and

   h. The resolution date.

The Contractor shall submit to the Division within thirty (30) calendar days of filing a copy of any report regarding specific Complaints, Grievances, or Appeals or its system for tracking Complaints, Grievances, and Appeals required to be filed with the Mississippi Department of Insurance.

P. <u>Confidentiality of Records</u>

The Contractor shall treat all information, including that relating to Members 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.

All information as to personal facts and circumstances concerning Members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the Division and the written consent of the Member, his/her attorney, or his/her responsible parent or guardian, except as may be required by the Division. The use or disclosure of information concerning Members shall be limited to purposes directly connected with the administration of the Contract. All of the Contractor officers and employees performing any work for or on the Contract shall be instructed in writing of this confidentiality requirement and required to sign such a document upon employment and annually thereafter.

The Contractor shall immediately notify the Division of any unauthorized possession, use, knowledge or attempt thereof, of the Division's data files or other confidential information. The Contractor shall immediately furnish the Division full details of the attempted unauthorized possession, use or knowledge, and assist in investigating or preventing the recurrence thereof.

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 Division's Agent, shall have access to all confidential information in accordance with the requirements of this Contract and State and Federal law and regulations pertaining to such access. 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 C.F.R., Part 431, Subpart F and 45 C.F.R. Parts 160 and 164, Subparts A and E to the extent these requirements are applicable to the obligations under this Contract.

Q. Access to Records

Pursuant to the requirements of Title XIX, Section 1902(a)(27) of the Social Security Act, 42 C.F.R. § 434.6(a)(5) and 42 C.F.R. § 438.3(h), Section 1128A [42 U.S.C. 1320a-7a] and Miss. Code Ann. § 43-13-118,121,229 (1972, as amended), the Contractor and each of its Providers and Subcontractors 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 Division's Agent. Access will be at the discretion of the requesting authority and will be either through onsite review of records or by submission of records to the office of the requester. Any records requested hereunder shall be produced immediately for onsite 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 C.F.R. § 74.48, the Contract awarded to the Contractor and their Subcontractors 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 Contractor which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of Contractor that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained.

There will be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. Under the False Claims Act at 31 U.S.C. § 3731(b)(2), claims may be brought up to 10 years after the date on which a violation is committed. The right to audit exists for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later (42 C.F.R. § 438.3(h)).

Any person (including an organization, agency or other entity, but excluding a Member) that fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations or other statutory functions of the Inspector General of the Department of Health and Human Services, the Division, or any other duly authorized representative, shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of $15,000 for each day of the failure to make accessible all books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases (collectively referred to as records). In addition, the Division may make a determination to terminate the Contract.

R. 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, claims, Grievances and Appeals, and Disenrollment for other than loss of Medicaid eligibility. The Contractor must collect data on Member 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.

It is a Division requirement that the Contractor send all clinical data, as aggregated by the Contractor in the management of the Division's beneficiaries, to the Division in a Meaningful Use Stage 2 Consolidated Clinical Document Architecture (C-CDA in XML) on a regular basis (regular basis shall be further defined by the Division, however, it should be assumed that regular basis will be at a minimum of once per day).

This clinical data could be in a variety of formats within the Contractor, including the HL7 format, the CCD or C-CDA format, or various other formats (such as input into systems by the providers or for the Contractor Disease Management Programs and systems). Therefore, it is a Division requirement for the Contractor to aggregate all of the clinical data on a Division beneficiary into a Meaningful Use Stage 2 C-CDA (XML) for regular transmission to the Division.

The clinical data that is aggregated by the Contractor in the management of the Division's beneficiaries should include the following information specific to the Medicaid beneficiary:

1. Patient Identification Data;
2. Patient Demographic Data;
3. Smoking Status;
4. Encounter Data;
5. Medications;
6. Diagnosis;
7. Procedures;
8. Immunizations;
9. Allergy;
10. Plan of Care Data;
11. Gaps in Care Data;
12. Laboratory Orders and Results;
13. Radiology Orders and Reports;

14. Pathology Orders and Reports;

15. Transcription Data;

16. Vital Signs;

17. Problems; and

18. Data from Disease Management Programs, including Diabetes, Organ Transplants, Congestive Heart Disease, Obesity, Asthma, and Hypertension.

The Contractor shall comply with Section 6504(a) of the PPACA, which requires that the State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act.

The Contractor shall ensure that all data received form providers is accurate and complete by verifying the accuracy and timeliness of reported data, including from network providers the Contractor is compensating on the basis of capitation payments; screening the data for completeness, logic, and consistency; and collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

The Contractor shall work with the Systems Work Group to define a mutual statement of work and schedule to implement software and hardware routing solutions required for the successful delivery of all available clinical data (including, but not limited to: Laboratory reports, Radiology reports, Admission/Discharge/Transfer data, Consolidated-Clinical Data Architecture, and Pathology reports) from the Contractor's Electronic Health Record system of record to the Division in either HL7 version (s) 2.3.1 or 2.5.1 or in Consolidated-Clinical Document Architecture (C-CDA) format.

The Contractor shall make all data collected in accordance with 42 C.F.R. § 438.242 available to the Division and upon request CMS. The Contractor shall provide to the Division all clinical data that is captured by providers and transmitted to the Contractor. Clinical data, includes but is not limited to diagnoses, procedures, medications, immunizations, allergies, smoking status, BMI, vitals, visit notes, radiology orders, tests ordered and results received for general labs and pathology labs. Clinical data shall be provided to the Division using the clinical data exchange standards of C-CDA and/or HL7 2.5. Transmission of clinical data shall occur through either direct transmission to the Division Interoperability platform or through the statewide Health Information Exchange (HIE) known as Mississippi Health Information Network (MS-HIN).

To facilitate sharing of clinical data, Contractor shall participate in MS-HIN and become a member of the organization at no additional cost to the Division. This participation shall include sharing clinical data with the HIE to support the goal of sharing clinical data with providers throughout the state as necessary to improve the quality, timeliness and cost of

care.

The Contractor shall ensure that the health information system possesses the collection and analytic capacity to execute a Population Health Management program to:

1. Support Providers in the optimal delivery of care;

2. Guide and support Members in managing their health needs and risks;

3. Support the Division in its goals to modernize and execute data analytic strategies;

4. Improve health outcomes; and

5. Reduce the total cost of care for MississippiCAN Members.

The Population Health Management program will address, at minimum, the elements identified in this subsection. The Division must review and approve the Population Health Management program, including policies and procedures, prior to implementation by the Contractor, and semi-annually thereafter.

1. Data Analytics

   The Division will support the Contractor in achieving program goals by providing a common data platform. The use of a common data platform will allow Providers to access all Member health information and analytics via a single sign-on process. The Contractor may choose to leverage their own technologies to support Member data analysis. However, the Contractor will be financially responsible for ensuring that such technology may be accessed through the Division's single sign-on process.

2. Reducing Health Disparities

   The Contractor will develop and implement strategies to address disparities in health outcomes and access to care based on factors such as geographic location, race, ethnicity, income level, age, gender, language barriers and physical disabilities. While each Contractor will provide coverage across the state, strategies implemented here must reflect significant regional variation in these factors.

   The Contractor will also develop protocols for providing population health management services in alternative and community-based settings, which may include providing services in:

   a. Homeless shelters, group homes, or other residential placements;

   b. Public or non-profit community organization facilities; and

c. The Member's home, school, or place of employment, as applicable and allowed by State law.

3. Community Partnerships

The Contractor will seek out and enter into agreements with community-based entities to address social determinants of health in each region of the state. Such agreements will be designed to support the implementation of coordinated, culturally competent care strategies and will include, but are not limited to, protocols for:

a. Data sharing and data protection;

b. Implementing health promotion and disease prevention initiatives;

c. Coordinating services delivery with the Member's Health Home;

d. Tracking Member outcomes and measuring success.

4. Health Education & Promotion

The Contractor will employ creative and innovative educational programs that are designed to raise Member awareness, enhance Member participation in self-care, and promote ongoing engagement. Programs must focus on helping Members identify and understand common risk factors and evidence-based strategies that they can employ to reduce their own health risk. Such programs may include those designed by the Contractor as well as coordinated referral to programs operated by local public health or community-based organizations. Program design must consider the appropriate use of multiple information sources, which may include social media and other web-based initiatives, as well as telephonic and paper-based resources and in-person events.

5. Health Education & Promotion

To effectively address the specific health needs of enrolled Members, the Contractor must employ a comprehensive risk assessment and stratification methodology. The Contractor will conduct a health risk assessment at the time of enrollment and update at regular intervals thereafter based on the Member's initial risk level. The risk assessment must include both qualitative data reported by the Member and available quantitative data to support appropriate stratification. The risk assessment must consider socioeconomic and environmental risk factors that may impact the Member's health outcomes, as well as the Member's health behaviors and readiness to change.

Based on the health risk assessment, the Contractor will stratify their members according to their identified risk level. A minimum of four risk levels should be employed: low, moderate, rising, and high risk. The Contractor will design and

execute risk management strategies that are tailored to Member needs at each risk level and communicate such strategies with network Providers. Regardless of risk level, Contractor will provide all members with resources aimed to maintain their health, improve health care decision-making skills, and increase adoption of healthy behaviors.

6. Care Management

The Contractor will provide Care Management using a set of Member-centered, goal-oriented, culturally relevant and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. The Contractor will develop and implement a Care Management system to ensure and promote:

a. Ongoing, culturally relevant support for Members to achieve personal health goals;

b. Timely access to and delivery of health care and services required by Members;

c. Continuity of Members' care;

d. Coordination and integration of Members' care in accordance with 42 C.F.R. § 438.208, including physical and behavioral health/substance use disorder services; and

e. Coordination with appropriate resources to reduce socioeconomic disparities, including housing, employment, and nutrition programs.

All Members will have access to Care Management at levels of intensity appropriate to their identified risk, which will include services and supports to promote evidence-based health education and disease prevention, continuity of care, transition of care and discharge planning. Care Management programs must meet applicable National Committee for Quality Assurance (NCQA) and/or URAC accreditation standards. The Contractor shall implement transition of care policies in accordance with 42 C.F.R. § 438.62.

The Contractor will participate as a partner with Providers and Members in arranging for the delivery of healthcare services that improve health status in a cost-effective way. The Division expects the Contractor to connect all Members to a Health Home. Care management strategies employed by the Contractor should support this model of care.

7. Targeted Interventions

The Contractor will offer evidence-based interventions to address subpopulations

experiencing unique health risks. Subpopulations may include Members with disabilities, specific chronic conditions or comorbidities, those with specific environmental risk factors or those with a history of high or inappropriate service utilization.

The Contractor shall coordinate with the Mississippi Department of Health (MSDH) for high-risk pregnant women who may be eligible for MSDH's Perinatal High Risk Management/Infant Services System (PHRM/ISS) Program. The Contractor will work with MSDH to identify Members who meet the Program criteria. MSDH will provide Case Management services to those Members, and the Contractor will coordinate with MSDH to confirm the Case Management will support all of the Members health care needs.

8. Reporting

The Contractor must report to the Division and network Primary Care Providers, at intervals designated by the Division, on the efficacy of its Population Health Management program. The report will be designed collaboratively by the Division and the Contractor and will include, but is not limited to, measures to identify changes in:

a. Health disparities among subpopulations;

b. Targeted health outcomes;

c. Member participation in health promotion and disease prevention initiatives;

d. Percent of members in each risk stratification level; and

e. Member utilization of inpatient and emergency department services.

S. Member Encounter Data

In accordance with C.F.R. § 438.818, the Contractor must submit complete, accurate and timely Member Encounter Data to the Division that meets Federal requirements and allows the Division to monitor the program at least monthly following the month in which the claims were adjudicated (paid, amended or denied status). Member Encounter Data consists of a separate record each time a Member has an Encounter with a health care Provider including Member Encounter Records reflecting a zero dollar ($0) amount as well as Member Encounter Records where the Contractor has a capitation arrangement with the provider. For any services which the Contractor has entered into capitation reimbursement arrangement with providers, the Contractor shall comply with all Member Encounter Data submission requirements in this section. The Contractor shall require timely submissions from its providers as a condition of the capitation payment. A service rendered under this Agreement is considered an Encounter regardless of whether or not it has an associated Claim. The Contractor shall only submit Member Encounter Data for Members enrolled with

the Contractor on date of service and not submit any duplicate records. Adjustments necessitated by administrative payments or recoupments, program integrity recoupments, lump sum payments and payment errors, processed during that payment cycle are not considered duplicate records.

All Member Encounter Data must be submitted to the Division's Agent by the Contractor. The Division will not accept any Member Encounter Data submissions or correspondence directly from any Subcontractors, and the Division will not forward any electronic media reports or correspondence directly to a Subcontractor. The Contractor will be required to receive all electronic files and hardcopy material from the Division, or its Agent, and distribute them within its organization or to its the 30 Subcontractors as needed.

The Contractor must maintain appropriate systems and mechanisms to obtain all necessary data from its Providers or Subcontractors to ensure its ability to comply with the Member Encounter Data reporting requirements. The failure of a Provider or Subcontractor to provide the Contractor with necessary Member Encounter Data shall not excuse the Contractor's non-compliance with this requirement. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance.

1. Data Format

   The Contractor must provide Member Encounter Data in the format required by the Division, necessary for capitation rate development, program oversight, and reporting requirements, including inpatient claims and encounter payment simulations. The Contractor must submit Member Encounter Data to the Division's Agent using established protocols. The Contractor shall be able to receive, maintain and utilize data extracts from the Division and its contractors, e.g., pharmacy data from the Division or its PBM.

   The Contractor must comply with state and federal requirements, including the Division's Encounter Companion Guide for Professional, Institutional, Dental, and Pharmacy encounter claims guide posted on the Division's managed care website. The Division may change the Member Encounter Data Transaction requirements in the system companion guide. The Contractor shall be given a minimum of sixty (60) calendar days' written notice of any new edits or changes that the Division intends to implement regarding Member Encounter Data. The Contractor shall, upon notice from the Division, communicate these same changes to Subcontractors.

   The Contractor shall provide Member Encounter Data files electronically to the Division. The Contractor's system shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but not limited to the following:

   a. ASC X12N 837P Professional Claim/Encounter Transaction;

b. ASC X12N 837I Institutional Claim/Encounter Transaction:

c. ASC X12N 837D Dental Claim/Encounter Transaction;

d. ASC X12N 834 Benefit Enrollment and Maintenance;

e. ASC X12N 835 Claims Payment Remittance Advice Transaction;

f. ASC X12N 277 Claims Status Response; and

g. NCPDP Version D.0 Pharmacy.

2. Provider Claims

The Contractor shall encourage Providers to submit claims as soon as possible after the dates of service. Providers shall have one-hundred eighty (180) calendar days to submit claims from the date of service. For the purpose of timely filing, the "Through" date shall be used for determining claims filing. Claims filed within the appropriate time frame but denied may be resubmitted for reconsideration to the Contractor within ninety (90) calendar days from the date of denial. The Contractor will be responsible for processing claims in accordance with 42 C.F.R. § 447.46, as specified in Section 18, Claims Management, of this Contract.

The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

3. Member Encounter Data Provision, Submissions, and Processing Requirements

The Contractor shall submit Member Encounter Data that meets established Division data quality standards. These standards are defined by the Division to ensure receipt of complete and accurate data for program administration and will be closely monitored and strictly enforced. The Division will revise and amend these standards as necessary to ensure continuous quality improvement. The Contractor shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with the Division's data quality standards as originally defined or subsequently amended. The Contractor shall comply with industry-accepted Clean Claim standards for all Member Encounter Data, including submission of complete and accurate data for all fields required on standard billing forms, or electronic claim formats to support proper adjudication of a claim. The Contractor shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail in order to support comprehensive financial reporting and utilization analysis.

The level of detail associated with encounters from providers with whom the Contractor has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the Contractor received and settled a fee-for-

service claim. The Contractor must collect and maintain sufficient Member Encounter Data to identify the provider who delivers any item(s) or service(s) to Members. The Provider's National Provider Identifier (NPI) shall be used when submitting required Member Encounter Data. Member Encounter Data elements must include all of the data the Division is required to report to CMS under 42 C.F.R. § 438.818 including but not limited to:

a. Accurate enrollee and provider identifying information;

b. Date of service;

c. Procedure and diagnosis codes;

d. Allowed amount and Paid amount;

e. Third party liability amounts;

f. Claim received date;

g. Claim adjudication date; and

h. Claim payment dates.

The Contractor must submit complete and accurate Member Encounter Data processed by the Contractor and any Subcontractor no later than the 60th calendar day after the date of adjudication and that includes all Member Encounter Data, Member Encounter Data adjustments, encounters reflecting a zero-dollar amount ($0.00), encounters reflecting claim voids, encounter claims reflecting denied claims and encounters in which the Contractor has a capitation arrangement with a provider. The files shall contain settled claims and claim adjustments, including but not limited to adjustments necessitated by administrative payments or recoupments, program integrity recoupments, lump sum payments and payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the Contractor has a capitation arrangement. Submissions shall be comprised of encounter records or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claim records of all contracted services rendered to the Member in the current or preceding months.

Within two (2) business days of the end of a payment cycle the Contractor shall generate Member Encounter Data files for that payment cycle from its claims management system(s) and/or other sources. If the Contractor has more than one (1) payment cycle within the same calendar week, the Member Encounter Data files may be merged and submitted within two (2) business days of the end of the last payment cycle during the calendar week. The Contractor shall submit the Encounter Data to the Division no less frequently than on a weekly basis.

The Contractor shall submit Member Encounter Data according to standards and formats as defined by the Division, including those referenced in the companion Guide(s), complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. All Member Encounter Data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing. Any batch submission which contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the Contractor for immediate correction. When the Division or its Agent rejects a file of encounter claims, the resubmittals of rejected files must be resubmitted with all of the required data elements in the correct format by the Contractor within fourteen (14) calendar days from the date the Contractor received the rejected file. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

The Contractor shall be able to receive, maintain, and utilize data extracts from the Division and its Contractors. The Contractor shall correct and resubmit rejected Encounter Records as an adjustment within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Division's Agent.

Member Encounter Records that deny or suspend due to Division's Agent's edits are returned to the Contractor and the Contractor must make the requested corrections. The Contractor shall resubmit denied Encounter Records as a "new" Encounter Record if appropriate and within the time frame referenced above.

The Contractor must make an adjustment to encounter claims when the Contractor discovers the data is incorrect, no longer valid, or some element of the claim not identified as part of the original claim needs to be changed. If the Division or its Agent discovers errors or a conflict with a previously adjudicated encounter claim the Contractor shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by the Division. The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance with these requirements.

Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the Contractor's applicable reimbursement methodology for that service.

The Contractor shall correct and resubmit rejected Encounter Records as an adjustment within the time frame referenced above. Corrections and resubmissions must pass all edits before they are accepted by the Division's Agent.

The Contractor shall ensure that the payment information on the Subcontractors'

Member Encounter Data reflect the date and the amount paid to the provider by the Subcontractor.

Failure of Subcontractors to submit Member Encounter Data timely shall not excuse the Contractor of noncompliance with this requirement, and the Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for non-compliance.

4. Encounter File Specifications

The Contractor must adhere to the file size and format specifications provided by the Division. The Contractor must also adhere to the Encounter file submission schedule provided by the Division.

5. Data Completeness

The Contractor shall submit records each time a Member has an Encounter with a health care Provider. The Contractor must have a data completeness monitoring program in place that:

a. Demonstrates that all Claims and Encounters submitted to the Contractor by Providers and Subcontractors are submitted accurately and timely as Encounters to the Division's Agent. In addition, demonstrates that denied Encounters are resolved and/or resubmitted;

b. Evaluates Provider and Subcontractor compliance with contractual reporting requirements; and

c. Demonstrates the Contractor has processes in place to act on the information from the monitoring program and takes appropriate action to ensure full compliance with Member Encounter Data reporting to the Division.

The Contractor must submit an annual Data Completeness Plan for review and approval. This Data Completeness Plan must include the three (3) elements listed above. The Contractor must report findings from its annual Data Completeness internal audits on at least an annual basis, or at the request of the Division.

6. Accuracy of Data

The Contractor will assist the Division in reconciliation of Cash disbursement check amount totals to Contractor Paid Amount totals for submitted claims. The Contractor shall submit at least ninety-eight percent (98%) of all Member Encounter Data in a valid format, which will be deemed valid by the Division, including those of Subcontractors or delegated vendors as provided for in this Section, both for the original and any adjustment or void. The Division or its Agent will validate Member

Encounter Data submissions according to the Cash Disbursement Journal of the Contractor and any of its applicable Subcontractors. If the Contractor fails to submit complete Member Encounter Data, as measured by a comparison of encounters to cash disbursements, Contractor may be subject to liquidated damages or other available remedies as outlined in Section 16, Default and Termination, of this Contract.

Ninety-eight percent (98%) of the records in the Contractor's encounter batch submission must pass X12 EDI compliance edits and the Mississippi Medicaid MMIS threshold and repairable compliance edits. The X12 EDI compliance edits are established through Strategic National Implementation Process (SNIP) levels one (1) through four (4). MMIS threshold and repairable edits that report exceptions are set forth in the Companion Guide.

7. Data Validation

Member Encounter Data quality will be validated by chart review of a sample of enrollees against monthly Member Encounter Data reported by the Contractor. The Contractor agrees to assist the Division in its validation of Member Encounter Data by making available Medical Records and claims data as requested. The validation may be completed by the Division staff and/or independent, external review organizations.

In addition, the Contractor will validate files sent to them when requested.

8. Secondary Release of Member Encounter Data

All Member Encounter Data recorded to document services rendered to Members under this Agreement are the property of the Division. Access to this data is provided to the Contractor and its agents for the sole purpose of operating the MississippiCAN Program under this Agreement. The Contractor and its agents are prohibited from releasing any data resulting from this Agreement to any third party without the advance written approval of the Division.

The Division will impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract for any Member Encounter Data not received monthly or in cases that the data does not meet the Division's requirements.

T. Drug Utilization Data

The Contractor shall report drug (i.e., j-code) utilization data to the Division's Agent as authorized by the Omnibus Budget Reconciliation Act of 1990, Section 1927 of the Social Security Act, and as required by CMS per 42 C.F.R. § 438.5(c), for the purposes of accurate, timely collection of quarterly drug rebates. The Contractor must include national drug code

(NDCs) numbers and corresponding quantities (i.e., HCPCS codes and units for Physician-Administered Drugs and Implantable Drug System Devices) in a format to be specified by the Division. The Contractor shall submit to the Division the drug utilization data necessary for the collection of drug rebates in formats to be specified by the Division weekly. The Contractor must resolve any disputes related to the data within thirty (30) calendar days from notification by the Division.

U. Data Certifications

All data, reports, documents, records, Member 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, to the accuracy, completeness and truthfulness of the data and to the accuracy completeness and truthfulness of the documents. The Contractor must submit the certification in writing with the signature of the appropriate certifier, at the time the certified data, documents, reports, records, Member Encounter Data, or other information is submitted to the Division.

V. Fraud and Abuse Reporting

The Contractor shall report Member or Provider Fraud or Abuse which it had reasonable cause to suspect, or should have had reasonable cause to suspect, immediately to the Division, and shall cooperate with the Division regarding the investigation. Failure to do so could result in criminal and/or civil penalties. The Contractor must report Member or Provider Fraud or Abuse in a format, to be specified by the Division. The Contractor must use the most current version of the Division's Standard Operating Procedure for MississippiCAN Fraud and Abuse for Referrals and Reporting to the Division of Medicaid, Office of Program Integrity (PI). The Office of Program Integrity will oversee all Fraud, Waste and Abuse activities conducted by the Contractor as outlined in 42 C.F.R. § 438.608 and Part 455.

All retrospective and prepayment reviews must be pre-approved by the Mississippi Division of Medicaid, Office of Program Integrity. The Contractor must submit a request to retrospectively audit or place providers on prepayment review by submitting weekly reports to the Office of Program Integrity. If Division approves the investigation, the Contractor will be responsible for collecting the Overpayment for any provider audited. If it is determined that the Division, Office of Program Integrity will conduct the investigation, the Division will be responsible for collecting the Overpayments of providers audited. The Contractor will be required to report to the Office of Program Integrity twice a year all Overpayments recovered from providers. This information, along with Office of Program Integrity Overpayments, will be reported to the entity that is responsible for the rate setting.

The Contractor must implement and maintain procedures that are designed to detect and prevent fraud, waste and abuse. The procedures must include the following:

1. Provision for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud to the State.

2. Provision for prompt notification to the State when it receives information about changes in a Member's circumstances that may affect the Member's eligibility including all of the following:

    a. Changes in the Member's residence;

    b. The death of a Member.

3. Provision for notification to the State when it receives information about a change in a Network Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

4. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Network Providers were received by Members and the application of such verification processes on a regular basis.

5. In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

6. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the State Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

7. Provision for the Contractor's suspension of payments to a Network Provider for which the State determines there is a credible allegation of fraud in accordance with § 455.23.

W. <u>Internal Contractor Reporting</u>

The Contractor is responsible for reporting all suspected or confirmed instances of internal Fraud and Abuse relating to the provision of and payment for Medicaid services including, but not limited to Fraud and Abuse acts related to the Contract and/or the Division of Medicaid that is other than provider and enrollee Fraud and Abuse (e.g. internal to the health plan–employees/management, Subcontractors, vendors, delegated entities). This report shall include at a minimum:

1. The date reported ("Date reported" is the date the report was submitted to the Office of Coordinated Care);

2. The name of the Contractor reporting;

3. The name of the individual or entity;

4. The entity's tax identification number;

5. A description of the acts allegedly involving suspected Fraud or Abuse:

    a. Source of Complaint/detection tool utilized;

    b. Nature of Complaint;

    c. If applicable, case closed due to:

        i. Corrective action completed by provider;

        ii. Provider voluntarily left network;

        iii. Provider involuntarily terminated by Contractor;

        iv. Other (specify);

6. Potential exposure/loss identified;

7. If known, actual exposure/loss identified; and

8. If applicable, exposure/loss collected or recouped from individual or entity by the Contractor.

In accordance with the PPACA and the Mississippi Administrative Code Section 23, Part 301, the Contractor shall report Overpayments made by the Division of Medicaid to the Contractor as well as Overpayments made by the Contractor to a provider.

X. Subcontractor Disclosures

The Contractor must disclose all information in accordance with 42 C.F.R. § 455.104(b) regarding Subcontractors. The Contractor is responsible for obtaining all disclosure information from all Subcontractors, managing employees, and agent's employees, and submitting to the Division.

The Contractor must disclose all information from their Subcontractors as related to persons convicted of crimes in accordance with 42 C.F.R. § 455.106.

Y. Deliverables

The Contractor must obtain Division's prior written approval of all Deliverables prior to the operational date of the Initial Term and throughout the duration of the Contract unless otherwise specified by the Division. Deliverables include, but are not limited to operational policies and procedures, required materials, letters of agreement, Provider Agreements, Provider reimbursement methodology, reports, tracking systems, required files, and quality management program documents. Failure by the Division to respond to approval requests shall not be interpreted as approval of Deliverables.

The Contractor must meet the Division's required time frames for the submission of Deliverables in the event that requested Deliverables do not have a submission time frame specified in the Contract. The Division will specify the time frame for submission of Deliverables.

The Division may impose liquidated damages or other available remedies under Section 16, Default and Termination, of this Contract if the Contractor fails to submit Deliverables for approval based on the requirements set forth in this Contract.

Z. Small and Minority Business Reporting

The Division encourages the employment of small business and minority business enterprises. Therefore, the Contractor shall report, separately, the involvement in this Contract of small businesses and businesses owned by minorities and women. Such information shall be reported on an invoice annually on the Contract anniversary and shall specify the actual dollars contracted to-date with such businesses, actual dollars expended to date with such businesses, and the total dollars planned to be contracted for with such businesses on this contract.

SECTION 12 – PROGRAM INTEGRITY

A. General Requirements

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. The Contractor shall annually review and submit an updated Fraud and Abuse compliance plan to the Division for approval. The Contractor shall comply with all federal and state requirements regarding Fraud, waste, and Abuse including but not limited to 42 C.F.R. § 455, Section 1902 (a)(68) of the Social Security Act and 42 C.F.R. § 438.608.

The Contractor shall complete a minimum of three (3) Division acceptable provider-site audits per Contract year. The Division, at its sole discretion, may waive the minimum requirement. Additional provider on-site audits may be conducted by mutual agreement of

the Division and the Contractor.

At least one full-time investigator designated for the state of MS and a staff person responsible for all fraud and abuse detection activities, including the fraud and abuse compliance plan, as set forth in Section 11 of this Contract. The investigator will have full knowledge of provider investigations related to the MississippiCAN program and will be the key staff handling day-to-day provider investigation related inquiries from the Division, Office of Program Integrity.

The Mississippi Code of 1972, Title 43 Chapter 13 as amended, describes the penalties related to fraud in the Medical Assistance Program. Suspected Fraud/Abuse regarding a provider or Member should be addressed to the Division of Medicaid Office of Program Integrity. The Division of Medicaid Office of Program Integrity should be notified in writing within thirty (30) days of the discovery of any Overpayments made by Medicaid caused by billing errors, system errors, human error, etc.

The Division of Medicaid shall conduct investigations related to suspected provider Fraud, Waste, and Abuse cases and reserves the right to pursue and retain recoveries for any and all types of claims which the Contractor does not have an active investigation.

1. The Contractor shall be subject to onsite reviews; and comply with requests from the Division of Medicaid to supply documentation and records;

2. The Contractor shall not knowingly be owned by, hire or contract with an individual who has been debarred, suspended, or otherwise excluded from participating in federal procurement activities or has an employment, consulting, or other Agreement with a debarred individual for the provision of items and services that are related to the entity's contractual obligation with the State, in accordance with 42 C.F.R. § 438.610.

3. The Contractor and the Office of Program Integrity shall meet quarterly or more frequently as needed, to discuss areas of interest for past, current, and future investigations and to improve the effectiveness of Fraud, waste, and Abuse oversight activities.

4. The Division of Medicaid shall establish Performance Measures to monitor the Contractor's compliance with the Program Integrity requirements set forth in this Agreement.

The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:

1. The improperly paid funds have already been recovered by the State of Mississippi, either by the Mississippi Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act

cases; or

2. The improperly paid funds have already been recovered by the State's RAC; or

3. When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Mississippi, are the subject of pending Federal or State litigation or investigation, or are being audited by the Mississippi RAC.

This prohibition as described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. The Contractor shall confer with the Division of Medicaid, Office of Program Integrity before initiating any recoupment or withhold of any program integrity related funds to ensure that the recovery recoupment or withhold is permissible. In the event that the Contractor obtains funds in cases where recovery recoupment or withhold is prohibited under this section, the Contractor will return the funds to the Division of Medicaid.

In accordance with 42 C.F.R. § 438.604, the Contractor must submit to the State the following data:

1. Member Encounter Data in the form and manner described in § 438.818.

2. Data on the basis of which the State certifies the actuarial soundness of capitation rates to the Contractor under § 438.3, including base data described in § 438.5 (c) the is generated by the Contractor.

3. Data on the basis of which the State determines the compliance of the Contractor with the medical loss ratio requirement described in§ 438.8.

4. Data on the basis of which the State determines that the Contractor has made adequate provision against the risk of insolvency as required under § 438.116.

5. Documentation described in § 438.207(b) on which the State bases its certification that the Contractor has complied with the State's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in § 438.206.

6. Information on ownership and control described in § 455.104 of this chapter from the Contractor and Subcontractors as governed by § 438.230.

7. The annual report of overpayment recoveries as required in § 438.608(d)(3).

8. In addition to the data, documentation, or information listed above, the Contractor must submit any other data, documentation, or information relating to the performance of the entity's obligations under this part required by the State or the Secretary.

The data submitted will be posted to the State's website as required by § 438.10(c)(3). The data, documentation, or information submitted must be certified by either the Contractor's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification provided must attest that, based on best information, knowledge, and belief, the data, documentation, and information is accurate, complete and truthful and be submitted concurrently with the submission of the data, documentation, or information.

B. Fraud and Abuse Compliance Plan

The Contractor must submit its compliance plan, including Fraud and Abuse policies and procedures to the Office of Program Integrity for written approval within thirty (30) days before those plans and procedures are implemented. Failure to implement an approved plan within sixty (60) days may result in liquidated damages or imposition of other available remedies by the Division. The Office of Program Integrity may reassess the implementation of the Fraud and Abuse compliance plan every sixty (60) days until Program Integrity deems the plan to be in compliance.

In accordance with 42 C.F.R. § 438.608, the Fraud and Abuse compliance plan shall comply with the Division's policies and procedures for Fraud and Abuse and must include at a minimum all of the following elements:

1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.

2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.

3. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.

4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the Contract.

5. Effective lines of communication between the compliance officer and the organization's employees.

6. Enforcement of standards through well-publicized disciplinary guidelines.

7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.

8. Assistance to the Division in any investigation or prosecution of Fraud by providing the following:

    a. Access to and free copies of computerized data stored by the Contractor;

    b. Direct computer access to computerized data stored by the Contractor that is supplied without charge and in the form requested by the Division; and

    c. Access to any information possessed or maintained by any Provider of service(s) under the Medicaid State Plan to which the Division and the Contractor are authorized to access.

If the Contractor identifies that a Member or Provider is committing Fraud and Abuse, the Contractor may disenroll the Provider and request to the Division that the Member be disenrolled. However, the Contractor shall not indicate to the Provider or Member that they will be disenrolled from Medicaid.

The Division, designated parties and the Contractor shall meet quarterly to collaborate on Complaints of Fraud and Abuse.

SECTION 13 – FINANCIAL REQUIREMENTS

A. <u>Capitation Payments</u>

1. Monthly Payments

    On or before the tenth (10th) business day of each month during the term of this Contract, the Division shall remit to the Contractor the capitation fee specified for each Member listed on the Member Listing Report issued for that month. Payment is contingent upon satisfactory performance by the Contractor of its duties and responsibilities as set forth in this Contract. As a condition for receiving payment under a Medicaid managed care program, a Contractor entity must comply with the requirements in 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.61, as applicable. 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 Agent to generate and process monthly payments through the Division's internal billing procedures.

The Division will pay the Contractor monthly Capitation Payments based on the number of eligible and enrolled Members. The Division will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly capitation rate by Member Rate Cell. Capitation Payments will be developed in accordance with the requirements of 42 C.F.R. § 438.4(b). The Contractor must provide the Services and Deliverables, including covered services to Members, described in the Contract for monthly Capitation Payments to be paid by the Division.

The Division reserves the right to institute incentive arrangements with the Contractor through payments in excess of the approved Capitation Payments to support program initiatives. If such an arrangement is made, the Division will not provide payment in excess of five (5) percent above the approved Capitation Payments attributable to the enrollees or services covered by the incentive arrangement. For all such incentive arrangements, the arrangement will be for a fixed period of time, with performance measured during the rating period under the contract in which the incentive arrangement is applied. Arrangements will not to be renewed automatically.

The Contractor must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to the Division, delays or denials of required approvals, cost of claims incorrectly paid by the funding to Division, and cost overruns not reasonably attributable to the Division. The Contractor must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from the Division or any other state agency, nor will the failure of the Division or any other party to pay for such incidental or ancillary services entitle the Contractor to withhold services or Deliverables due under the Contract.

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. At time of capitation rate acceptance, the Contractor shall provide an actuarial certification that states the capitation rates are adequate in light of the Contractor’s specific circumstances. Members shall be entitled to receive all covered services for the entire period for which payment has been made by the Division.

The Contractor shall enroll all members identified as having one of the following chronic diseases into the high risk Care Management category:

a. Diabetes;

b. Asthma;

c. Cardiovascular disease; and

d. Chronic kidney disease.

Failure to enroll the identified members may result in Capitation Payment reduction. 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.

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, program changes, changes in the scope of mandatory services, or when capitation rate calculations are determined to have been in error. In such events, funds previously paid may be adjusted as well. Within thirty (30) calendar days following written notice by the Division, the Contractor agrees to refund any Overpayment to the Division, and the Division agrees to pay any underpayment to the Contractor. In addition, the Division will review rates annually and adjust rates as deemed necessary subject to approval from the Federal government.

4. Application of Sanctions

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

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 a Member who is determined to have been ineligible for Enrollment for any month. Upon notice by the Division of a Member who is ineligible, the Contractor may recoup from the Provider the amounts paid for any provided covered services.

6. Reserve Account

The Contractor shall establish and maintain an insured bank account or a secured investment which is in compliance with the Department of Insurance regulations referenced in Miss. Code Ann. § 83-41-325 (1972, as amended).

7. Reinsurance

The Contractor must supply a guarantee of coverage letter, with annual updates, for any outstanding claims.

The Contractor may insure any portion of the risk under the provision of the Contract based upon the Contractor's ability (size and financial reserves included) to survive a series of adverse experiences, including withholding of payment by the Division, or imposition of liquidated damages by the Division. These arrangements must be approved by the Division.

8. Third Party Resources

Medicaid is the payer of last resort and pays for covered services only after any liable third party sources have paid. Federal law requires Mississippi to have in place processes and procedures to identify third parties liable for payment of services under the Mississippi State Plan for Medical Assistance and for payment of claims involving third parties.

Federal law considers the program outlined in the Mississippi statute and the federal regulations to be the Third Party Liability (TPL) program. This involves identification of other payers, including, but not limited to, group health and other health insurers, Medicare, liability insurance and workers' compensation insurance.

In accordance with federal law, Mississippi state law considers all Medicaid Recipients to have assigned to the Division their rights to payment or recovery from a third party or private insurer. State law also requires that Medicaid Recipients cooperate with the Division in the enforcement of these assigned rights. Failure to cooperate with the Division violates the conditions for eligibility and may result in the recipient's loss of Medicaid eligibility. Mississippi law also subrogates the Division to the Medicaid Recipient's right to recover from a third party.

a. Division Responsibilities

The Division will be responsible for maintaining the contract(s) needed for insurance verification services or to identify third party coverage for all Medicaid beneficiaries, regardless of the health care service delivery system.

The Division will provide data to the Contractor regarding any third-party insurance coverage for any covered Medicaid Managed Care Member in the Contractor's Health Plan.

While the Division will make reasonable efforts to ensure accuracy of shared data, the Division cannot guarantee the accuracy of the data.

b. Contractor Responsibilities

The Contractor is responsible for administering the TPL program requirements in accordance with Section 1902(a)(25) of the Social Security Act and 42 C.F.R. § 433 Subpart D, as they apply to services provided under this Contract to Medicaid Managed Care Members. The Contractor:

i. Shall coordinate benefits in accordance with 42 C.F.R. § 433.135 and Division requirements;

ii. Must implement cost avoidance and post-payment recovery procedures in accordance with federal and State requirements;

iii. Must Take reasonable measures to identify any legally liable third party insurance coverage for its Members;

iv. If, after the Contractor makes all reasonable efforts to obtain member cooperation, a Member refuses to cooperate with the CONTRACTOR in pursuit of liable third parties, the CONTRACTOR will consult with the Division;

v. Must adjudicate the claim and use post-payment recovery if the probable existence of Third Party Liability was not established by either the Contractor or the Division prior to submission of the claim.

c. Cost Avoidance

In accordance with Division requirements, the Contractor must have processes, methods and resources necessary to receive TPL data from the Division and to identify third-party coverage for its members. The TPL data must be uploaded to the Contractor's claims system within 30 days. This information will be used in managing provider payment at the front end before the claim is paid.

The Contractor must have appropriate edits in the claims system to ensure that claims are properly coordinated when other insurance is identified.

If the probable existence of TPL has been established at the time the claim is filed, the Contractor must reject the claim and return it to the provider for a determination of the amount of any TPL.

The Contractor shall bill or inform the provider to bill the third-party coverage within thirty (30) days of identification.

For certain services, the Contractor should not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase". In accordance with the Division's billing manual, the Contractor should reimburse for EPSDT, Title IV-D, and pregnancy- related services prior to billing of the third party source, and then pursue recovery of Medicaid payment, for practitioner services. Claims submitted for inpatient and outpatient hospital charges for labor and delivery and postpartum must be cost avoided. By law, all other hospital claims are excluded from the above exceptions. Hospital claims must be filed with the third party prior to billing the Contractor.

d. Post-Payment Recovery

Post-payment recovery is necessary in cases where the Contractor has not established the probable existence of a liable third party at the time services were rendered or paid for or in situations when the Contractor was unable to cost-avoid.

The Contractor must have procedures in place to ensure that a provider who has been paid by the Contractor and subsequently receives reimbursement from a third party repays the Contractor.

After Payment Recovery, the Contractor must have established procedures for recouping post-payment and shall report all third-party cost-avoidance and recoveries for its Medicaid Managed Care Members in accordance with the format specified 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 Members pursuant to this Contract. All funds recovered by the Contractor from Third Party Resources shall be treated as income to the Contractor. The Contractor shall coordinate with the Division on all aspects of Third Party Resources.

The Contractor may delay payment of a Subcontractor or Out-of-network Provider for up to sixty (60) calendar 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 Out-of-network Provider is obligated to collect payment. If payment is made by the third party directly to a Subcontractor or Out-of-network Provider within sixty (60) calendar days following the date of service, the Contractor may pay the Subcontractor or Out-of-network Provider only the amount, if any, by which the allowable claim exceeds the amount of the Third Party Liability. If payment is not made

by the third party within such sixty (60) calendar day period, the Contractor must pay the Subcontractor or Out-of-network Provider and obtain a refund of any subsequent payments made by the third party. The Contractor may not withhold payment from a Subcontractor or Out-of-network Provider for services provided to a Member due to the existence of Third Party Resources, because the liability of a Third Party Resource cannot be determined, or because payment will not be available within sixty (60) calendar days.

The exception to the sixty (60) calendar day delayed payment rule is for prescribed drugs which are paid pursuant to an approved waiver described in 42 C.F.R. § 433.139(b)(2)(i) and for medical services provided to pregnant women and children as specified in 42 C.F.R. § 433.139 (b)(2)(ii) and (3). These services must be paid to the Subcontractor or Out-of-network Provider and the Contractor must pursue recovery from the liable Third Party Resource.

e. Third-Party Liability Recoveries by the Division

After one hundred and eighty (180) days from the date of payment of a claim subject to recovery, the Division reserves the right to attempt recovery independent of any action by the Contractor.

The Division will retain all funds received as a result of any state-initiated recovery.

9. Capitation Rates

Exhibit A, Capitation Rates, of this Contract includes the capitation rates per member per month (PMPM) varying by region and Rate Cell. Each Contractor will be paid based on the distribution of Members they have in each Rate Cell. In addition, Contractor Capitation Payments will vary based on their Members' county of residence**.** The SSI/Disabled and MA Adult rate cells will be risk adjusted and Rate Cells have a Risk Adjustment factor, calculated on a prospective basis using CDPS+RX, applied to each rates re-calculated based on each Contractor's actual risk scores.

B. Mississippi Hospital Access Program

The Mississippi Hospital Access Program (MHAP) is a pass-through payment program as defined in 42 C.F.R. § 438.6 for hospitals estimated using the total pool of funds and the expected enrollment for each Rating Period. The Division will annually distribute to the MississippiCAN Contractors the total of the MHAP payments in the amount of the annual limit. The limit for state fiscal years 2016 and 2017 is $533,110,956. The Contractor shall receive monthly Capitation Payments that will include MHAP effective December 1, 2015. Within five (5) business days of receipt of monthly Capitation Payments, the Contractor shall distribute the MHAP in full with no amount withheld for administrative cost. Annual settlement payments, recoupments or capitation rate adjustments will be issued by the

Division to ensure the full MHAP pool is distributed but not exceeded, due to fluctuations in member enrollment and the distribution of enrollment between Contractors. Within five (5) business days of receipt of any annual settlement payments, the Contractor shall distribute the MHAP in full with no amount withheld for administrative cost. The Division will notify Contractor fifteen (15) days in advance of a settlement recoupment.

The Contractor shall report the date and amount of all MHAP distributions, made by the Contractor or any Subcontractor, by hospital and in the Division's required format, by the first business day of each month following the date of payment. Total hospital MHAP distributions planned for each state and federal fiscal year must also be reported to the Division annually, no later than May 20th.

The Contractor shall ensure all MHAP payments are distributed for the purpose of protecting patient access to hospital care at all in-state hospitals of all classes and the out-of-state hospital that is authorized by federal law to submit intergovernmental transfers (IGT's) to the State of Mississippi and is classified as a Level I trauma center located in a county contiguous to the state line at least at a level of access available as of November 30, 2015.

These payments shall be transitioned to payments for value-based purchasing, delivery system reform, performance improvement initiatives or other CMS approved initiatives to improve outcomes, utilization, or quality in accordance with 42 C.F.R. § 438.6 and the MHAP corrective action plan filed with and approved by CMS. The contractors shall participate in stakeholder meetings and otherwise cooperate with the Division in transitioning pass–through payments as may be determined by the Division to be needed to maintain hospital funding and/or comply with federal requirements. The Division reserves the right to modify these payments to comply with state and federal regulations.

C. Maternity Kick Payment

A Maternity Kick Payment is a case rate payment to the Contractor for hospital inpatient physician and facility maternity services for a delivery, as defined by the Division. The Division will pay the Maternity Kick Payment to the Contractor on a monthly basis when a Member delivers a live baby or stillborn baby. The Contractor will be paid one Maternity Kick Payment per delivery, with the exception of delayed deliveries. A delayed delivery is a delivery not reported within the time frame for submission of a claim to be paid within timely filing guidelines of one hundred eighty (180) days. The Maternity Kick Payment is paid to the Contractor in addition to the monthly full risk, prepaid capitation rate for the rate cells of Pregnant Women and MA Adult Females

D. Indemnification and Insurance

The Contractor agrees to indemnify, defend, save, and hold harmless the Division, the State of Mississippi, their officers, agents, employees, representatives, assignees, Members and eligible dependents, and Agents. Specifically, the Contractor agrees:

1. To indemnify and hold harmless the State, its officers, Agents and employees, and the

Members and their eligible dependents from any and all claims or losses accruing or resulting from Contractor's negligence to any participating Provider or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.

2. To indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from liability deriving or resulting from the Contractor's Insolvency or inability or failure to pay or reimburse participating Providers or any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Contract.

3. It shall indemnify and hold harmless the State, its officers, Agents, and employees, and the Members and their eligible dependents from any and all claims for services for which the Contractor receives monthly Capitation Payments, and shall not seek payments other than the Capitation Payments from the State, its officers, Agents, and/or employees, and/or the Members and/or their eligible dependents for such services, either during or subsequent to agreement termination.

4. Any and all liability, loss, damages, costs or expenses which the Division or the State may incur, sustain or be required to pay by reason of the Contractor, its employees, agents or assigns: 1) failing to honor copyright, patent or licensing rights to software, programs or technology of any kind in providing services to the Division, or 2) breaching in any manner the confidentiality required pursuant to federal and State law(s) and regulations.

5. Any and all liability, loss, damage, costs or expenses which the Division may sustain, incur or be required to pay: 1) by reason of any person suffering personal injury, death or property loss or damage of any kind either while participating with or receiving services from the Contractor under this Contract, or while on premises owned, leased, or operated by the Contractor or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the Contractor or any officer, agent, or employee thereof; or 2) by reason of the Contractor or its employee, agent, or person within its scope of authority of this Contract causing injury to, or damage to the person or property of a person including but not limited to the Division or the Contractor, their employees or agents, during any time when the Contractor or any officer, agent, employee thereof has undertaken or is furnishing the services called for under this Contract.

6. All claims, demands, liabilities, and suits of any nature whatsoever arising out of the Contract because of any breach of the Contract by the Contractor, its agents or employees, including but not limited to any occurrence of omission or commission or negligence of the Contractor, its agents or employees.

7. All claims and losses accruing or resulting to any and all the Contractor employees, agents, Subcontractors, laborers, and any other person, association, partnership,

entity, or corporation furnishing or supplying work, services, materials, or supplies in connection with performance of this Contract, and from any and all claims and losses accruing or resulting to any such person, association, partnership, entity, or corporation who may be injured, damaged, or suffer any loss by the Contractor in the performance of the Contract.

The Contractor, Providers and other Contractor vendors do not hold Members liable for payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the Member would owe if the Contractor authorized the services directly.

If in the reasonable judgment of the Division a default by the Contractor is not so substantial as to require termination and reasonable efforts to induce the Contractor to cure the default are unsuccessful and the default is capable of being cured by the Division or by another resource without unduly interfering with the continued performance of the Contractor, the Division may provide or procure such services as are reasonably necessary to correct the default. In such event, the Contractor shall reimburse the Division for the cost of those services in accordance with Section 16.F, Retainage, of this Contract.

E. Limitation of Liability

Nothing in this Contract shall be interpreted as excluding or limiting any liability of the Contractor for harm caused by the intentional or reckless conduct of the Contractor, or for damages incurred in the negligent performance of duties by the Contractor, or for the delivery by the Contractor of products that are defective, or for breach of contract or any other duty by the Contractor. Nothing in the Contract shall be interpreted as waiving the liability of the Contractor for consequential, special, indirect, incidental, punitive or exemplary loss, damage, or expense related to the Contractor's conduct or performance under this Contract.

F. Federal, State, and Local Taxes

Unless otherwise provided herein, the Contract price shall include all applicable federal, state, and local taxes.

The Contractor shall pay all taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. The Division makes no representation whatsoever as to exemption from liability to any tax imposed by any governmental entity on the Contractor. In no event will the Division be responsible for the payment of taxes the Contractor may be liable as a result of this Contract.

G. Medical Loss Ratio

The Contractor shall provide quarterly and annual Medical Loss Ratio (MLR) reports as specified by the Division and in accordance with Exhibit C, Medical Loss Ratio (MLR)

Calculation Methodology, of this Contract. The Division reserves the right to make such reports available to the public in their entirety. If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-five percent (85%), the Contractor shall refund the Division the difference no later than the tenth (10th) business day of May following the end of the MLR Reporting Year. Any unpaid balances after the tenth (10th) business day of May shall be subject to interest of ten percent (10%) per annum.

See Exhibit C of this Contract for MLR calculation methodology and classification of costs.

H. Responsibility for Inpatient Services

Beginning December 1, 2015, the Contractor shall provide inpatient services to Members and follow all of the Division's guidelines for payment of inpatient hospital services for all Members as described in Section 17.C.

I. Health Insurance Providers Fee

Consistent with guidance issued by the IRS, and as otherwise permitted by law, the Division will reimburse Contractor Annually the full cost of the Health Insurance Providers Fee that Contractor incurs, becomes obligated to pay, and does actually pay pursuant to section 9010 of the PPACA. This provision shall not apply for any time period during which a moratorium or suspension of the collection of the Health Insurance Providers Fee occurs. Contractor shall provide all documentation requested by the Division in a timely manner in order for the Division to verify that Contractor incurred, became obligated to pay, and did actually pay the full cost of the Health Insurance Providers Fee. For purposes of this section, the "full cost of the Health Insurance Providers Fee" shall be the sum of: (1) the Health Insurance Providers Fee that Contractor incurred, became obligated to pay, and actually did pay pursuant to section 9010 of the ACA, and (2) the tax liability that Contractor incurred, became obligated to pay, and actually paid, if any, related to the Division's reimbursement to Contractor of the Health Insurance Providers Fee limited to Contractor's Federal income tax, State income tax, and State premium tax liability attributable to such reimbursement. Notwithstanding the foregoing, the Division shall not compensate the Contractor for any additional Federal income tax, State income tax, and/ or State premium tax that the Contractor incurs because of the Division's reimbursement to Contractor of any tax liability pursuant to the preceding sentence. In the event that the Contractor receives a refund from the Internal Revenue Service due to an overpayment of the Health Insurance Providers Fee, as provided to the Contractor from the IRS on an amended Letter 5067C, such refunded amount shall be paid by Contractor to the Division plus an amount equal to any reduction in the Contractor's Federal income tax, State income tax, and/or State premium tax liability attributable to such refund.

SECTION 14 – THIRD PARTY LIABILITY

The Contractor shall pursue payments from liable third parties in accordance with the State Plan and applicable federal and state laws and regulations. If the Contractor desires to Subcontract with any individual, firm, corporation, or any other entity, the Contractor shall abide by the

requirements of Section 15 (Subcontractual Relationships and Delegation) in regard to any such Subcontract.

When handling a subrogation case, all initial letters sent to third parties (i.e., attorneys or insurance companies) should place the third party on notice that the Division may have a separate lien for services not covered by the Contractor and provide contact information for the Division's designated third party staff member. Under no circumstances may the Contractor or any Subcontractor imply that they are an Agent of the State or Division. The Division will provide language that must be included in all of the form letters issued by the Contractor and/or any Subcontractors.

The Contractor shall obtain written approval from the Division for all form letter templates and form document templates prior to use. The Contractor shall submit a copy of all form letter templates and form document templates to the Division for written approval and as part of the readiness review process. The Division will impose liquidated damages or other available remedies in accordance with Section 16, Default and Termination, of this Contract in the event of non-compliance.

In the event the Division has a claim related to the accident, the Contractor will not be able to negotiate its claim without first notifying the Division. The Division subrogation claim takes priority over the Contractor's subrogation claim. In cases where the Division and Contractor both have claims related to the accident and the settlement or verdict amount is insufficient to satisfy both claims, at the sole discretion of the Division, the Division and Contractor may divide the proceeds.

Periodic meetings may be required with the Contractor's compliance personnel and the Division.

The Contractor shall prepare a standard subrogation release of claim that relates only to the claims the Contractor may have. The Contractor shall not execute releases sent in by third parties.

The Contractor will be prohibited from stating or implying that it is Division of Medicaid; however, it is appropriate to state that the Contractor provides services for Division of Medicaid.

The Contractor must educate insurers and attorneys who are representing the Contractor about Mississippi Medicaid and the MississippiCAN Program, the differences between the two (2) programs and how representation for issues related to the Contractor's role in management of the MississippiCAN Program do not imply representation for the full Medicaid program. Education must clarify that at no point may an insurer or attorneys imply that they are representing Medicaid, acting as an Agent of the State, or imply they are settling on behalf of the State or the Division of Medicaid.

For guidance with respect to Third Party Resources, please refer to Section 13.A, Capitation Payments, of this Contract.

SECTION 15 – SUBCONTRACTUAL RELATIONSHIPS AND DELEGATION

A. 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, subject to Division approval.

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.

B. Requirements

The Contractor has the right to Subcontract to provide services specified under this Contract, subject to Division approval. The Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the Division. 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 is solely responsible for fulfillment of the Contract terms with the Division and for the performance of any Subcontractor under such Subcontract approved by the Division. The Division will make Contract payments only to the Contractor.

If the Contractor delegates any activities or obligations under this Contract to a Subcontractor, the following conditions must be met:

1. The delegated activities or obligations, and related reporting responsibilities, are specified in the Contract or written agreement with the Subcontractor;

2. The Subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's obligations under this Contract; and

3. The Contract or written agreement between the Contractor and Subcontractor must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Division or Contractor determine that the Subcontractor has not performed satisfactorily.

4. The Subcontractor agrees that the Division, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect

any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract.

5. The Subcontractor will make available, for the purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of 42 C.F.R. § 438.230, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees or Members.

6. The right to audit under paragraph (c)(3)(i) of 42 C.F.R. § 438.230 will exist through ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later.

If the Division, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

The Contractor shall not Subcontract any portion of the services to be performed under this Contract without the prior written approval of the Division. All Subcontracts may be subject to review and approval by the Division and must include all Division required terms and conditions. At contract award, the Division will provide a checklist of specific requirements that the Contractor must include in every Subcontract supporting the MississippiCAN Program. When submitting the Subcontract to the Division for approval, the Contractor must provide the completed checklist to indicate where within the Subcontract the requirement is addressed.

A Subcontract that must be submitted to the Division for advance written approval is any Subcontract between the Contractor and any individual, firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, or any other entity to perform part or all of the selected Contractor's responsibilities under this Contract. This provision includes, but is not limited to, Subcontracts for Behavioral Health/Substance Use Disorder Services, vision services, dental services, claims processing, pharmacy services, third party services and Member services. This provision does not include, for example, purchase orders. The Contract language for Subcontractors must be standardized, as approved by the Division. The Contractor must submit the Subcontract to the Division for advance written approval not less than thirty (30) calendar days in advance of its desire to Subcontract. If such Subcontract is approved, the Contractor shall notify the Division not less than thirty (30) calendar days in advance of its desire to amend or terminate such Subcontract. The Contractor shall include a copy of the proposed Subcontract amendment with notification of and information about the proposed amendment. The proposed amendment must receive written approval from the Division prior to its effective date.

When requested by the Division, any subcontract between a Subcontractor and any individual, firm, corporation, business, university, governmental entity, affiliate, subsidiary, nonprofit organization, or any other entity to perform part or all of the Contractor's

responsibilities under this Contract that have been subcontracted to the Subcontractor, shall be submitted to the Division for review not less than thirty (30) calendar days in advance of the Subcontractor's desire to subcontract (or amend or terminate such subcontract).

The Contractor must oversee and will be held accountable for any functions and responsibilities that it delegates to any Subcontractor or subsidiary. All Subcontracts and agreements must be in writing, must specify the activities and report responsibilities delegated to the Subcontractor, and provide for revoking delegation or imposing other sanctions and/or remedies if the Division or Contractor determines that the Subcontractor's performance is inadequate, and shall contain provisions such that it is consistent with the Contractor's obligations pursuant to this Contract. All Subcontractors must agree to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.

Approval of any Subcontract shall neither obligate the Division nor the State of Mississippi as a party to that Subcontract nor create any right, claim, or interest for the Subcontractor against the State of Mississippi or the Division, their Agents, their employees, their representatives, or successors.

The Contractor must monitor each Subcontractor's performance on an ongoing basis, subject it to formal review at least once a year, and include the results of this review in Annual Quality Management Program Evaluation. If the Contractor identifies deficiencies or areas for improvement in the performance of any of its Subcontractors that is providing services under this Contract, 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 if they provide services not covered under this Contract on a Fee-for-Service basis.

Subcontracts and revisions to Subcontracts must be maintained and available for review at one (1) central office in Mississippi designated by the Contractor and approved by the Division.

The Division may refuse to enter into or renew an agreement with a Contractor if any Subcontractor entity has any person who has an ownership or control interest in the Subcontract entity, or who is an agent or managing employee of the Subcontractor, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XIX Services Program.

The Division may refuse to enter into or may terminate this Contract if it determines that the Contractor did not fully and accurately make any disclosure of any Subcontractor entity required under 42 C.F.R. § 455.106.

Disclosure by Providers and State Medicaid agencies must be in accordance with 42 C.F.R. § 1002.3. Before the Division enters into or renews a Contract, or at any time upon written request by the Division, the Contractor must disclose to the Division the identity of any

person described in 42 C.F.R. §§ 1001.1001(a)(1) and 1002.3 related to any Subcontractor entities.

The Division may refuse to enter into or renew this Contract if any person who has ownership or control interest in any Subcontractor entity, or who is an agent or managing employee of the Subcontractor entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the Title XIX Services Program.

The Division may refuse to enter into, or terminate, this Contract if it determines that the Subcontractor entity did not fully and accurately make any disclosure required under 42 C.F.R. § 1002.3(a).

The Contractor shall give the Division immediate written notice by certified mail, facsimile, or any other carrier that requires signature upon receipt of any action or suit filed and prompt notice of any claim made against the Contractor or Subcontractor which in the opinion of the Contractor may result in litigation related in any way to the Contract with the Division.

C. Remedies

The Division shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to revoke delegated activities or obligations or 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 may be investigated by the Division at investigatory agency and/or its contractors.

SECTION 16 – DEFAULT AND TERMINATION

A. Sanctions

In the event the Division finds the Contractor to be non-compliant with program standards, performance standards, provisions of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the Division shall issue a written notice of deficiency, request a corrective action plan, and/or specify the manner and time frame in which the deficiency is to be cured. If the Contractor fails to cure the deficiency as ordered to the satisfaction of the Division, the Division shall have the right to exercise any of the administrative sanction options described in this section, in addition to any other rights and remedies that may be available to the Division:

1. 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 Members into the Contractor. The Division, when exercising this option, must notify the Contractor in writing of its intent to suspend new Enrollment at least seven (7) business days prior to the beginning of the suspension period. The suspension period

may be for any length of time specified by the Division, or may be indefinite. The Division may also notify existing Members of the Contractor non-compliance and provide an opportunity to disenroll from the Contractor and/or to re-enroll with another contractor;

2. Suspension or recoupment of the capitation rate paid for:

    a. Any month for any Member denied the full extent of covered services meeting the standards set by this Contract or who received or is receiving substandard services after notification by the Division of a determination of a contract violation. Whenever the Division determines that the Contractor has failed to provide to a Member 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 ($25,000.00). The Contractor shall be given at least fifteen (15) calendar days from the date of the written notice prior to the withholding of any Capitation Payment;

    b. Months in which reports are not submitted as required in this Contract after notification by the Division of a determination of a Contract violation. 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 and to the satisfaction of the Division;

    c. Members enrolled after the effective date of any sanctions imposed herein, and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

3. Notwithstanding the provisions contained in this Contract, the Division may withhold portions of Capitation Payments from the Contractor as provided herein;

4. Civil money penalties of up to one hundred thousand dollars ($100,000.00) for acts of discrimination against individuals on the basis of their health status or need for health care services, or Providers, or misrepresentation or falsification of information furnished to CMS or the Division;

5. Civil money penalties of up to twenty-five thousand dollars ($25,000.00) for misrepresentation or falsification of information furnished to individuals or Providers, or for failure to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210, or the Division determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, Marketing materials that have not been approved by the Division or that contain false or materially misleading information.

6. Civil money penalties of up to twenty-five thousand dollars ($25,000.00), or double the amount of excess charges, whichever is greater, for premiums or charges in excess of the amounts permitted under the Medicaid program.

7. Temporary management upon a finding by the Division that the Contractor has repeatedly failed to meet substantive requirements of this Contract, there is continued egregious behavior by the Contractor, there is substantial risk to the health of Members, or it is necessary to ensure the health of the Members, in accordance with § 1932 of the Social Security Act;

8. Termination of this Contract;

9. Reduce or eliminate Marketing and/or community event participation;

10. Refuse to allow participation in Contractor pay for performance programs;

11. Refuse to renew the Contract;

12. In the case of inappropriate Marketing activities, referral may also be made to the Department of Insurance for review and appropriate enforcement action;

13. Require special training or retraining of Marketing representatives including, but not limited to, business ethics, Marketing policies, effective sales practices, and State Marketing policies and regulations, at the Contractor's expense;

14. In the event the Contractor becomes financially impaired to the point of threatening the ability of the State to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or its assets, the State may, at its option, immediately terminate this Contract effective the close of business on the date specified;

15. Refuse to consider for future contracting a Contractor that fails to submit Member Encounter Data on a timely and accurate basis;

16. Refer any matter to the applicable Federal agencies for civil money penalties;

17. Refer any matter to the state and/or federal agencies responsible for investigating or addressing civil rights matters, where applicable;

18. Exclude the Contractor from participation in the Medicaid program; and

19. Refer any matter to the state or federal agencies responsible for investigating or addressing Consumer Affairs matters, where applicable; and,

20. Impose any other sanctions as provided by 42 C.F.R. § 438.700 et seq.

The Division shall provide the Contractor written notice fifteen (15) calendar days before sanctions as specified above are imposed, which will include the basis and nature of the sanction. The type of action taken shall be in relation to the nature and severity of the deficiency. The basis for imposition of sanctions under this section includes, but is not limited to:

1. The Division determines that Contractor acts or fails to act as follows:

    a. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to a Member covered under the Contract.

    b. Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

    c. Acts to discriminate among Members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

    d. Misrepresents or falsifies information that it furnishes to CMS or to the Division.

    e. Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider.

    f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. §§ 422.208 and 422.210.

2. The Division determines that the Contractor has distributed directly, or indirectly through any agent or independent contractor, Marketing materials that have not been approved by the Division or that contain false or materially misleading information.

3. The Division determines that the Contractor has violated any of the requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

The Division retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in this section shall prevent the Division from exercising that authority.

The Division will give CMS written notice whenever it imposes or lifts a sanction for one of the violations listed in 42 C.F.R. Section 438.700*et seq.* The notice will be given no later

than thirty (30) days after the Division imposes or lifts the sanction, and will specify the type of sanction, and the reason for the Division's decision to impose or lift the sanction.

B. Disputes of Sanctions or Damages

In order to Appeal the Division imposition of any sanctions or damages, the Contractor shall request review in accordance with the Disputes provisions provided in Section 17.J. The imposition of sanctions and liquidated damages is not automatically stayed pending Appeal. Pending final determination of any dispute hereunder, the Contractor shall proceed diligently with the performance of this Contract and in accordance with the Contract Officer's direction.

C. Inspection and Monitoring

Pursuant to the requirements of 42 C.F.R. § 438.3 the Division, the Division's Office of Program Integrity, the State Medicaid Fraud Control Unit, the Mississippi Department of Audit, the U.S. Department of Health and Human Services (DHHS), the Mississippi Division of Family and Children's Services (DFCS), CMS, OIG, the Comptroller General, the GAO, and any other auditing agency prior-approved by the Division, or authorized representatives or designees of the aforementioned parties, shall, at any reasonable time, any time, have the right to enter onto the Contractor's or Subcontractor's premises, or such other places where duties under this Contract or Medicaid-related activities are being performed, with or without notice, to inspect, audit, monitor, or otherwise evaluate (including periodic systems testing) the work being performed by the Contractor, Subcontractor, Subcontractor's contractor, or supplier. § 3The right to audit exists for ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later (42 C.F.R. § 438.3(h)). All inspections and evaluations shall be performed in such a manner as will not unduly delay work. Refusal by the Contractor to allow access to all records, documents, papers, letters or other materials, shall constitute a breach of contract. All audits performed by persons other than Division staff will be coordinated through the Division and its staff.

Such monitoring activities shall include, but are not limited to, onsite inspections of all service locations, and health care facilities, and equipment; auditing and/or review of all records developed under this Contract including periodic medical audits, Grievances, Enrollments, Disenrollments, termination, utilization and financial records, reviewing management systems and procedures developed under this Contract and review of any other areas of materials relevant to or pertaining to this Contract. Because of the importance of having accurate service utilization data for program management, 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. If the Division, CMS, or OIG determines that there is a reasonable possibility of fraud or similar risk, the Division, CMS, or OIG may inspect, evaluate, and audit the Subcontractor at any time.

D. 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 corrective action 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, or other similar entities, for investigation and possible criminal prosecution.

E. Liquidated Damages

1. Failure to Meet Contract Requirements

   The Division reserves the right to assess actual or liquidated damages, upon the Contractor's failure to provide timely services required pursuant to this Contract. It is agreed by the Division 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 shall pay the Division liquidated damages in the fixed amounts as stated in Table 11, and such liquidated damages are a reasonable estimate of the loss which will be incurred. Unless a different amount is specifically set forth below, the Division may, at its sole discretion, assess liquidated damages between one dollar ($1.00) and one million dollars ($1,000,000.00) for each failure that occurs or remains uncorrected. However, 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.

   The Division's failure to assess liquidated damages in one or more of the particular instances described herein will in no event waive the right for the Division to assess additional liquidated damages or actual damages. Continued violations of the

Deliverable requirements set forth in Table 11 may result in termination of the Contract by the Division.

The assessment of any actual or liquidated damages will be offset against the subsequent monthly payments to the Contractor. Assessment of any actual or liquidated damages does not waive any other remedies available to the Division pursuant to this Contract or State or Federal law. If liquidated damages are known to be insufficient then the Division has the right to pursue actual damages.

Table 11. Liquidated Damages

Failed Deliverable	Damages
Administrative Service	For each day Contractor fails to timely perform or perform as required under the Contract an Administrative Service not otherwise specified in this table that in the Division's determination results in harm to a Member, places a Member at risk of harm, or affects the Division's ability to administer the program, the Division may assess up to $5,000.00 per calendar day for each incident of noncompliance.
Call Center Performance	If the Contractor's average abandonment rate for any period exceeds five percent (5%) for the Member Services and/or Provider Services Call Centers, the Contractor shall pay liquidated damages of up to ten thousand dollars ($10,000.00) per monthly period.
Claims Payment	If the Contractor fails to meet the targets outlined in Section 17. A., Claims Payment, of this Contract, the Division shall deem this to be an instance of unsatisfactory claims performance and the Contractor shall pay liquidated damages 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.

Failed Deliverable	Damages
Corrective Action	If the Contractor fails to submit an acceptable corrective action plan to the Division within the timeframe requested by the Division, the Division may assess liquidated damages for each day beyond that time that the Division has not received an acceptable corrective action plan in the amount of one thousand dollars ($1,000.00) per day for ten (10) days and two thousand five hundred dollars ($2,500.00) per day thereafter. If the Contractor fails to implement or complete corrective action as required in this Contract and the corrective action plan has been approved by the Division, the Contractor shall pay liquidated damages in the amount of three thousand dollars ($3,000.00) per calendar day for each day the corrective action is not implemented or completed as required.
Covered Service	For each day the Contractor fails to timely provide or provide as required under the Contract a Covered Service not otherwise specified in this table that in the Division's determination results in harm to a Member, places a Member at risk of harm, or affects the Division's ability to administer the program, the Division may assess up to $7,500.00 per calendar day for each incident of noncompliance.

Failed Deliverable	Damages
Member Encounter Data	The Contractor shall submit complete Member Encounter Data to the Division that meets Federal and Division requirements and allows the Division to monitor the program. 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. If the Contractor does not meet these standards, the Contractor may be assessed liquidated damages each month Member Encounter Data is not submitted or not submitted in compliance with the Division's requirements for timeliness, completeness, and accuracy. If the Contractor fails to submit data derived from processed encounter claims in the required form or format by the terms of this Contract for one (1) calendar month, the Division shall withhold an amount equal to five percent (5%) of the Contractor's capitation payment for the month following non-submission and shall retain the amount withheld until the data is received, reviewed, and accepted by the Division. Additionally, the Division may assess liquidated damages up to the following amounts: Ten thousand dollars ($10,000.00) per calendar day for each day Member Encounter Data is received after the due date, Ten thousand dollars ($10,000.00) per calendar day for each day after the due date that the monthly encounter data has not been received in the format and per specifications outlined in the Contract, and Ten thousand dollars ($10,000.00) per calendar day for each day the Contractor fails to correct and resubmit Member Encounter Data that was originally returned to the Contractor for correction because the error rate for the submitted data was in excess of the five percent (5%), until acceptance.
EPSDT Screening and Immunization	Failure to achieve the targets specified in Table 10 of this Contract will require a refund of one hundred dollars ($100.00) per Member for all EPSDT Eligible Members who did not receive the required screening or immunization. The Division will periodically re-evaluate this level and notify the Contractor in writing of changes.

<table>
<tr><th>Failed Deliverable</th><th>Damages</th></tr>
<tr><td>Deliverables</td><td>For each day that a Deliverable is late, incorrect, or deficient, the Contractor may be liable to the Division for liquidated damages in an amount per calendar day per Deliverable as specified in the table below for Deliverables not otherwise specified in this table. Liquidated damages have been designed to escalate by duration and by occurrence over the term of this Contract.
<table>
<tr><th>Occurrence</th><th>Daily Amount for Days 1-14</th><th>Daily Amount for Days 15-30</th><th>Daily Amount for Days 31-60</th><th>Daily Amount for Days 61 and Beyond</th></tr>
<tr><td>1-3</td><td>$750</td><td>$1,200</td><td>$2,000</td><td>$3,000</td></tr>
<tr><td>4-6</td><td>$1,000</td><td>$1,500</td><td>$3,000</td><td>$5,000</td></tr>
<tr><td>7-9</td><td>$1,500</td><td>$2,000</td><td>$4,000</td><td>$6,000</td></tr>
<tr><td>10-12</td><td>$2,000</td><td>$3,000</td><td>$5,000</td><td>$8,000</td></tr>
<tr><td>13 and Beyond</td><td>$4,000</td><td>$7,000</td><td>$9,500</td><td>$12,000</td></tr>
</table></td></tr>
<tr><td>Marketing</td><td>If the Division determines that the Contractor has violated the requirements of the Contractor’s obligations with respect to Marketing and Marketing materials, the Contractor shall pay up to twenty-five thousand dollars ($25,000.00) for each violation, in connection with an audit or investigation.</td></tr>
<tr><td>Medicaid Investigated Grievances</td><td>If the Contractor is subject to more than three (3) valid Medicaid Investigated Grievances in any one (1) month, The Division may assess liquidated damages of up to ten thousand dollars ($10,000.00) for each such valid Medicaid Investigated Grievance above three (3) per month.</td></tr>
</table>

Failed Deliverable	Damages
Network Access Report and Provider Network Reports	If the Division determines that the Contractor has not met the established Provider Network access standards, the Division shall assess liquidated damages on the Contractor and require submission of a Correction Action Plan to the Division within fifteen (15) business days following assessment of liquidated damages. Determination of failure to meet network access standards shall be made following a review of the Contractor's Network Geographic Access Assessment (GeoAccess) Report. Contractor shall pay 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 quarters, the Division shall immediately suspend Enrollment of MississippiCAN Members with the Contractor until 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.
Non-Emergency Transportation	The Contractor shall authorize and schedule routine NET services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request. Contractor shall authorize and schedule routine NET services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request. If the Contractor fails to achieve these targets, the Contractor will be assessed liquidated damages up to ten thousand dollars ($10,000.00) per monthly period.
Physician Incentive Plan	If Contractor fails to comply with the Section 7.K., Physician Incentive Plan, the Division may assess liquidated damages of up to twenty-five thousand dollars an ($25,000.00) for each failure to comply.
Provider Credentialing	If the Division determines that the Contractor has not completed credentialing of Providers within ninety (90) calendar days, or if the approved Credentialing application is not loaded in the Contractor's Claims Processing system within thirty (30) days after approval, the Division may impose liquidated damages of up to five thousand dollars ($5,000.00) per violation.
Premium	If Contractor imposes premiums or charges on Members that are in excess of those permitted, the Division may assess liquidated damages of up to twenty-five thousand dollars ($25,000.00) or double the amount of the excess charges, whichever is greater. The Division will also deduct the amount of the overcharge from assessed liquidated damages and return it to the affected Member.

<table>
<tr><th>Failed Deliverable</th><th>Damages</th></tr>
<tr><td>Prior Authorizations</td><td>If the Contractor fails to meet the Prior Authorization performance standards for the completion timelines for review determinations, the Division may assess liquidated damages in the amount of $100.00 per workday for each failure to meet the performance standard.

If the Contractor fails to meet the Prior Authorization performance standards for the completion timelines for review determination notification, the Division may assess liquidated damages in the amount of $100.00 per workday for each failure to meet the performance standard.</td></tr>
<tr><td>Responsiveness to Division Requests</td><td>If Contractor fails to meet the requirements of Section 1.J, Responsiveness to Division Requests, the Division may assess liquidated damages in an amount per calendar day per request as specified in the table below. Liquidated damages have been designed to escalate by duration and by occurrence over the term of this Contract.
<table>
<tr><th>Occurrence</th><th>Daily Amount for Days 1-14</th><th>Daily Amount for Days 15-30</th><th>Daily Amount for Days 31-60</th><th>Daily Amount for Days 61 and Beyond</th></tr>
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<tr><td>13 and Beyond</td><td>$4,000</td><td>$7,000</td><td>$9,500</td><td>$12,000</td></tr>
</table>
Liquidated damages under this section shall begin on the first day the contract requirement is not met, including but not limited to, the first day the Division request is not acknowledged or completed as required or in the required timeframe.</td></tr>
<tr><td>Third Party Liability Form Letters and Form Documents</td><td>If the Contractor fails to submit form letter templates and form document templates to the Division for advance written approval or fails to use the approved letter templates and form document templates, the Division may impose liquidated damages of up to five thousand dollars ($5,000.00) per violation.</td></tr>
<tr><td>Subcontractor Prior Approval</td><td>The Contractor’s failure to obtain advance written approval of a Subcontract will result in the assessment of liquidated damages in the amount of one (1) month’s Capitation Payment rates for each day that the Subcontractor was in effect without the Division’s approval.</td></tr>
</table>

With the exception of Member Encounter Data submissions, the Division will utilize the following guidelines to determine whether a report is correct and complete for the purposes of liquidated damages: (a) The report must contain one hundred percent (100%) of the Contractor's data; (b) ninety-nine percent (99%) of the required items for the report must be completed; and (c) ninety-nine point five percent (99.5%) of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by the Division.

Liquidated damages for late Deliverables shall begin on the first day the Deliverable is late. Liquidated damages for incorrect or deficient Deliverables shall begin on the sixteenth (16th) calendar day after the date on the notice provided by the Division to the Contractor that the Deliverable remains incorrect or deficient.

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.

2. Termination of the Contract

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)/ Medicaid Enterprise System (MES) 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 Members and mass MMIS changes, in effecting additional staffing changes, in procuring alternate health care arrangements for Members and in modifying any Member service materials identifying the Contractor; and that such expense is difficult or impossible to accurately estimate.

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 ($10,000.00) plus, for each month of the Contract term remaining after the effective date of termination, five percent (5%) of the maximum monthly Capitation Payment, such payment to be made no later than thirty (30) calendar days following the date of the notice of termination. 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 shall 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.

The Division and the Contractor agree that this Paragraph E.2., Section 16, relating to liquidated damages does not apply if the Contract is terminated without cause in accordance with Paragraph I, Section 16 of this Contract.

F. Retainage

If the Contractor's failure to perform satisfactorily exposes the Division to the likelihood of contracting with another person or entity to perform services required of the Contractor under this Contract, upon notice setting forth the services and retainage, the Division may withhold from the Contractor payments in an amount commensurate with the costs anticipated to be incurred. If costs are incurred, the Division shall account to the Contractor and return any excess to the Contractor. If the retainage is not sufficient, the Contractor shall immediately reimburse the Division the difference or the Division may offset from any payments due the Contractor. The Contractor will cooperate fully with the retained Contractor and provide any assistance it needs to implement the terms of its agreement for services for retainage.

The Contractor shall cooperate with the Division or those procured resources in allowing access to facilities, equipment, data or any other Contractor resources to which access is required to correct the failure. The Contractor shall remain liable for ensuring that all operational performance standards remain satisfied.

G. Stop Work Order

1. **Order to Stop Work:** The Division Contract Administrator may, by written order to the Contractor at any time and without notice to any surety, require the Contractor to stop all or any part of the work called for by this Contract. This order shall be for a specified period not exceeding ninety (90) calendar days after the order is delivered to the Contractor, unless the parties agree to an extension. Any such order shall be identified specifically as a stop work order issued pursuant to this clause. Upon receipt of such an order, the Contractor shall forthwith comply with its terms and take all reasonable steps to minimize the occurrence of costs allowable to the work covered by the order during the period of work stoppage. Before the stop work order expires, or within an extension to which the parties shall have agreed, the Contract Administrator shall either:

    a. Cancel the stop work order; or

    b. Terminate the work covered by such order as provided in the "Termination for

Default Clause" or the "Termination for Convenience Clause" of this Contract.

2. **Cancellation or Expiration of the Order:** If a stop work order issued under this clause is canceled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the Contractor shall have the right to resume work. An appropriate adjustment shall be made in the delivery schedule or Contractor price, or both, and the Contract shall be modified in writing accordingly, only if:

    a. The stop work order or extension results in an increase in the time required for, or in the Contractor's cost properly allocable to, the performance of any part of this Contract; and

    b. The Contractor asserts a claim for such an adjustment within thirty (30) calendar days after the end of the stop work order or extension.

3. **Termination of Work:** If a stop work order or extension is not canceled and the work covered by such stop work order or extension is terminated for default or convenience, adjustment to the Contract price will be negotiated between the Division and the Contractor.

H. 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 Members 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 Member 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.

I. Option to Terminate

This Contract may be terminated without cause by either party upon ninety (90) calendar days' 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 performance of all obligations upon termination as defined in this Contract, and payment in full of any

refunds, outstanding liquidated damages, or other sums due the Division pursuant to this Contract.

J. Termination by the Division

1. General Requirements

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

   a. For default by the Contractor;

   b. For convenience;

   c. For the Contractor's bankruptcy, Insolvency, receivership, liquidation; and d.

   d. For non-availability of funds.

   At the Division's option, termination for reasons (a) through (d) listed herein may also be considered termination for convenience.

   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) calendar days' notice of the possible occurrence of events as described in this Contract.

2. Termination for Default by the Contractor

   The Division may immediately terminate this Contract in whole or in part whenever the Division determines that the Contractor has failed to satisfactorily perform its contractual duties and responsibilities and is unable to resolve such failure within a period of time specified by the Division, after considering the gravity and nature of the default. The Division has the authority to immediately terminate this Contract in whole or in part whenever the Division determines that the Contractor has failed to meet applicable requirements of Sections 1903(m), 1905(t), and 1932 of the Act. Such termination shall be referred to herein as "Termination for Default." Upon determination by the Division of any such failure to satisfactorily perform its contractual duties and responsibilities, the Division may notify the Contractor of the failure and establish a reasonable time period in which to resolve such failure. If the Contractor does not resolve the failure within the specified time period, The Division will notify the Contractor that the Contract in full or in part has been terminated for default. Such notices shall be in writing and delivered to the Contractor by certified mail, return receipt requested, or in person.

   If, after Notice of Termination for default, it is determined that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance

was due to causes beyond the control and without error or negligence on the part of the Contractor or any Subcontractor, the Notice of Termination shall be deemed to have been issued as a termination for the convenience of the Division, and the rights and obligations of the parties shall be governed accordingly.

In the event of Termination for Default, in full or in part as provided by this clause, the Division may procure, upon such terms and in such manner as the Division may deem appropriate, supplies or services similar to those terminated, and the Contractor shall be liable to the Division for any excess costs for such similar supplies or services for the remainder of the Contract period. In addition, the Contractor shall be liable to the Division for administrative costs incurred by the Division in procuring such similar supplies or services.

In the event of a termination for default, the Contractor may, at the Division's discretion, be paid for those Deliverables which the Contractor has delivered to the Division. Payments for completed Deliverables delivered to and accepted by the Division shall be at the Contract price.

The rights and remedies of the Division provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under the Contract.

3. Termination for Convenience

The Division may terminate performance of work under the Contract in whole or in part whenever for any reason the Division shall determine that such termination is in the best interest of the Division.

In the event that the Division elects to terminate the Contract pursuant to this provision, it shall notify the Contractor by certified mail, return receipt requested, or delivered in person. Termination shall be effective as of the close of business on the date specified in the notice, which shall be at least thirty (30) calendar days from the date of receipt of the notice by the Contractor.

Upon receipt of Notice of Termination for convenience, the Contractor shall be paid the following:

a. The Contract price(s) for completed Deliverables delivered to and accepted by the Division; and

b. A price commensurate with the actual cost of performance for partially completed Deliverables, which also requires acceptance by the Division.

4. Termination for the Contractor Bankruptcy

In the event that the Contractor shall cease conducting business in the normal course,

become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or its assets, or shall avail itself of, or become subject to, any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to Insolvency or the protection of the rights of creditors, the Division may, at its option, terminate this Contract in whole or in part.

In the event the Division elects to terminate the contract under this provision, it shall do so by sending Notice of Termination to the Contractor by certified mail, return receipt requested, or delivered in person. The date of termination shall be the close of business on the date specified in such notice to the Contractor. In the event of the filing of a petition in bankruptcy by or against a principal Subcontractor, the Contractor shall immediately so advise the Division.

The Contractor shall ensure and shall satisfactorily demonstrate to the Division that all tasks related to the Subcontract are performed in accordance with the terms of this Contract.

5. Availability of Funds

It is expressly understood and agreed that the obligation of the Division to proceed under this agreement is conditioned upon the appropriation of funds by the Mississippi State Legislature and the receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to the State, the State shall have the right upon ten (10) working days written notice to the Contractor, to terminate this agreement without damage, penalty, cost, or expense to the State of any kind whatsoever. The effective date of termination shall be as specified in the notice of termination.

K. Procedure on Termination

1. Notice of Termination

Upon termination of the Contract for any reason except as described in Section 16.H, Action of the Mississippi Department of Insurance, of this Contract, 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 Members of the Division's intent to terminate the Contract and give Members the opportunity to disenroll immediately from the Contractor without cause with the option to enroll with another Contractor, as appropriate.

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.

2. Contractor Responsibilities

Upon delivery by certified mail, return receipt requested, or in person to the Contractor a Notice of Termination specifying the nature of the termination, the extent to which performance of work under the Contract is terminated, and the date upon which such termination becomes effective, the Contractor shall:

a. Stop work under the Contract on the date and to the extent specified in the Notice of Termination;

b. Place no further orders or Subcontracts for materials, services or facilities, except as may be necessary for completion of such portion of the work in progress under the Contract until the effective date of termination;

c. Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the Notice of Termination;

d. Deliver to the Division within the time frame as specified by the Division in the Notice of Termination, copies of all data and documentation in the appropriate media and make available all records required to assure continued delivery of services to beneficiaries and Providers at no cost to the Division;

e. Complete the performance of the work not terminated by the Notice of Termination;

f. Take such action as may be necessary, or as the Division may direct, for the protection and preservation of the property related to the Contract which is in the possession of the Contractor and in which the Division has or may acquire an interest;

g. Fully train the Division staff or other individuals at the direction of the Division in the operation and maintenance of the process;

h. Notify the Contractor's Provider Network of the planned termination;

i. Reimburse the Division for additional costs related to mailings to Members and other stakeholders, additional Enrollment costs, additional procurement costs, attorney's fees, and Member notification;

j. Promptly transfer all information necessary for the reimbursement of any outstanding claims;

k. Promptly transfer all Member records, financial records, State and Federal data, such as encounter and quality data, and outstanding Provider and/or Member Complaints, Grievances, and Appeals; and

l. Complete each portion of the Turnover Phase after receipt of the Notice of Termination. The Contractor shall proceed immediately with the performance of the above obligations notwithstanding any allowable delay in determining or adjusting the amount of any item of reimbursable price under this clause.

The Contractor has an absolute duty to cooperate and help with the orderly transition of the duties to the Division or its designated contractor following termination of the Contract for any reason.

3. Division Responsibilities

Except for termination for Contractor's default, the Division will make payment to the Contractor on termination and at Capitation Payment rate for the number of Members enrolled on the first day of the last month of operations. The Contractor shall be reimbursed for partially completed Deliverables, accepted by the Division, at a price commensurate with actual cost of performance.

In the event of the failure of the Contractor and the Division to agree in whole or in part as to the amounts to be paid to the Contractor in connection with any termination described in this Contract, the Division shall determine on the basis of information available the amount, if any, due to the Contractor by reason of termination and shall pay to the Contractor the amount so determined.

The Contractor shall have the right of Appeal, as stated under Section 17.J, Disputes, of this Contract from any such determination made by the Division.

L. 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 Members or to assure the health of Members during a time or for an orderly termination or reorganization of the Contractor 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 Members the right to terminate Enrollment with the Contractor.

M. Excusable Delays

The Contractor and the Division shall be excused from performance under this Contract for any period that they are prevented from performing any services under this Contract as a

result of an act of God, war, civil disturbance, epidemic, court order, government act or omission, or other cause beyond their control. The Contractor must notify the Division within seven (7) calendar days in writing under circumstances in which the Contractor seeks an excusable delay.

N. 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 Members 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:

1. Continue providing covered services to all Members until midnight on the last day of the calendar month for which a capitation rate payment has been made by the Division;

2. Continue providing all covered services to all infants of female Members who have not been discharged from the hospital following birth, until each infant is discharged;

3. Continue providing covered services to any Members who are hospitalized on the termination date, until each Member is discharged;

4. Arrange for the transfer of patients and Medical Records to other appropriate Providers as directed by the Division;

5. Supply to the Division such information as it may request respecting any unpaid claims submitted by Out-of-network Providers and arrange for the payment of such claims within the time periods provided herein;

6. Take such action as may be necessary, or as 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

7. Provide for the maintenance of all records for audit and inspection by the Division or its Agents, CMS, the Office of the Inspector General, Comptroller General, 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.

SECTION 17 – FEDERAL, STATE, AND GENERAL REQUIREMENTS

The Contractor agrees that all work performed as part of this Contract will comply fully with administrative and other requirements established by federal and state laws, regulations and guidelines, and assumes responsibility for full compliance with all such laws, regulations and guidelines, and agrees to fully reimburse the Division for any loss of funds, resources, Overpayments, duplicate payments or incorrect payments resulting from noncompliance by the Contractor, its staff, or agents, as revealed in any audit.

A. HIPAA Compliance

The Contractor shall abide by the Administrative Simplification Provisions of the HIPAA 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.

B. Conflict of Interest

The Contractor shall comply with the conflict of interest safeguards described in 42 C.F.R. § 438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to Contract Officers, employees, or independent contractors.

In accordance with 1902(a)(4)(C) and 1932(d)(3) of the Social Security Act, the Contractor shall comply with conflict of interest safeguards with respect to officers, Contract Officers, employees, and independent contractors of the Division having responsibilities relating to this Contract. The Division shall comply with conflict of interest safeguards on the part of Division officers, employees, and agents who have responsibilities relating to this Contract or the enrollment processes specified in 42 C.F.R. § 438.54(b). Such safeguards shall be at least as effective as described in section 27 of the Federal Procurement Policy Act (41 U.S.C. § 423).

The Contractor shall have no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services

hereunder. The Contractor shall not employ any individual or entity having any such known interests, including subsidiaries or entities that could be misconstrued as having a joint relationship, and shall not employ immediate family members of Medicaid Providers. No public official of the State of Mississippi and no official or employee of the Division, Department of Health and Human Services (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, Division's Agent, or by DHHS, CMS or any agents of DHHS or CMS or is a public official of the State of Mississippi. In addition, such violation will be reported to the State Ethics Commission, Attorney General, and appropriate federal law enforcement officers for review. This Contract will be terminated by the Division if it is determined that a conflict of interest exists.

C. Offer of Gratuities

The Contractor certifies that no Member 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.

D. Contractor Status

1. Independent Contractor

   It is expressly agreed that the Contractor is an independent Contractor performing professional services for the Division and is not an officer or employee of the State of Mississippi or the Division. It is further expressly agreed that the Contract shall not be construed as a partnership or joint venture between the Contractor and the Division.

   The Contractor shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business. Should the Contractor default on these or other responsibilities jeopardizing the Contractor's ability to perform services effectively, the Division, in its sole discretion, may terminate this Contract.

   The Contractor shall not purport to bind the Division, its officers or employees nor the State of Mississippi to any obligation not expressly authorized herein unless the Division has expressly given the Contractor the authority to do so in writing.

   The Contractor shall give the Division immediate notice in writing of any action or

suit filed, or of any claim made by any party which might reasonably be expected to result in litigation related in any manner to this Contract or which may impact the Contractor's ability to perform.

No other agreements of any kind may be made by the Contractor with any other party for furnishing any information or data accumulated by the Contractor under this Contract or used in the operation of this program without the written approval of the Division. Specifically, the Division reserves the right to review any data released from reports, histories, or data files created pursuant to this Contract.

In no way shall the Contractor represent itself directly or by inference as a representative of the State of Mississippi or the Division of Medicaid except within the confines of its role as a Contractor for the Division of Medicaid. The Division's approval must be received in all instances in which the Contractor distributes publications, presents seminars or workshops, or performs any other outreach.

The Contractor shall not use the Division name or refer to the Contract, and the services provided therein, directly or indirectly in any advertisement, news release, professional trade or business presentation without prior written approval from the Division.

2. Employment of Division Employees

The Contractor shall not knowingly engage on a full-time, part-time, or other basis during the period of the Contract, any professional or technical personnel who are or have been at any time during the period of the Contract in the employ of the Division, without the written consent of the Division. Further, the Contractor shall not knowingly engage in this project, on a full-time, part-time, or other basis during the period of the Contract, any former employee of the Division who has not been separated from the Division for at least one (1) year, without the prior written consent of the Division.

The Contractor shall give priority consideration to hiring interested and qualified adversely affected State employees at such times as requested by the Division to the extent permitted by this Contract or applicable state laws, such as the Ethics in Government Act.

3. Personnel Practices

All employees of the Contractor involved in the Medicaid function will be paid as any other employee of the Contractor who works in another area of their organization in a similar position. The Contractor shall develop any and all methods to encourage longevity in Contractor's staff assigned to this Contract.

Employees of the Contractor shall receive all benefits afforded to other similarly situated employees of the Contractor.

4. Property Rights

   No property rights inure to the Contractor except for compensation for work that has already been performed.

E. Provider Exclusions

The Division will not reimburse the Contractor for services rendered by any Provider that is excluded or debarred from participation by Medicare, Medicaid, including any other states' Medicaid program, or CHIP, including any other states' or CHIP program, except for Emergency Services.

The Contractor must ensure that all their Providers and Subcontractor entities screen their employees for excluded persons. The Contractor must communicate this obligation to all Providers and Subcontractors upon credentialing and re-credentialing and upon renewal of any Subcontracts.

The Division will require the Contractor to search the following sources for names of any individual or entity upon Provider enrollment, re-enrollment, and at least monthly thereafter to capture exclusions and reinstatements: HHS-OIG's List of Excluded Individuals and Entities (LEIE), General Services Administration (GSA) Excluded Parties List Service (EPLS), CMS' Medicare Exclusion Databank (MED), the State Board of Examiners, and the System for Award Management (SAM). The process shall also include routine checks of the following databases: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB), and Health Integrity and Protection Databank (HIPDB). These searches must include any Providers, entities and individuals with ownership or control interests in any entity to ensure that the State does not pay Federal funds to excluded Providers or entities.

The Division may impose civil monetary penalties against the Contractor if they employ or enter into a contract with excluded individuals or entities to provide items or services to Medicaid beneficiaries.

F. Compliance with State and 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 C.F.R. Part 15), which prohibit the use under non-exempt federal contracts, grants, or loans of facilities included on the EPA list of Violating Facilities. The Contractor shall report violations to the applicable grantor federal agency and the U. S. EPA Assistant Administrator for Enforcement.

The Contractor and its Subcontractors shall abide by mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conversation

Contractor issued in compliance with the Energy Policy and Conservation Act (Pub. L.94-165).

The Contractor shall comply with all applicable Federal and State laws, regulations, policies, or reporting requirements needed to comply with the policies and regulations set forth in Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, as amended, the PPACA, and the Health Care and Education Reconciliation Act of 2010.

G. 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.

H. No Waiver

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

I. Severability

In the event that any provision of this Contract (including items incorporated by reference) is declared to be illegal, unlawful, void, 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 it shall not be affected by such declaration or finding, continue in full force and effect, and all remaining provisions shall be binding upon each party to this Contract and be fully performed. If the laws or regulations governing this Contract should be amended or judicially interpreted so as to render the fulfillment of this Contract impossible or economically infeasible, as determined jointly by 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.

J. Disputes

Any disputes regarding the terms and conditions of this Contract which cannot be disposed of by agreement between the parties shall be decided by the Executive Director, or their designee. Such decision shall be in writing and mailed or otherwise furnished to the Contractor. The decision of the Executive Director, or their designee, shall be final and conclusive, unless within ten (10) calendar days following the date of such decision the Contractor mails or otherwise furnishes a written Appeal to the Division's Executive Director.

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 Executive Director, or their designee, until a final decision is rendered by the Executive Director or his or her representative. This does not impair Contractor's right to any available judicial remedies upon exhaustion of internal dispute process as outlined in this section.

1. Cost of Litigation

   In the event that the Division deems it necessary to take legal action to enforce any provision of the contract, the Contractor shall bear the cost of such litigation, as assessed by the court, in which the Division prevails. Neither the State of Mississippi nor the Division shall bear any of the Contractor's cost of litigation for any legal actions initiated by the Contractor against the Division regarding the provisions of the Contract. Legal action shall include administrative proceedings.

2. Attorney Fees

   The Contractor agrees to pay reasonable attorney fees incurred by the State and the Division in enforcing this agreement or otherwise reasonably related thereto.

K. Proprietary Rights

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.

1. Ownership of Documents

   Where activities supported by this Contract produce original writing, sound recordings, pictorial reproductions, drawings, or other graphic representation and works of any similar nature, the Division shall have the right to use, duplicate, and disclose such materials in whole or in part, in any manner, for any purpose

whatsoever and to have others do so. If the material is qualified for copyright, the Contractor may copyright such material, with approval of the Division, but the Division shall reserve a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such materials, in whole or in part, and to authorize others to do so.

2. Ownership of Information and Data

The Division, the Department of Health and Human Services (DHHS), The Centers for Medicare and Medicaid Services (CMS), the State of Mississippi, and/or their agents shall have unlimited rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the Contractor under this Contract.

The Contractor agrees to grant in its own behalf and on behalf of its agents, employees, representatives, assignees, and Subcontractors to the Division, DHHS, CMS and the State of Mississippi and to their officers, agents, and employees acting in their official capacities a royalty-free, non-exclusive, and irrevocable license throughout the world to publish, reproduce, translate, deliver, and dispose of all such information now covered by copyright of the proposed Contractor.

Excluded from the foregoing provisions in this subsection, however, are any pre-existing, proprietary tools owned, developed, or otherwise obtained by Contractor independent of this Contract. Contractor is and shall remain the owner of all rights, title and interest in and to the Proprietary Tools, including all copyright, patent, trademark, trade secret and all other proprietary rights thereto arising under Federal and State law, and no license or other right to the Proprietary Tools is granted or otherwise implied. Any right that the Division may have with respect to the Proprietary Tools shall arise only pursuant to a separate written agreement between the parties.

3. Licenses, Patents and Royalties

The Division does not tolerate the possession or use of unlicensed copies of proprietary software. The Contractor shall be responsible for any liquidated damages or fines imposed as a result of unlicensed or otherwise defectively titled software.

The Contractor, without exception, shall indemnify, save, and hold harmless the Division and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or non-patented invention, process, or article manufactured by the Contractor. The Division will provide prompt written notification of a claim of copyright or patent infringement.

Further, if such a claim is made or is pending, the Contractor may, at its option and expense, procure for the Division the right to continue use of, replace or modify the article to render it non-infringing. If none of the alternatives are reasonably available,

the Contractor agrees to take back the article and refund the total amount the Division has paid the Contractor under this Contract for use of the article.

If the Contractor uses any design, device, or materials covered by letters, patent or copyright, it is mutually agreed and understood without exception that the proposed prices shall include all royalties or costs arising from the use of such design, device, or materials in any way involved in the work.

L. Omissions

In the event that either party discovers any material omission in the provisions in this contract which such party believes is essential to the successful performance of this Contract, both parties shall negotiate in good faith with respect to such matters for the purpose of making such adjustments as may be necessary to reasonably perform the objectives of this Contract, provided that such adjustments do not adversely affect the interests of either party.

M. Entire Agreement

This Contract, together with all attachments, represents the entire agreement between the Contractor and the Division with respect to the subject matter stated herein and supersedes all other contracts and agreements between the parties.

1. Change Orders and/or Amendments

   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.

   The Executive Director of the Division or designated representative may, at any time, by written order delivered to the Contractor at least thirty (30) calendar days prior to the commencement date of such change, make administrative changes within the general scope of the Contract. If any such change causes an increase or decrease in the cost of the performance of any part of the work under the Contract an adjustment commensurate with the costs of performance under this Contract shall be made in the Capitation Payment rate or delivery schedule or both. Any claim by the Contractor for equitable adjustment under this clause must be asserted in writing to the Division within thirty (30) calendar days from the date of receipt by the Contractor of the notification of change. Failure to agree to any adjustment shall be a dispute within the meaning of the Disputes clause of this Contract. Nothing in this clause, however, shall in any manner excuse the Contractor from proceeding diligently with the Contract as changed.

   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.

N. Compliance with Mississippi Employment Protection ACT (MEPA)

Contractor represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et seq. of the Miss. Code Ann. (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 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 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 understands and agrees that any breach of these warranties may subject Contractor 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 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 would also be liable for any additional costs incurred by the State due to contract cancellation or loss of license or permit.

O. Employment Practices

The Contractor shall not discriminate against any employee or applicant for employment because of race, color, religion, gender, national origin, age, marital status, political affiliations, disability, genetic information, or any other consideration made unlawful by federal, State or local laws. The Contractor must act affirmatively to ensure that employees, as well as applicants for employment, are treated without discrimination because of their race, color, religion, gender, national origin, age, marital status, political affiliation, genetic information, or disability.

Such action shall include, but is not limited to the following: employment, promotion, demotion or transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment notices setting forth the provisions of this clause.

The Contractor shall, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, gender, national origin, age, marital status, political affiliation, genetic information, or disability, except where it relates to a bona fide occupational qualification or requirement.

The Contractor shall comply with the non-discrimination clause contained in Federal Executive Order 11246, as amended by Federal Executive Order 11375, relative to Equal Employment Opportunity for all persons without regard to race, color, religion, sex, or national origin, and the implementing rules and regulations prescribed by the Secretary of Labor and with Title 41, Code of Federal Regulations, Chapter 60. The Contractor shall comply with related state laws and regulations, if any.

The Contractor shall comply with the Civil Rights Act of 1964, and any amendments thereto, and the rules and regulations thereunder, and Section 504 of Title V of the Rehabilitation Act of 1973, as amended, and the Mississippi Human Rights Act of 1977.

If the Division finds that the Contractor is not in compliance with any of these requirements at any time during the term of this Contract, the Division reserves the right to terminate this Contract or take such other steps as it deems appropriate, in its sole discretion, considering the interests and welfare of the State.

P. Lobbying

The Contractor certifies, to the best of its knowledge and belief, that no federal appropriated funds have been paid or will be paid, by or on behalf of the Contractor to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Contractor shall complete and submit “Disclosure Form to Report Lobbying,” in accordance with its instructions.

This certification is a material representation of fact upon which reliance is placed when entering into this Contract. Submission of this certification is a prerequisite for making or entering into this Contract imposed under Title 31, Section 1352, and U. S. Code. Failure to file the required certification shall be subject to civil penalties for such failure.

The Contractor shall abide by lobbying laws of the State of Mississippi.

Q. Bribes, Gratuities and Kickbacks

The receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.

No elected or appointed officer or other employee of the Federal Government or of the State of Mississippi shall benefit financially or materially from this Contract. No individual employed by the State of Mississippi shall be permitted any share or part of this Contract or any benefit that might arise therefrom.

The Contractor represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

R. Transparency

In accordance with the Mississippi Accountability and Transparency Act of 2008, Section 27-104-151, et seq., of the Mississippi Code of 1972, as amended, the American Accountability and Transparency Act of 2009 (P.L. 111-5), where applicable, and Section 31-7-13 of the Mississippi Code of 1972, as amended, where applicable, a fully executed copy of this agreement shall be posted to the State's accountability website at: https://www.transparency.mississippi.gov.

Unless exempted from disclosure due to a court-issued protective order, this Contract is required to be posted to the Department of Finance and Administration's independent agency contract website for public access. Prior to posting the Contract to the website, any information identified by the Contractor as trade secrets, or other proprietary information including confidential vendor information, or any other information which is required confidential by state or federal law or outside the applicable freedom of information statutes will be redacted.

In the event that either party to this agreement receives notice that a third party requests divulgence of confidential or otherwise protected information and/or has served upon it a subpoena or other validly issued administrative or judicial process ordering divulgence of confidential or otherwise protected information, that party shall promptly inform the other party and thereafter respond in conformity with such subpoena to the extent mandated by State law. This provision shall survive termination or completion of this agreement. The parties agree that this provision is subject to and superseded by Miss. Code Ann. § 25-61-1, et seq. regarding Public Access to Public Records.

SECTION 18 – CLAIMS MANAGEMENT

A. Claims Payment

The Contractor will be responsible for processing claims. In accordance with 42 C.F.R. § 447.46, the Contractor must pay at least ninety percent (90%) of all Clean Claims (as defined by Miss. Code Ann. § 83-9-5) for covered services, within thirty (30) calendar days of receipt and pay at least ninety-nine percent (99%) of all Clean Claims within ninety (90) calendar days of receipt, except to the extent an alternative payment schedule has been agreed to in the Contract. For other claims, the Contractor shall notify the Provider of the status (e.g., pend, deny, or other reason) of the claim and if applicable, the reason the claim cannot be paid within thirty (30) calendar days of the adjudication of the claim. The Contractor must pay all other claims, except those from Providers under investigation for Fraud and Abuse, within twelve (12) months of the date of receipt.

Claims pending or suspended for additional information must be processed (paid or denied) by the thirtieth (30th) calendar day following the receipt of information requested, otherwise the Contractor must close (pay or deny) any other suspended claim if all requested information is not received prior to the expiration of the thirty (30) calendar day period. The Contractor shall send Providers written notice for each claim that is denied, including the reason(s) for the denial. The Contractor shall respond to provider inquiries promptly and resolve provider claims within a thirty (30) calendar day period for incorrectly paid or incorrectly denied claims. The determination that a pattern of inappropriate denials or delays of provider payments exists is at the sole discretion of the Division. Failure to resolve the issue through the Corrective Action Plan may result in liquidated damages or imposition of other available remedies in accordance with Section 16 E, Liquidated Damages.

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 Out-of-network Provider.

The Contractor shall submit to the Division for review and approval fifteen (15) calendar days prior to use its criteria for authorization or denial of payment for services rendered by Out-of-network Providers. The Division shall review all such criteria for conformity with the Division's Policy for Claims Payment and must approve the criteria prior to implementation by the Contractor. The Contractor shall distribute its criteria for approval or denial of out-of-network services to all Out-of-network Providers to whom Members 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 of the Member's residence. 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 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.

B. Claims Processing and Information Retrieval Systems

The Contractor's claims processing system must have the capability to process Claims consistent with timeliness and accuracy requirements identified in this Contract. Any updates to the Contractor's claim system must be completed within a timeframe mutually agreed upon by the Contractor and the Division. The Contractor shall implement all subsequent updates using the same effective dates as the Division.

The Contractors' claims processing and information retrieval systems must be in compliance with all components of 42 C.F.R. § 433.116.

The Contractor's information retrieval system must have the capability to accept claims history data from the Division or its Agent.

C. Inpatient Claims

The Contractor shall follow all the Division's guidelines for payment of inpatient hospital services for all enrolled MississippiCAN Medicaid Members using the same mapper and grouper version, health care-acquired condition (HCAC) utility, Never Events and all inpatient payment parameters as are used by the Division for other Medicaid beneficiaries. The Contractor shall implement all subsequent updates using the same effective dates as the Division.

The Contractor shall submit to the Division reports related to hospital claims activity in the Division required format.

For the purposes of the contractual requirements between Contractor and the Division, these beneficiaries will be handled as follows:

1. For those beneficiaries who were covered by MississippiCAN (for other than inpatient services) prior to November 20, 2015 (the monthly enlistment date) and who were an inpatient in an acute care hospital at midnight of November 30, 2015; the Division will pay the acute care hospital the full APR-DRG reimbursement for the hospital admission. The Division will then pro-rate the portion of the APR-DRG payment that is beyond December 1, 2015, based on the length of stay of the admission, and invoice that portion of the APR-DRG payment to Contractor. The capitation payment for these beneficiaries for the month of December shall remain as previously paid in full.

2. For those beneficiaries who were NOT covered by MississippiCAN prior to November 20, 2015 (the monthly enlistment date) and for whom the Contractor received a capitation payment for the month of December 2015, and who were

inpatient in an acute care hospital at midnight of November 30, 2015; the Division will pay the acute care hospital the full APR-DRG reimbursement for the hospital admission. The Division will then recoup from Contractor the full amount of the capitation payment previously paid to Contractor for the month of December and these beneficiaries will revert to FFS as of December 1, 2015.

3. Following the month of November 2015, for those beneficiaries, except newborns, who were covered by MississippiCAN (for other than inpatient services) prior to the 20th of the month, (the monthly enlistment date) and who were an inpatient in an acute care hospital at midnight of the last day of the month; the Division will pay the acute care hospital the full APR-DRG reimbursement for the hospital admission. The Division will then pro-rate the portion of the APR-DRG payment that is beyond the first day of the following month, based on the length of stay of the admission, and invoice that portion of the APR-DRG payment to Contractor. The capitation payment for these beneficiaries for the months of the stay shall remain as previously paid in full.

4. Effective December 1, 2015, newborns will be covered by the Contractor for all services from their date of birth. Therefore, the APR-DRG reimbursement to the acute inpatient hospital for newborns shall be paid by the Contractor for all months beginning December 1, 2015. The Capitation Payments for a newborn's initial month(s) will be paid to include the month of delivery and the following month(s) once enrollment and MississippiCAN lock-in are accomplished by the Division and trigger the capitation payments.

5. Following the month of November 2015, for those beneficiaries who were NOT covered by MississippiCAN prior to the 20th of the month, (the monthly enlistment date) and for whom the Contractor received a capitation payment for the following month, and who were an inpatient in an acute care hospital at midnight of the last day of the month; the Division will pay the acute care hospital the full APR-DRG reimbursement for the hospital admission. The Division will then recoup from Contractor the full amount of the capitation payment previously paid to Contractor for the following month and these beneficiaries will revert to FFS as of that month.

6. If a Member opts out or otherwise loses MississippiCAN Enrollment, but is in a hospital stay on the last day of MississippiCAN coverage and the stay continues into the next month, the Contractor will be responsible for payment of the inpatient hospital claim for the entire stay based on The Division's guidelines. The Contractor will then pro-rate the portion of the APR-DRG payment, based on the length of stay of the admission, and request payment of that portion of the APR-DRG payment from the Division. However, if the person is no longer eligible for Mississippi Medicaid inpatient hospital benefits, the payment for inpatient hospital services beyond the end of Medicaid eligibility is not required.

7. All calculations for prorated payments will be made according to the Division's guidelines and will be shared between the Contractor and the Division.

SECTION 19 – CMS

A. <u>Review and Approval</u>

This Contract 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 Contract may be enacted pursuant to the provisions described in the RFP and this Contract.

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:_____
DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

DATE: _____

CONTRACTOR

BY: _____

DATE: _____

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, DAVID J. DZIELAK, 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 Amendment 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., 2017.

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 Amendment 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., 2017.

NOTARY PUBLIC

My Commission Expires:

EXHIBIT A: CAPITATION RATES

(Attached under a separate cover)

EXHIBIT B: EXTERNAL QUALITY REVIEW

External Quality Review (EQR) is a requirement under Title XIX of the Social Security Act, Section 1932(c)(2) for states to obtain an independent, external review body to perform an annual review of the quality of services furnished under state contracts with managed care organizations, including, but not limited to, the evaluation of quality outcomes, timeliness, network adequacy and access to services. The requirements for EQR are further outlined in 42 C.F.R. Parts 433 and 438: External Quality Review of Medicaid Managed Care Organizations. EQR refers to the analysis and evaluation of aggregated information on timeliness, access, and quality of health care services furnished to Members. The EQR will consist of the mandatory activities, and may include the optional activities, described in 42 C.F.R. § 438.358.

The results of the EQR are made available, upon request, to interested parties such as participating health care providers, Members and potential Members of the Contractor, beneficiary advocacy groups, and members of the general public. This is one of many tools that facilitate achieving continuous quality improvement in the delivery of care, health care outcomes, and timeliness of care, access to services, quality and utilization management systems, and program oversight. The Division requires that the Contractor:

1. Actively participate in planning and developing the measures to be utilized with the Division and the EQRO. The Contractor's Quality Leadership Team will be given an opportunity to provide input into the measures to be utilized.

2. Accurately, completely and within the required time frame identify eligible Members and network providers to the EQRO.

3. Ensure the appropriate technical specifications (HEDIS and the Division) are used for the calculation of each performance measure.

4. Correctly identify and report the numerator and denominator for each measure.

5. Actively encourage and require Providers, including Subcontractors, to provide complete and accurate Provider Medical Records within the time frame specified by the EQRO.

6. Demonstrate how the results of the EQR are incorporated into the Contractor's overall Quality Management Program and demonstrate progressive improvements during the term of the Contract.

7. Implement a process to ensure that all deficiencies identified during the EQR are addressed and corrections made.

8. Develop a monitoring strategy for assessing the quality of encounter data.

9. Provide information to the EQRO as requested to fulfill the requirements of the mandatory and optional activities required in 42 C.F.R. Parts 433 and 438.

10. Ensure that data, clinical records and workspace located at the Contractor's work site are available to the independent review team and to the Division, upon request.

EXHIBIT C: MEDICAL LOSS RATIO (MLR) REQUIREMENTS

The Contractor is required to rebate a portion of the Capitation Payment to the Division in the event the Contractor does not meet the eighty-five percent (85%) minimum MLR standard. This Exhibit describes requirements for 1) reporting MLR, 2) methodology for calculation of MLR, 3) record retention 4) payment of any rebate due to the Division, and 5) liquidated damages that may be assessed against the Contractor for failure to meet requirements.

A. Reporting Requirements

1. General Requirements

   For each MLR Reporting Quarter and Year, the Contractor must submit to the Division a report which complies with the requirements that follow concerning Capitation Payments received and expenses related to MississippiCAN Members (referred to hereafter as MLR Report).

2. Timing and Form of Report

   The report for each MLR Reporting Year must be submitted to the Division by April 1 of the year following the end of an MLR Reporting Year, in a format and in the manner prescribed by the Division.

   The report for each MLR Reporting Quarter must be submitted to the Division by the sixtieth (60th) calendar day following the end of the MLR Reporting Quarter, in a format and in the manner prescribed by the Division.

3. Capitation Payments

   A Contractor must report to the Division the total Capitation Payments received from the Division for each MLR Reporting Year. Total Capitation Payments means all monies paid by the Division to the Contractor for providing benefits and services as defined in the terms of the Contract.

4. Additional Reporting

   During each MLR Reporting Year, Contractor must submit the following additional reports to the Division in a manner that meets the definition of 42 C.F.R. § 438.8 (k) at the time of the submission of the Annual MLR Report:

   a. Total incurred claims

   b. Expenditures on quality improving activities

   c. Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1) through (5), (7), (8) and (b)

d. Non-claims costs

e. Premium revenue

f. Taxes, licensing and regulatory fees

g. Methodology(ies) for allocation of expenditures

h. Any credibility adjustment applied

i. Supporting schedules/documentation for any adjustments made to items a-h.

j. Reconciling supplemental schedule(s) supporting the amounts claimed for all third parties (including related parties) and/or sub-capitated vendors included in amounts reported on the MLR Report for items a-i. Obtained in accordance with the requirements of 42 C.F.R. § 438.8(k)(3)

k. The Calculated MLR

l. Any remittance owed to the State

m. A comparison of the information reported in the MLR Report to the Audited Financial Statement

n. A description of the aggregation method used

o. The number of Member Months

5. Attestation

Contractor must attest to the accuracy of the calculation of the MLR in accordance with the requirements of 42 C.F.R. § 438.8(n) when submitting reports required under this section.

6. Recalculation of MLR

In any instance where the State makes a retroactive change to the Capitation Payments for a MLR Reporting Year where the MLR Report has already been submitted to the State, Contractor must re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR Report meeting the requirements of this section. Refer to 42 C.F.R. § 438.8(m)

B. Reimbursement for Clinical Services Provided to Members

The MLR Report must include direct claims paid to or received by Providers (including under capitated contracts with Network Providers), whose services are covered by the Subcontract for clinical services or supplies covered by the Division's Contract with the Contractor. Reimbursement for clinical services as defined in this section is referred to as "incurred claims."

1. Specific requirements include:

    a. Unpaid claims liabilities for the MLR Reporting Year, including claims reported that are in the process of being adjusted or claims incurred but not reported;

    b. Withholds from payments made to network providers;

    c. Claims that are recoverable for anticipated coordination of benefits;

    d. Claims payments recoveries received as a result of subrogation;

    e. Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity;

    f. Changes in other claims-related reserves; and

    g. Reserves for contingent benefits and the medical claim portion of lawsuits.

2. Amounts that must be deducted from incurred claims include:

    a. Overpayment recoveries received from Network Providers;

    b. Prescription drug rebates received and accrued;

3. Expenditures that must be included in incurred claims include:

    a. The amount of incentive and bonus payments made, or expected to be made, to Network Providers;

    b. The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include activities specified in paragraph 42 C.F.R. § 438.8(e)(4);

4. Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

5. Amounts that must be excluded from incurred claims:

    a. Non-claims Costs, as defined in this Contract, which include amounts paid to third party vendors for secondary network savings; amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management; amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in 42 C.F.R. § 438.3(e) and provided to a Member; and fines and penalties assessed by regulatory authorities.

    b. Amounts paid to the State as remittance under 42 C.F.R. § 438.8(j).

    c. Amounts paid to network providers under 42 C.F.R. § 438.6(d).

C. <u>Activities that Improve Health Care Quality</u>

1. General Requirements

    The MLR Report may include expenditures for activities that improve health care quality, as described in this section. The expenditures must meet the following requirements:

    a. An activity that meets the requirements of 45 C.F.R. § 158.150(b) and is not excluded under 45 C.F.R. § 158.150(c).

    b. An activity related to any EQR-related activity as described in 42 C.F.R. § 438.358(b) and (c).

    c. Any expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 C.F.R. § 158.151, and is not considered incurred claims.

2. Activity Requirements

    Activities conducted by the Contractor to improve quality must meet the following requirements:

    a. The activity must be designed to:

        i. Improve health quality;

        ii. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;

iii. Be directed toward individual Members or incurred for the benefit of specified segments of Members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-Members;

iv. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations;

v. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations. Examples include the direct interaction of the Contractor (including those services delegated by Subcontract for which the Contractor retains ultimate responsibility under the terms of the Contract with the Division) with Providers and the Member or the Member's representative (for example, face-to-face, telephonic, web- based interactions or other means of communication) to improve health outcomes, including activities such as:

(a) Effective Care Management, Care Coordination, chronic disease management, and medication and care compliance initiatives including through the use of the Medical Homes model as defined in the section 3502 of PPACA;

(b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine;

(c) Quality reporting and documentation of care in non-electronic format;

(d) Health information technology to support these activities;

vi. Accreditation fees directly related to quality of care activities;

vii. Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA),42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

viii. Prevent hospital readmissions through a comprehensive program for

hospital discharge. Examples include:

(a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(b) Patient-centered education and counseling;

(c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional;

(d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and,

(e) Health information technology to support these activities.

ix. Improve patient safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(a) The appropriate identification and use of best clinical practices to avoid harm;

(b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns;

(c) Activities to lower the risk of facility-acquired infections;

(d) Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions;

(e) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and

(f) Health information technology to support these activities.

x. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health include, but are not limited to:

(a) Wellness assessments;

(b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(d) Public health education campaigns that are performed in conjunction with State or local health departments;

(e) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS (Public Health Service) Act

(f) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(g) Coaching or education programs and health promotion activities designed to change Member behavior and conditions (for example, smoking or obesity); and,

(h) Health information technology to support these activities.

xi. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 C.F.R. § 158.151.

3. Exclusions

Expenditures and activities that must not be included in quality improving activities are:

a. Those that are designed primarily to control or contain costs;

b. The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

c. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from

premium revenue;

d. Those activities that can be billed or allocated by a Provider for care delivery and which are, therefore, reimbursed as clinical services;

e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended;

f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

g. All retrospective and concurrent utilization review;

h. Fraud prevention activities;

i. The cost of developing and executing Provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason;

j. Provider credentialing;

k. Marketing expenses;

l. Costs associated with calculating and administering individual Member or employee incentives;

m. That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

n. Any function or activity not expressly included in paragraph one (1) or two (2) of this section, unless otherwise approved by and within the discretion of the Division, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement.

D. <u>Activities Related to External Quality Review</u>

1. General rule. The State, its agent that is not a Contractor or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities in this section.

2. Mandatory activities. For each Contractor and PIHP, the EQR must use information from the following activities:

a. Validation of performance improvement projects required by the State to comply with requirements set forth in § 438.240(b)(1) and that were underway during the preceding 12 months.

b. Validation of Contractor or PIHP performance measures reported (as required by the State) or Contractor or PIHP performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in § 438.240(b)(2).

c. A review, conducted within the previous 3-year period, to determine the Contractor's or PIHP's compliance with standards (except with respect to standards under § 438.240(b)(1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of § 438.204(g).

3. Optional activities. The EQR may also use information derived during the preceding 12 months from the following optional activities:

a. Validation of Member Encounter Data reported by a Contractor or PIHP.

b. Administration or validation of consumer or provider surveys of quality of care.

c. Calculation of performance measures in addition to those reported by a Contractor or PIHP and validated by an EQRO.

d. Conduct of performance improvement projects in addition to those conducted by a Contractor or PIHP and validated by an EQRO.

e. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

4. Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of Contractors or PIHPs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

E. Expenditures Related to Health Information Technology and Meaningful Use Requirements

1. General Requirements

Contractor may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in 45 C.F.R. § 158.150 and that are designed for use by the Contractor, health care Providers, or Members for the electronic creation, maintenance, access, or

exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

a. Making incentive payments to health care Providers for the adoption of certified electronic health record technologies and their ``meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services; as defined in 45 C.F.R. § 158.140

b. Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care Providers, including those not eligible for Medicare and Medicaid incentive payments;

c. Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

d. Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures) and costs for public reporting mandated or encouraged by law

e. Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

f. Advancing the ability of Members, Providers, the Contractor or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic health records accessible by Members and appropriate Providers to monitor and document an individual patient's medical history and to support Care Management;

g. Reformatting, transmitting or reporting data to national or international government-based health organizations, as may be required by the Division, for the purposes of identifying or treating specific conditions or controlling the spread of disease; and,

h. Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

F. Non-Claims Costs

1. General Requirements

   The MLR Report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims (as defined in section B), expenditures for activities that improve health care quality (as defined in section C) or licensing and regulatory fees or Federal and State taxes (as defined in section L).

2. Non-Claims Costs Other

   The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation payments for clinical services to Members, or expenditures on quality improvement activities as defined above. Expenses for administrative services include the following:

   a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity;

   b. Loss adjustment expenses not classified as a cost containment expense;

   c. Workforce salaries and benefits;

   d. General and administrative expenses; and

   e. Community benefit expenditures.

   Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue based assessments.

Expenses for administrative services may include amounts that exceed a third party's costs (profit margin), but these amounts must be justified and consistent with prudent management and fiscal soundness requirements to be includable when these transactions are between related parties. Refer to Medicare Final Rule 42 C.F.R. § 422.516(b).

G. Mississippi Hospital Access Program

The MLR Report must exclude all MHAP payments from both year-to-date medical and administrative expenses and Capitation Payments.

H. Allocation of Expenses

1. General Requirements

   Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the

remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

I. Description of the Methods Used to Allocate Expenses

1. General Requirements

The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from Contractor activities in Mississippi. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

a. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses;

b. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense; and,

c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, Capitation Payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

J. Third Party Subcontractors

Third party Subcontractors or vendors providing claims adjudication activity services to enrollees are required to supply all underlying data to the Contractor within 180 days of the end of the MLR reporting period or within 30 days of such data being requested by the Contractor in accordance with the requirements of 42 C.F.R. § 438.8(k)(3). The Contractor should validate the cost allocation reported by third parties to ensure the MLR accurately

reflects the breakdown of amounts paid to the vendor between incurred claims, activities to improve health care quality, and non-claims cost.

1. Sub-Capitated Vendors

   The Contractor must report to the Division the total expenses incurred by the third party vendor for clinical services provided to members, activities that Improve Health Care Quality, activities related to external Quality review, expenditures related to Health Information Technology and Meaningful Use Requirements, and non-claims cost incurred by the sub-capitated vendors. The sub-capitated payments should be adjusted to reflect the aforementioned expenses to the third party. When the sub-capitation payments to the third party vendor exceed third party vendor's actual costs, the excess (profit margin), should be considered administrative non-claim costs from non-related vendors. When these transactions occur between related parties, there must be justification that these higher costs are consistent with prudent management and fiscal soundness policies to be included as allowable administrative non-claim costs. Refer to Medicare Final Rule 42 C.F.R. § 422.516(b)

2. Management Fee Arrangement

   The Contractor is encouraged to report to the Division the total expenses incurred by the management organization for the plan. These costs should be adjusted for any non-allowable activities. In the absence of specific State guidance, the Contractor should refer to other Federal regulations concerning the identification of non-allowable costs.

K. Maintenance of Records

The Contractor must maintain and retain, and require Subcontractors to retain, as applicable, for a period of no less than ten (10) years, in accordance with 42 C.F.R. § 438.3(u), and make available to the Division upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under this Exhibit C were accurately implemented in preparing the MLR Report.

L. Formula for Calculating Medical Loss Ratio

1. Medical Loss Ratio

   a. Contractor's MLR is the ratio of the numerator and the denominator, as defined:

      i. The numerator of the Contractor's MLR for an MLR Reporting Year must equal: (1) the Contractor's incurred claims, plus (2) the Contractor's expenditures for activities that improve health care quality, plus (3) the Contractor's expenditures for fraud reduction

activities (as discussed in subsection d below).

ii. The denominator of the Contractor's MLR for an MLR Reporting Year must equal the Contractor's Adjusted Premium Revenue. The Adjusted Premium Revenue is Premium Revenue minus the Contractor's Federal, State, and local taxes, licensing and regulatory fees (as defined in subsection c of this Section) and is aggregated in accordance with subsection f below.

b. A Contractor's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

c. Federal, State, and local taxes and licensing and regulatory fees. Taxes, licensing and regulatory fees for the MLR Reporting Year include:

i. Statutory assessments to defray the operating expenses of any State or Federal department.

ii. Examination fees in lieu of premium taxes as specified by State law.

iii. Federal taxes and assessments allocated to Contractor, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

iv. State and local taxes and assessments including:

(a) Any industry wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

(b) Guaranty fund assessments.

(c) Assessments of state or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by states.

(d) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(e) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

v. Payments made by Contractor that are otherwise exempt from

Federal income taxes, for community benefit expenditures as defined in 45 C.F.R. § 158.162(c), limited to the highest of either:

(a) Three percent (3%) of earned premium; or

(b) The highest premium tax rate in the State for which the report is being submitted, multiplied by Contractors earned premium in the State.

d. Fraud Prevention Activities: The Contractor's expenditures on activities related to fraud prevention as adopted for the private market at 45 C.F.R. part 158. Such expenditures must not include expenses for fraud reduction efforts associated with "incurred claims" wherein the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses.

e. Credibility Adjustment: The Contractor may add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is Partially Credible. The Credibility Adjustment is added to the reported MLR calculation before calculating any remittance due. The Contractor may not add a Credibility Adjustment to a calculated MLR if the MLR Reporting Year experience is fully credible.

f. Aggregation of Data: Contractor will aggregate data for all Medicaid eligibility groups covered under the Contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

2. Rebating Capitation Payments if the eighty-five percent (85%) Medical Loss Ratio Standard is Not Met

a. General Requirement

For each MLR Reporting Year, the Contractor must provide a rebate to the Division if the Contractor's MLR does not meet or exceed the eighty-five percent (85%) minimum requirement.

b. Amount of Rebate

For each MLR Reporting Year, the Contractor must rebate to the Division the difference between the total amount of Adjusted Premium Revenue received by the Contractor from the Division multiplied by the required minimum MLR of eighty-five percent (85%) and the Contractor's actual MLR.

c. Timing of Rebate

The Contractor must provide any rebate owing to the Division no later than the tenth (10th) business day of May following the year after the MLR Reporting Year.

d. Late Payment Interest

If Contractor that fails to pay any rebate owing to the Division in accordance within the time periods set forth in this Exhibit, then, in addition to providing the required rebate to the Division, Contractor must pay the Division interest at the current Federal Reserve Board lending rate or ten percent (10%) annually, whichever is higher, on the total amount of the rebate, accruing from May 1.

EXHIBIT D: MEMBER COMPLAINT, GRIEVANCE, APPEAL, AND STATE FAIR HEARING PROCESS

The Contractor's Member Complaint, Grievance, and Appeal procedures shall meet the following requirements:

1. Resolving Complaint, Grievances, and Appeals expeditiously by Contractor personnel at a decision-making level with authority to require corrective action.

2. Providing for separate tracks for administrative and utilization management Complaints, Grievances, and Appeals.

3. Describing procedures for the submission and resolution of a Complaint, Grievance, or Appeal and request for a State Fair Hearing.

4. Maintaining written documentation of each Complaint, Grievance, Appeal, and the actions taken by the Contractor.

5. Distributing a written description and educating Network Providers of the Contractor's Complaint, Grievance, and Appeal process and how Providers can submit a Grievance or Appeal for a Member, or on their own behalf.

6. Making available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

7. Designating a specific individual as the Contractor's Medicaid Member Complaints, Grievances, and Appeals coordinator with the authority to administer the policies and procedures for resolution of a Complaint, Grievance, or Appeal, to review patterns/trends in Complaints, Grievances, and Appeals, and to initiate corrective action.

8. Ensuring that the individuals who make decisions on Complaint, Grievances, or Appeals are not involved in any previous level of review or decision-making. The Contractor shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

    a. An Appeal of an Adverse Benefit Determination that is based on lack of medical necessity;

    b. An Adverse Benefit Determination that is upheld in an Expedited Resolution; and

    c. Complaint, Grievance, or Appeal that involves clinical issues.

9. Ensuring that punitive or retaliatory action is not taken against a Member or service

Provider that files a Complaint, Grievance, or an Appeal, or a Provider that supports a Member's Complaint, Grievance, or Appeal.

10. Ensuring that there is a link between the Complaint, Grievance, and Appeal processes and the Quality Management and Utilization Management programs.

11. Designating and training sufficient staff to be responsible for receiving, processing, and responding to Complaints, Grievances, and Appeals in accordance with the requirements in this Exhibit and Contract.

The following parties have a right to file a Complaint, Grievance, and Appeal on behalf of the
Member:

1. The legal guardian of the Member for a minor or an incapacitated adult,

2. A representative of the Member as designated in writing to the Contractor, or

3. A service Provider acting on behalf of the Member and with the Member's written consent.

All notices sent to Members must comply with 42 C.F.R. § 438.404(a).

Notices indicating the resolution of Grievances must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding.

Notices indicating the resolution of Appeals must be in writing and must meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding. The notice must explain the following:

1. Adverse Benefit Determination the Contractor has taken or intends to take (e.g., resolution of the Grievance or Appeal).

2. Reasons for the Adverse Benefit Determination (e.g., findings and conclusions based on the investigation, all information considered in investigating the Grievance or Appeal).

3. Member's right to request a State Fair Hearing.

4. Procedures for exercising State Fair Hearing rights.

5. Member's right to have benefits continue pending resolution of the State Fair Hearing, how to request that benefits be continued, and circumstances under which the Member may be required to pay the costs of these services.

A. Complaint: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Complaint", received by any employee of the Contractor orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt. Any Complaint not resolved within one (1) calendar day shall be treated as a Grievance. A Complaint includes, but is not limited to, inquiries, matters, misunderstandings, or misinformation that can be promptly resolved by clearing up the misunderstanding, or providing accurate information.

A Member or Authorized Representative may file a Complaint either orally or in writing with the Contractor within thirty (30) calendar days of the date of the event causing the dissatisfaction.

The Contractor shall have procedures for receiving, responding to, and documenting resolution of Member Complaints within one (1) calendar day of receipt do not require a formal written response or notification.

The Contractor shall contact the Member within twenty-four (24) hours of the initial contact via telephone if the Contractor is unavailable for any reason or the matter cannot be readily resolved during the initial contact. Any Complaint that is not resolved within one (1) calendar day shall be treated as a Grievance, in accordance with requirements set forth below.

B. Grievance: An expression of dissatisfaction, regardless of whether identified by the Provider as a "Grievance", received by any employee of the Contractor orally or in writing about any matter or aspect of the Contractor or its operation, other than a Contractor Adverse Benefit Determination as defined in this Contract. A Grievance includes, but is not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness or a Provider or an employee, or failure to respect the Members rights.

A Member or Authorized Representative may file a Grievance either orally or in writing with the Contractor at any time after the event causing the dissatisfaction.

Within five (5) calendar business days of receipt of the Grievance, the Contractor shall provide the grievant with written notice that the Grievance has been received and the expected date of its resolution. For telephonic Grievances received, the Contractor may provide grievant with verbal notice of expected date of resolution. If requested by the Member or his/her representative, a written resolution will be provided.

The investigation and final Contractor resolution process for Grievances shall be completed within thirty (30) calendar days of the date the Grievance is received by the Contractor, or as expeditiously as the Member's health condition requires, and shall include a resolution letter to the grievant.

The Contractor may extend by of up to fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member,

the Contractor shall give the Member written notice of the reason for the extension within two (2) calendar days of the decision to extend the time frame.

Upon resolution of the Grievance, the Contractor shall mail a resolution letter to the Member. This resolution letter may not take the place of the acknowledgment letter referred above, unless the resolution of the Grievance has been completed and can be communicated to the Member in the same correspondence acknowledging receipt of the Grievance.

C. Appeal: A request for review by the Contractor of an Adverse Benefit Determination.

A Member or Authorized Representative may file an Appeal either orally or in writing of an Adverse Benefit Determination within sixty (60) calendar days of receiving the Contractor's notice of Adverse Benefit Determination. The Contractor shall consider the Member, Authorized Representative, or estate representative of a deceased Member as parties to the Appeal.

The Contractor has thirty (30) calendar days from the date the initial verbal or written Appeal is received by the Contractor to resolve the Appeal, or as expeditiously as the Member's health condition requires. The Contractor shall appoint at least one (1) person to review the Appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision. Within this same thirty (30) calendar day time frame, the Contractor shall provide written notice to the Member and/or Provider, if the Provider filed the Appeal.

Within ten (10) calendar days of receipt of the Appeal, the Contractor shall provide the grievant with written notice that the Appeal has been received and the expected date of its resolution. The Contractor shall confirm in writing receipt of verbal Appeals, unless the Member or the service Provider requests an Expedited Resolution.

The Contractor shall have a process in place that ensures that a verbal or written inquiry from a Member seeking to Appeal an Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal). A verbal Appeal shall be followed by a written Appeal that is signed by the Member within thirty (30) calendar days of the filing date. The Contractor shall use its best efforts to assist Members as needed with the written Appeal and may continue to process the Appeal.

The Contractor may extend the thirty (30) calendar day time frame by fourteen (14) calendar days if the Member requests the extension, or the Contractor determines that there is need for additional information, and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the extension and the reason for the extension within two (2) calendar days of the decision to extend the time frame.

The Contractor shall provide the Member or the Member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

The Contractor shall provide the Member or the representative the opportunity, before and during the Appeals process, to examine the Member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the Appeals process. The Contractor shall include as parties to the Appeal the Member and his or her representative, or the legal representative of a deceased Member's estate.

The Contractor shall continue the Member's benefits if all of the following are met:

1. Member files a timely Appeal of an Adverse Benefit Determination. Timely filing means filing for continuation of benefits on or before the later of ten (10) calendar days from the Contractor sending the Notice of Adverse Benefit Determination or the intended effective date of the Contractor's proposed Adverse Benefit Determination;

2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized service Provider;

4. The time period covered by the original authorization has not expired; and

5. Member requests extension of the benefits.

The Contractor shall provide benefits until one of the following occurs:

1. The Member withdraws the Appeal;

2. Ten (10) calendar days have passed since the date of the notice, provided the resolution of the Appeal was against the Member and the Member has not requested a State Fair Hearing or taken any further action;

3. The Division of Medicaid issues a State Fair Hearing decision adverse to the Member; and

4. The time period or service limits of a previously authorized service has expired.

If the final resolution of the Appeal is adverse to the Member, that is, the Adverse Benefit Determination is upheld, the Contractor may recover the cost of the services furnished to the Member while the Appeal was pending, to the extent that services were furnished solely because of the requirements of this section and in accordance with the policy in 42 C.F.R. § 431.230(b).

If the Contractor or the Division reverses a decision to deny, limit, or delay services, and these services were not furnished while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it receives notice reversing

the determination. If the Contractor or the Division of Medicaid reverses a decision to deny, limit or delay services and the Member received the disputed services while the Appeal was pending, the Contractor shall pay for these services.

D. Expedited Resolution of Appeals:

An expedited review by the Contractor of an Adverse Benefit Determination.

The Contractor shall establish and maintain an expedited review process for Appeals when the Contractor determines that allowing the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. Such a determination is based on:

1. A request from the Member;
2. A Provider's support of the Member's request;
3. A Provider's request on behalf of the Member; or
4. The Contractor's independent determination.

The Contractor shall ensure that the expedited review process is convenient and efficient for the Member.

The Contractor shall resolve the Appeal within seventy-two (72) hours of receipt of the request for an expedited Appeal. In addition to written resolution notice, the Contractor shall also make reasonable efforts to provide and document verbal notice.

The Contractor may extend the time frame by up to fourteen (14) calendar days if the Member requests the extension, or the Contractor demonstrates to the Division that there is need for additional information and the extension is in the Member's interest. For any extension not requested by the Member, the Contractor shall give the Member written notice of the reason for the delay.

The Contractor shall ensure that punitive action is not taken against a Member or a service Provider who requests an Expedited Resolution or supports a Member's expedited Appeal.
The Contractor shall provide an Expedited Resolution, if the request meets the definition of an expedited Appeal, in response to a verbal or written request from the Member or service Provider on behalf of the Member.

The Contractor shall inform the Member of the limited time available to present evidence and allegations in fact or law.

If the Contractor denies a request for an Expedited Resolution of an Appeal, it shall:

1. Transfer the Appeal to the thirty (30) calendar day time frame for standard

resolution, in which the thirty (30) calendar day period begins on the date the Contractor received the original request for Appeal; and

2. Make reasonable efforts to give the Member prompt verbal notice of the denial, and follow up with a written notice within two (2) calendar days.

The Contractor shall document in writing all verbal requests for Expedited Resolution and shall maintain the documentation in the case file.

E. State Fair Hearing:

A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. Part 431, Subpart E.

A Member or Authorized Representative may request a State Fair Hearing if he or she is dissatisfied with an Adverse Benefit Determination that has been taken by the Contractor within one hundred twenty (120) calendar days of the notice of appeal resolution by the Contractor. The Member must exhaust all Contractor level Appeal procedures prior to requesting a State Fair Hearing with the Division of Medicaid.

For Member Appeals, the Contractor is responsible for providing to the Division and to the Member an Appeal summary describing the basis for the denial. For standard Appeals, the Appeal summary must be submitted to the Division and the Member at least ten (10) calendar days prior to the date of the hearing. For expedited Appeals, (that meet criteria set forth in 42 C.F.R. § 438.410 the Appeal summary must be faxed to the Division and faxed or overnight mailed to the Member, as expeditiously as the Member'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 Contractor attend the hearing either via telephone or in person. The Contractor is responsible for absorbing any telephone/travel expenses incurred. These records shall be made available to the Member upon request by either the Member or the Member's legal counsel. In addition, the Division will provide the Member with a hearing process that shall adhere to 42 C.F.R. Part 438, Subpart F and 42 C.F.R. Part 431, Subpart E.

Failure of the Contractor to comply with the State Fair Hearing requirements of the State and Federal Medicaid law in regard to an Adverse Benefit Determination taken by the Contractor or to appear and present evidence will result in an automatic ruling in favor of the Member.

The Member must exhaust all Contractor level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division.

Any Adverse Benefit Determination or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. § 431, Subpart E. Adverse Benefit Determinations 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 time frames may also be appealed. Appeals must be requested in writing by the Member or the Member's representative within one hundred twenty (120) calendar days of the Member's receipt of notice of an Adverse Benefit Determination unless an acceptable reason for delay exists. An acceptable reason shall include, but not be limited to, situations or events where:

1. Appellant was seriously ill and was prevented from contacting the Contractor;

2. Appellant did not receive notice of the Contractor's decision;

3. Appellant sent the request for Appeal to another government agency in good faith within the time limit; and

4. Unusual or unavoidable circumstances prevented a timely filing.

The Contractor shall comply with the Division's State Fair Hearing decision. The Division's decision in these matters shall be final and shall not be subject to Appeal by the Contractor.

EXHIBIT E: NON-EMERGENCY TRANSPORTATION (NET) REQUIREMENTS

The Contractor, in its delivery of NET services, shall comply with all requirements of Exhibit H, Reporting Requirements, of this Contract.

The Contractor shall administer and provide NET services to Members, including but not limited to the establishment of a network of NET Providers, and authorization, coordination, scheduling, management, and reimbursement of NET service requests.

The Contractor is required to provide NET services according to Division policies. The Division will provide assistance as needed with interpretation and clarification of Division policy and will notify the Contractor as changes are made that affect the NET Program.

The Contractor will be responsible for reimbursing NET Providers. The Contractor is not required to reimburse for unauthorized NET services provided by Out-of-network Providers.

The Contractor shall meet with the Division as needed throughout the term of the Contract to discuss and resolve administrative and operational issues. Meetings may be conducted in person, by teleconference or by videoconference.

The Contractor shall develop written policies and procedures that describe how the Contractor, in the delivery of NET services, shall comply with the requirements of the Agreement, including this Exhibit.

A. NET Service Requests

Requests for NET services may be made by Members; their family members, guardians or representatives; and by Providers. The Contractor shall screen all NET requests to determine each of the following items:

1. The Member's medical need which requires NET services;

2. The Member's lack of access to available transportation. The Contractor shall require the Member to orally certify this lack of access;

3. The medical service for which NET service is requested is a covered medical service;

4. The most economical mode of transportation appropriate to meet the medical needs of the Member, based on the Member's mobility status and personal capabilities on the date of service. The Contractor must document in detail the reasons for approval of a mode of transportation that is not the most economical;

5. Close proximity of Provider to the Member; and

6. Necessity of attendant or assistance request. The Contractor may require a medical

certification statement from the Member's physician in order to approve door-to-door service or hand-to-hand service.

The Contractor shall educate Members on how to request NET services. The Contractor shall instruct Members that requests for NET services must be made at least three (3) business days before the NET service is needed. Because scheduling issues will occasionally occur, the Contractor must develop processes for handling urgent trips, last minute requests from Members, scheduling changes, and NET Providers who do not arrive for scheduled pick-ups. The Contractor shall provide additional education to Members who habitually request transportation less than two (2) business days in advance of the appointment date.

B. Prior Authorizations and Denials

If the Contractor receives a request for NET services that meets one of the denial reasons listed below, the Contractor shall deny the request and record the reason(s) for the denial in its information system on the same business day. The Contractor shall generate and mail denial letters to Members no later than the next business day following the date the denial decision was made. The denial letter shall notify the Members of the right to Appeal the denial. All costs of generating and sending denial notices shall be borne by the Contractor. In the event a Member does not have sufficient information to arrange the transport and has to hang up and call back at a later time, the initial phone call with incomplete information will not be considered a trip denial for reporting purposes.

Denial reasons include:

1. The Member is not eligible for NET Services on the date of service;

2. The Member does not have a medical need that requires NET services;

3. The medical service for which NET service is requested is not a covered medical service;

4. The Member has access to available transportation;

5. Transportation to the medical service for which NET Service is requested is covered under another Program

6. The request was for post-transportation Authorization and was not received timely or did not meet established criteria;

7. The medical appointment is not scheduled or was not kept;

8. The Contractor cannot confirm that the Member had a medical appointment;

9. The Contractor cannot accommodate the request as the trip was not requested timely;

10. The Contractor requested additional documentation which was not received timely;

11. The Member refuses the appropriate mode of transportation; or

12. The Member refuses the NET Provider assigned to the trip and another appropriate NET Provider is not available.

The Contractor shall authorize and schedule routine NET services for ninety-eight percent (98%) of all requests within three (3) business days after receipt of the request. Contractor shall authorize and schedule routine NET services for one hundred percent (100%) of all requests within ten (10) business days after receipt of a request. The Contractor shall report these requirements to the Division via a monthly Deliverable report.

If the Contractor requires additional information to authorize a request, the Contractor shall place the request on hold and shall request the additional information within twenty-four (24) hours after receipt of the request. The Contractor shall specify the date by which the additional information must be submitted. Timely requests by the Contractor for additional information shall stay the authorization period. If the Contractor does not receive additional information by the date specified by the Contractor, the Contractor shall deny the request except NET services to an appointment for chemotherapy, dialysis, and high-risk pregnancy. In those instances, the Contractor shall authorize Single Trips and pursue receipt of necessary information to authorize a Standing Order.

C. Appropriate Type of Transportation

Table 11 outlines the modes of transportation the Contractor must use to provide NET services to Members.

Table 11. Modes of Transportation

Mode	Description
Fixed Route	Transportation by means of a public transit vehicle that follows an advertised route on an advertised schedule, does not deviate from the route or the schedule, and picks up passengers at designated stops.
Basic Vehicle	A motorized vehicle used for the transportation of passengers whose medical condition does not require use of a wheelchair, hydraulic lift, stretcher, medical monitoring, medical aid, medical care or medical treatment during transport. This does not include Private Auto.
Enhanced Vehicle	A motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs or other mobility devices, or is equipped specifically for the transportation of passengers who cannot sit upright and are required to remain in a lying position during transport. Enhanced Vehicles can only be used to transport passengers that do not require medical

Mode	Description
	monitoring, medical aid, medical care or medical treatment during transport. This does not include Private Auto.
Non-Emergency Ambulance	A motorized vehicle equipped specifically for the transportation of a passenger whose medical condition requires transfer by stretcher with medical supervision. The patient's condition may also require the use of medical equipment, monitoring, aid, care or treatment, including the administration of drugs or oxygen, during the transport.
Other Transportation	Any commercial carrier, such as Amtrak, buses (such as Greyhound) or airplanes.

The Contractor is encouraged to maximize the utilization of fixed route transportation whenever more economical and appropriate. The Contractor shall be familiar with schedules of fixed route transportation in communities where it is now available and in areas where it becomes available during the term of the Contract. The Contractor shall distribute or arrange for the distribution of fixed route passes to Members for whom fixed route transportation is the most appropriate mode of transportation.

The furthest distance a Member may be required to walk to or from a fixed route transportation stop is one quarter (1/4) mile. If the Contractor determines that fixed route transportation is an appropriate mode of transportation for a Member, but the Member requests a different mode of transportation, the Contractor may require the Member to verify his or her mobility limitations, including, but not limited to, requiring the Member to supply documentation from his or her physician. The Contractor shall consider the following when determining whether to allow an exception:

a. The Member's ability to travel independently, including the age of the Member, and any permanent or temporary debilitating physical or mental condition that precludes use of fixed route transportation;

b. The availability of the fixed route transportation in the Member's area or community, including the accessibility of the location to which the Member is traveling and whether the Member must travel more than one quarter (1/4) of a mile to or from the fixed route transportation stop;

c. Inclement weather conditions (including extreme heat or cold) or other pertinent factors that make use of fixed route transportation unfeasible;

d. The compatibility of the fixed route transportation schedule with the Member's appointment times for the covered medical service. The schedule of the fixed route transportation should allow the Member to arrive at the drop off location no more than sixty (60) minutes prior to the scheduled appointment time, and will allow the Member forty-five (45) minutes after the estimated time the appointment will end to arrive at the pick-up location; and

e. Any special needs of the Member that requires the coordination of services with other Providers.

1. Trip Type

Table 12 outlines requirements for specific types of trips to be used by the Contractor to provide NET services to Members.

Table 12. Types of Transportation

Mode	Description
Single Trip Request	The Contractor shall require that requests for NET service to a single appointment be made via the Member Services Call Center. Other methods of single trip requests may be allowed with Division approval.
Standing Order Trip Requests	The Contractor shall establish procedures to handle trip requests so that Members are not required to continually arrange for repetitive appointments. The Contractor shall include in its procedure to recertify the need of a Standing Order with the Medical Provider at least every ninety (90) calendar days. These orders may be accepted via phone, fax, or a web-based reservation system.
Emergency Transports	In limited situations, a Member may be transported by emergency medical air ambulance (fixed-wing or helicopter) or emergency medical ground ambulance to a medical facility. Upon discharge, if the Member can be transported home via an ambulatory vehicle, wheelchair accessible vehicle, or commercial air, the Contractor shall make the appropriate arrangements for the one-way transport for the Member and up to one (1) attendant.

D. Network of NET Providers

The Contractor shall establish a network of NET Providers and negotiate reimbursement with qualified transportation entities. The Contractor is encouraged to develop innovative and creative strategies to reduce per trip costs such as providing reimbursement for gasoline and making greater use of fixed-route public transportation.

The Contractor shall identify, recruit, and negotiate contracts with NET Providers, including all Modes of Transportation, sufficient to meet the needs of Members. The Contractor shall secure sufficient NET Provider resources (numbers and types of vehicles, drivers) under contracts so that the failure of any NET Provider to perform will not impede the ability of Contractor to provide NET services in accordance with the requirements of the Contract.

1. NET Provider Contracts

The Contractor shall receive advance written approval from the Division for the

model contract the Contractor intends to use with NET Providers. The model contract shall address, at a minimum, the following items:

a. Identification of the NET Provider;

b. Payment administration and timely payment;

c. Modes of transportation;

d. Geographic coverage area(s);

e. Attendant services;

f. Telephone and vehicle communication systems;

g. Information systems;

h. Scheduling;

i. Dispatching;

j. Pick-up and delivery standards;

k. Urgent Trip requirements;

l. Driver qualifications;

m. Expectations for Door to Door, Hand to Hand, Curb to Curb;

n. Driver conduct;

o. Driver manifest delivery;

p. Vehicle requirements;

q. Back-up service;

r. Quality assurance;

s. Non-compliance with standards;

t. Training for drivers;

u. Confidentiality of Information;

Specific provision, that in the instance of default by Contractor, the agreement will pass to the Division or its Agent for continued provision of NET services. All terms, conditions and rates established by the agreement shall remain in effect until or unless renegotiated with the Division or its Agent subsequent to default action or unless otherwise terminated by the Division at its sole discretion;

a. Indemnification language to protect the State of Mississippi and the Division;

b. Evidence of insurance for vehicle and driver;

c. Submission of documentation as required by the Division; and

d. The procedures for Appeal and dispute resolution.

E. Notification and Dispatch of Trips

If possible, the Contractor shall inform the Member or the Member's representative of the transportation arrangements during the phone call requesting the NET service. Otherwise, the Contractor shall inform the Member or representative by later phone call, by facsimile, or by letter. If the Contractor sends a letter, the letter shall be mailed in time to be received by the Member prior to the date of NET service.

The Contractor shall receive requests for NET services; screen each request and, if authorized; schedule and assign the trip to an appropriate NET Provider. The Contractor should strive to maintain existing relationships between NET Providers and Members, and should try to accommodate a Member's request for a specific NET Provider in the Contractor's network, especially in the transportation of Members with disabilities. The following standards must be maintained.

The Contractor shall ensure that the average waiting time for pick-up does not exceed fifteen (15) minutes. The Contractor shall ensure that Members arrive at pre- arranged times for appointments and are picked up at pre-arranged times for the return trip if the covered medical service follows a reliable schedule. The pre- arranged times may not be changed by the NET Provider or driver without prior permission from the Contractor.

The Contractor shall require NET Providers to make his or her presence known to the Member and wait until at least five (5) minutes after the scheduled pick-up time. If the Member is not present for pick up, the driver shall notify the NET Provider's dispatcher before departing from the pick-up location. NET Providers cannot change the assigned pickup time without permission from the Contractor. If the NET Provider cannot arrive on time to the pick-up location, the NET Provider or Contractor shall contact the Member or the Member's representative and the Provider. No more than two percent (2%) of the scheduled trips shall be late or missed per day.

The Contractor and a NET Provider may group Members and trips to promote efficiency and

cost effectiveness. The Contractor may contact Providers in this process.

For multi-passenger trips, trips should be scheduled so that a Member does not remain in the vehicle for more than forty-five (45) minutes longer than the average travel time for direct transportation of that Member.

The Contractor shall notify the NET Provider of the assignment at least two (2) business days prior to the trip, if possible, and shall timely assign the trip to another NET Provider if necessary.

The Contractor shall contact an appropriate NET Provider so that pick-up occurs within three (3) hours of a hospital discharge.

The Contractor shall report the above requirements to the Division via a monthly Deliverable report.

F. Vehicle Requirements

See Mississippi Administrative Code, Title 23, Part 201, Rule 2.7 Vehicle Requirements

G. Driver Requirements

See Mississippi Administrative Code, Title 23, Part 201, Rule 2.6 Driver Requirements

1. Contractor Driver Requirements

   The Contractor must ensure NET Providers employ drivers in accordance with or exceeding local, State and Federal requirements and the Mississippi Administrative Code. The Contractor must supply NET Providers with a copy of the driver requirements and inspect the NET Provider employee records prior to the Operations Start Date and at least every six (6) months thereafter. The Contractor must maintain records of bi-annual inspections and make them available to the Division via a quarterly Deliverable report.

H. Trip Monitoring

The Contractor shall require that the NET Providers' drivers to maintain daily trip logs containing, at a minimum: date of service, driver's name, driver's signature, Member's name, Member's signature, Vehicle Identification Number (VIN) or other identifying number on file, NET Provider's name, request tracking number, mode of transportation authorized, scheduled arrival time in military time, actual arrival time in military time, actual drop off time in military time, miles driven per odometer, destination and/or Medicaid Provider information, and other notes.

Fixed route transportation is excluded from this requirement. The Contractor shall require

NET Providers to make the trip logs available to the Contractor or the Division upon request, within five (5) business days.

I. Validation Checks

The Contractor's payment procedures shall ensure that NET Provider claims for reimbursement match authorized trips and that the trips actually occurred. The Contractor shall validate that transportation services paid for under the Contract are properly authorized and rendered. The Contractor shall perform validation checks on at least five percent (5%) NET service requests in a month, both prior to the authorization of the request and after the services are rendered, as specified below.

The Division, at its sole discretion, may require validation checks of trips to specific services.

The Contractor shall conduct pre-transportation validation checks prior to authorizing the request for no fewer than three percent (3%) of the NET services requests received in a month. The Contractor shall contact the Provider and verify that the Member has an appointment for a covered medical service. The Contractor shall not verify the medical necessity of an appointment. If the Contractor verifies with the Provider that no appointment exists, or that the service is not a covered medical service, the Contractor shall record in its computer system the reason for the failed validation check, and the Contractor shall deny the request. If a pre-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer, the Contractor shall flag the request for a post-transportation validation check, and the attempt at validation shall not be counted toward the three percent (3%) requirement.

The Contractor shall conduct post-transportation validation checks on no fewer than two percent (2%) of the NET services requests received in a month. The Contractor shall contact the Provider and verify that the Member had an appointment for a covered medical service. The Contractor shall verify that the Member received a covered medical service. The Contractor shall not verify the necessity of the transportation or of the medical service, but only that the service occurred. If the Contractor verifies with the Provider that there was no appointment, that the appointment was not kept or that the service was not a covered medical service, the Contractor shall record in its computer system the reason for the failed validation check. If a post-transportation validation check cannot be completed because the call to the Provider resulted in a busy signal or no answer after three (3) attempts, the Contractor shall enter into its system information that will alert the Member Services Call Center staff that any future requests to this specific Provider shall be validated before it can be authorized.

The Contractor shall perform pre-transportation and post-transportation validation checks for three percent (3%) of fixed route transportation requests.

The Contractor shall report all validation check findings to the Division, by NET Provider, via a quarterly Deliverable report.

EXHIBIT F: PERFORMANCE MEASURES

	Performance Measure	Source
OBESITY		
	BMI for adults *Percentage of Members who had an outpatient visit and their body mass index (BMI) documented during the measurement period*	Adult BMI Assessment (ABA) (HEDIS®)
22	BMI, weight assessment for nutrition and physical activity counseling for children and adolescents *Percentage of Members who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year (BMI Percentile Total)*	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *BMI percentile (Total)* (HEDIS®)
		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Nutrition (Total)* (HEDIS®)
		Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – *Counseling for Physical Activity (Total)* (HEDIS®)
ASTHMA		
4.	Use of appropriate medications for people with asthma *Percentage of Members ages 5-11 and 12-50 who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year*	Use of Appropriate Medications for People with Asthma – Total (ASM) (HEDIS®)
6.	Asthma-related ER visits *Percentage reduction in asthma-related ER visits*	N/A – The Division to provide reporting specifications
7.	Avoidable asthma-related re-hospitalizations *Percentage reduction in avoidable asthma-related hospitalizations*	N/A – The Division to provide reporting specifications

Performance Measure	Source
WELL-CHILD AND EPSDT	
8. EPSDT Screening, as defined by the Division *Percentage of EPSDT eligible members who received a Periodic Health Screening Assessment*	Quarterly 416 Report
9. Lead Screening for Children *Percentage of Members 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday*	Lead Screening in Children (LSC) (HEDIS®)
10. Childhood Immunizations *Percentage of Members 2 years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) H influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); two (2) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday*	Childhood Immunization Status – Combo 2 (CIS) (HEDIS®) **Note: The HEDIS measure calculates a rate for each vaccine and nine separate combination rates. This sample HEDIS measure uses Combo 2, which is a combination of vaccines.*
11. Childhood Immunizations *Percent of EPSDT eligible members who have received up-to-date immunizations using the ACIP Recommended Immunization Schedule and AAP Bright Futures*	Contractually required
13. Well-Child Visits in the First 15 Months of Life *The percentage of members who turned 15 months old during the measurement year and who had 0, 1, 2, 3, 4, 5, 6, or more well-child visits with a PCP during their first 15 months of life.*	Well-Child Visits in the First 15 Months of Life (W15) (HEDIS®)

Performance Measure	Source
14. . Screening, as defined by the Division *EPSDT eligible Percentage of Members under age twenty-one (21) who received a Periodic Health Screening Assessment*	CMS 416 Report
DIABETES	
15. . Nephropathy screening *Percentage of Members with diabetes who received a nephropathy screening test*	Comprehensive Diabetes Care (CDC) - Medical Attention for Nephropathy (HEDIS®)
18. . Blood sugar poorly controlled in people with diabetes *Members with HbA1c results greater than or equal to 9.0 percent*	Comprehensive Diabetes Care (CDC) - HbA1c Poor Control (>9.0 percent) (HEDIS®) **Note: Lower rates are desired for this measure.*
19. . Blood sugar well-controlled in people with diabetes *Percentage of Members with HbA1c results less than or equal to 8.0 percent*	Comprehensive Diabetes Care (CDC) – HbA1c Good Control (<8.0 percent) (HEDIS®)
CONGESTIVE HEART FAILURE	
20. . Ace inhibitor therapy *Percentage of Members 18 and older on persistent medications (ACE inhibitors) for at least 180 days who received at least one annual monitoring*	Annual Monitoring for Patients on Persistent Medications (MPM) (HEDIS®)
21. . Congestive Heart Failure *Percentage decrease in CHF-related hospital readmissions*	N/A – The Division to provide reporting specifications

Performance Measure	Source
MATERNAL AND CHILD HEALTH	
22. . Pre and post-natal complications *Number and percent of deliveries that meet the following criteria, based on gestational weight: low birth weight, very low birth weight, or large for gestational age* *Number and percentage of deliveries with prenatal complications (list prenatal complications)*	N/A – The Division to provide reporting requirements
26. . Pregnancy Outcome for Members Enrolled Throughout the Pregnancy *For those Members who were enrolled in the first trimester and maintained Enrollment with the same Contractor throughout the pregnancy, report the outcome of the pregnancy*	N/A – The Division to provide reporting requirements
28. . Prenatal and Postpartum Care *Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit as a Member of the organization in the first trimester or within 42 days of Enrollment in the organization* *Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.* *Report the number of Members (that received a postpartum visit on or between 21 and 56 days of delivery*	Prenatal and Postpartum Care (PPC) (HEDIS®)

Performance Measure	Source
MEMBER SATISFACTION	
29. . Member Satisfaction *Improve overall rating of health plan (Contractor)* *Improve percentage of Members reporting they receive needed care*	CAHPS®
BEHAVIORAL HEALTH	
30. . Behavioral/Mental Health Utilization *Number and percentage of Members receiving behavioral/mental health services by service type (e.g., any service inpatient, intensive outpatient/partial hospitalization, outpatient or Emergency Department)* *For Members receiving Behavioral Health Services and enrolled in high-risk Care Management:* *Treatment plan: number and percentage of Members receiving Behavioral/Mental Health/Substance Use Disorder Services with a treatment plan (therapy, medications, etc.)* *Number of emergency department visits for Members receiving Behavioral Health/Substance Use Disorder Services*	Behavioral/Mental Health Utilization (MPT) (HEDIS®)

Performance Measure	Source
31. Screening for Clinical Depression and Follow-Up Plan *Number and percent of Members 18 years and older who were screened for clinical depression using a standardized tool* *Number of Members screened who were referred for behavioral health/substance Use Disorder Care Management or Behavioral Health/Substance Use Disorder Services (Note: Initial Performance Measure will involve the Contractor developing and using a standardized tool)*	Percentage of Members 18 years and older screened for clinical depression using a standardized tool and with documented follow-up, including referral to therapy, inpatient treatment, medication, intensive therapy, etc. CMS Core Adult Measure
32. Follow-up After Hospitalization for Behavioral Health/Substance Use Disorder *Percentage of Members completing a follow-up appointment after hospitalization for a behavioral health/substance use disorder within 30 days and/or 7 days of discharge.* *Contractor to report percentage of Members who did not complete a follow-up appointment within the standards who had a re-admission for behavioral health within 15 days of what would have been the 7 day appointment or 45 days from what should have been the 30 day appointment.*	Follow-Up After Hospitalization (FUH) (HEDIS®)
Inpatient Hospitalization-Plan all Cause Readmissions	For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

MississippiCAN Program
Office of the Governor – Division of Medicaid

EXHIBIT G: QUALITY MANAGEMENT

The Division will monitor the Quality Management (QM) of the Contractor and retains the right of advance written approval of all QM activities. The Contractor must design its QM program to assure and improve upon the accessibility, availability and quality of care provided for the MississippiCAN Program. The Contractor's QM programs must, at a minimum:

1. Contain a written program description, work plan and program evaluation which meet requirements outlined in the Contract that focus on the areas of importance as identified by the Contract in collaboration with the Division.

2. Be based on and actively evaluate claims data Member demographic information, Member and Provider surveys and other data, as applies, and to use these data for the identification of prevalent medical conditions and barriers to care to be targeted for quality improvement.
3. Continuously evaluate the effectiveness of its activities and make adjustments to the program or to various methodologies or approaches based on these evaluations.

4. Contain written policies and procedures that meet the requirements outlined in the Contract, and monitor internal compliance with these policies and procedures.

5. Maintain a structure and actively ensure that the program is implemented and overseen by professionals with adequate and appropriate experience in QM.

The Contractor must submit to the Division for approval an improvement plan, as determined by the Division, and within time frames established by the Division, to resolve any performance or quality of care deficiencies identified by the Division. The Division must approve the improvement plan. Failure by the Contractor to comply with requirements and improvement actions requested by the Division may result in the application of liquidated damages or other available remedies.

Standard I: The scope of the QM program must be comprehensive in nature, and support the ability of MississippiCAN to improve health outcomes and satisfaction for the Members. This includes, but is not limited to, assessment of access to care, barriers to care, quality of care, Care Management and continuity of services. At a minimum, the Contractor's QM programs, must:

1. Adhere to current Federal, State, and Division rules and regulations.

2. Be developed and implemented by professionals with adequate and appropriate experience in QM.

3. Ensure that all QM activities and initiatives undertaken by the Contractor are chosen based upon claims data, Member demographic information, Member and Provider surveys, Medical Record review data and other data as applies.

4. Contain policies and procedures for all functions of the QM program. The policies and procedures must include ongoing review of the program provided by the Contractor ensuring that all demographic groups and special needs populations are addressed. The Contractor must submit to the Division for approval all policies and procedures prior to initial implementation and upon all changes.

5. Contain one (1) detailed written program description, which must be approved by the Contractor's Governing Body and the Division prior to implementation and on an ongoing basis as the program description is modified. The program description must address all standards, requirements and objectives established by the Division and describe the goals, objectives and structure of the Contractor's QM program; at a minimum, it must be updated and submitted to the Division annually. The written program description must include:

    a. Standards and mechanisms to monitor Members to receive timely accessibility of primary care, specialty care, in accordance with time frames outlined in Section 7.B, Provider Network Requirements, of this Contract.

    b. Mechanisms for assessment, analysis and reporting of the quality of care provided through the Contractor including, but not limited to:

        i. Primary care;

        ii. Preventive care;

        iii. Acute and/or chronic conditions;

        iv. Care Management and care coordination, including coordination of behavioral health/substance use disorder and physical health services;

        v. Continuity of care;

        vi. Behavioral Health Services/Substance Use Disorder; and vii.

        vii. Inpatient hospitalization.

    c. Assessment of the timely, accurate, complete collection and/or analysis of Member and Provider surveys.

6. The Contractor must submit to the Division for approval the detailed annual work plans and timetables approved by the Contractor's Governing Body prior to implementation, including:

    a. Individual(s) accountable for each task;

b. Target dates for start dates;

c. Target dates for completion of all phases of all QM activities;

d. At least updates on a quarterly basis;

e. Annual submission, which must include prospective QM initiatives for the year;

f. Data collection methods and analysis target dates;

g. Evaluation and reporting of findings to the Division;

h. Implementation of improvement actions where applicable; and

i. Status of each activity.

7. The annual QM Program Evaluation will include:

   a. Studies and activities undertaken;

   b. Rationales and methodologies for activities and studies undertaken;

   c. Results of activities;

   d. Subsequent improvement actions;

   e. An analysis of claims data, Member demographic information, Member and

   f. Provider surveys and other data as applies;

   g. Systematic analysis and re-measurement of barriers to care and the quality of care provided to Members.

8. Include mechanisms and processes that ensure that related and relevant operational components, activities and initiatives from the QM program are communicated and integrated into activities and initiatives undertaken by other departments within the Contractor's organization, delegated Subcontractors, and Care Management programs.

9. Include procedures for informing Providers about the written QM program, and for securing cooperation with the QM program with all PCPs and community-based services.

10. Include procedures for feedback and interpretation of findings from analysis of

quality data to PCPs, Care Management staff, community-based services, and Members and their family members.

11. Include mechanisms and processes that allow for the development and implementation of specific improvement actions in response to identified barriers and quality of care concerns within the QM program or the communication of the findings to the Division.

12. Cooperate and coordinate with State initiatives. The Contractor must participate in State health initiatives. This may include, but is not limited to:

    a. Provider outreach and education;

    b. Member outreach and education;

    c. Quality studies; and

    d. Participation in workgroups.

Standard II: The organizational structures of the Contractor must ensure that there is adequate support of the quality management work plan. The Contractor may determine that one (1) Governing Body will oversee all the Quality Management activities.

1. The Governing Body must:

    a. Formally designate an entity, such as the Quality Management Committee (QMC), to have the accountability for and oversight of all aspects of the MississippiCAN Program and evaluation of the effectiveness of the population served.

    b. Regularly receive written reports on the QM program activities that describe actions taken, progress in meeting objectives and improvements made. The Governing Body reviews, on at least an annual basis, the written program description, work plan and program evaluation of the QM program activities.

    c. Document actions taken by the Governing Body in response to findings from QM program activities and supply them to the Division upon request.

    d. Delegate a liaison that is directly accountable to the Division, the Governing Body and the QMC for all QM activities and initiatives.

2. The Quality Management Committee (QMC):

    a. Operates under policies and procedures that describe the role, structure and function of the QMC that:

i. Demonstrate that the QMC has oversight responsibility and input, including review and approval, for all QM program activities;

ii. Ensure membership on the QMC and active participation by individuals, representative of the composition of the PCPs; and

iii. Document actions taken by the QMC in response to findings from QM program activities and supply them to the Division upon request;

b. Meets at least quarterly, and otherwise as needed; and

c. Opportunity must be provided for Members to offer suggestions for changes in policies and procedures and how these suggestions will be communicated with the Division.

3. The Contractor must have sufficient material resources, and staff with the education, experience and training to effectively implement the written QM program and related activities. The Contractor must submit to the Division for approval the organizational chart and job descriptions prior to implementation.

Standard III: The QM program must include and implement methodologies that allow for the objective and systematic monitoring, measurement and evaluation of the quality, appropriateness of care and services provided to Members through quality of care studies and related activities, with a focus on identifying and pursuing opportunities for continuous and sustained improvement. The QM program must include professionally developed practice guidelines and standards of care that are written in measurable and accepted professional formats, based on scientific evidence, applicable to PCPs for the delivery of certain types or aspects of health care, and regularly reviewed and updated.

1. The QM program must include clinical and/or quality indicators in the form of written, professionally developed, objective and measurable variables of a specified clinical or health services delivery area, which are reviewed over a period of time to screen delivered health care and/or monitor the process or outcome of care delivered in that clinical area.

2. Practice guidelines and clinical indicators must be measurable and address the health care needs of the populations served by the Contractor. The clinical areas addressed must include, but are not limited to:

a. Adult preventive care;

b. Pediatric and Adolescent preventive care with a focus on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

c. Division-defined clinical areas;

d. Care Management Related Clinical Outcomes and Performance;

e. Behavioral health/Substance Use Disorder;

f. Maternity; and

g. Inpatient discharge planning.

3. The QM program must provide practice guidelines, clinical indicators and Medical Record keeping standards to all Providers and appropriate Subcontractors. The Contractor must also provide this information to Members upon request.

4. The QM program must have policies and procedures for implementing and monitoring improvement plans. These policies and procedures must include the following:

   a. Person(s) or body responsible for making the final determinations regarding quality problems; and

   b. Types of actions to be taken, such as:

      i. Education;

      ii. Follow-up monitoring and re-evaluation;

      iii. Changes in the Contractor's processes, structures and forms;

      iv. Informal counseling;

      v. Assessment of the effectiveness of the actions taken; and

      vi. Reporting of issues to the Division.

5. The QM program must include methodologies that allow for the identification, tracking, verification and analysis of outpatient quality of care concerns, Member quality of care Complaints and quality of care referrals from other sources. The Contractor must report findings from this analysis of quality of care concerns, Complaints and quality of care referrals to the Division, with a discussion of how these findings will inform the Contractor’s quality improvement work plan and how the Contractor will address these concerns. The Contractor will include this information in the QM Program Evaluation.

6. The QM program must contain procedures for the completion of Consumer

Assessment of Healthcare Providers and Systems (CAHPS®) Member satisfaction surveys, and the Contractor must conduct this survey annually. The Contractor must report findings from this survey to the Division, with a discussion of how the findings from the survey will inform the Contractor's quality improvement work plan and effect changes to the program description.

7. The QM program must contain procedures for completion of a Provider satisfaction survey of the PCPs, and must conduct this survey at least annually. The Contractor must report findings from this survey to the Division, with a discussion of how the findings from the survey will inform the Contractor's quality improvement work plan and effect changes to the program description.

Standard IV: The Contractor must develop and implement mechanisms for integration of disease and health management programs that rely on prevention of complications as well as treatment of chronic conditions for Members identified through clinical and financial analysis of claims data provided by the Division, detailed health risk assessments, Member demographic information, and utilization patterns for preventive, secondary and tertiary care.

Standard V: The Contractor must have formal accountability for the QM program. If the Contractor delegates this responsibility, the Contractor must:

1. Have a detailed written description and work plan, approved by the Division, of the delegated activities, the delegate's accountability for these activities and the frequency of reporting to the Contractor and the Division.

2. Have written procedures approved by the Division for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

3. Document evidence to be submitted to the Division, of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans, quality meeting minutes and regular specified reports.

4. Make available to the Division, and its authorized representatives, any and all records, documents and data detailing its oversight of delegated QM program functions.

5. Ensure that delegated entities make available to the Division, and its authorized representatives, any and all records, documents and data detailing the delegated QM program functions undertaken by the entity of behalf of the Contractor.

6. Ensure the delegated entity adheres to the standards of the current Agreement.

Standard VI: The Contractor must have written policies and procedures for record keeping on all of the Contractor activities.

1. The Contractor must ensure that these records are accurate, timely, and readily accessible and permit prompt and systematic retrieval of information. Written policies and procedures must contain standards for records that promote maintenance of records in a legible, current, detailed, organized and comprehensive manner that permits effective quality review.

2. The Division and/or its authorized Agents (i.e., any individual, corporation, or entity employed, contracted or subcontracted with the Division) must be afforded prompt access to all records whether electronic or paper. All record copies are to be forwarded to the requesting entity within fifteen (15) calendar days of such request and at no expense to the requesting entity. The Division is not required to obtain written approval from a Member before requesting a Member's record from the Contractor or any other agency.

Standard VIII: The Contractor must maintain systems that document implementation of the written QM program descriptions. The Contractor must document that it is monitoring the quality of care across all services, all treatment modalities and all sub-populations according to its written QM program description.

Standard IX: The Contractor must have standards and mechanisms to oversee the PCPs and report findings to the Division.

1. The Contractor must oversee that the PCPs are adhering to:

    a. Federal, State and Division rules and regulations;

    b. PCP requirements;

    c. Members' rights; and

    d. Clinical and preventive guidelines of the program.

2. The Contractor must submit to the Division for approval the initial versions and any revisions made to the following documents that relate to the QM program:

    a. Table of Organization including job descriptions;

    b. Employee tools to include scripts, algorithms and criteria;

    c. Program Descriptions;

    d. Work Plans;

    e. Program Evaluations;

f. Performance Improvement Projects;

g. Focused Studies; and

h. Other documents related to the QM program, as designated by the Division.

3. The Division may request additional information from the Contractor to assist in the determination of Contract compliance. To the extent possible, the Division shall provide reasonable advance notice of such reports. These may include:

   a. Committee Meeting Minutes;

   b. Work Plan Updates;

   c. Contractor Documentation;

   d. Ad Hoc Reports and Information;

   e. Contractor Demonstrations; and

   f. Access to materials and the ability to observe during onsite evaluations.

EXHIBIT H: REPORTING REQUIREMENTS

Additional reporting requirements will be provided to the Contractor in the Reporting Manual. The requirements listed herein may be amended by mutual agreement by both parties. Any modifications will be reflected in the Reporting Manual.

Contractor Report	Frequency	Timeframe
Care Management		
Unduplicated Number of Newly Enrolled Members in Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Care Management Members		
Unduplicated Number of Members Contacted for Purposes of Care Management		
Number of Successful Care Management Contacts		
Health Risk Assessment (HRA)		
Adult Physical Exams		
Medical Care Management		
Unduplicated Number of Newly Enrolled Members in Medical Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Medical Care Management Members		
Unduplicated Number of Members Enrolled in the Medical Care Management Program and Contracted for Purposes of Care Management		
Number of Successful Care Management Contacts to Members Enrolled in the Medical Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of Services for Members Enrolled in the Medical Care Management Program	Quarterly	15th business day after the close of the quarter
Care Management Staffing Ratios for Members Enrolled in the Medical Care Management Program	Monthly	5th business day of the second month following the reporting period
Medical Home Linkage for Members Enrolled in the Medical		

Care Management Program		
Behavioral Health Care Management		
Unduplicated Number of Newly Enrolled Members in Behavioral Health Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Behavioral Health Care Management Members		
Unduplicated Number of Members Enrolled in the Behavioral Health Care Management Program and Contacted for the Purposes of Care Management		
Number of Successful Care Management Contacts to Members Enrolled in the Behavioral Health Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of services for Members Enrolled in the Behavioral Health Care Management Program	Quarterly	15th Business day after the close of the quarter
Care Management Staffing Ratios for Members Enrolled in the Behavioral Health Care Management Program	Monthly	5th business day of the second month following the reporting period
Medical Home Linkage for Members Enrolled in the Behavioral Health Care Management Program		
Maternal Health Care Management		
Unduplicated Number of Newly Enrolled Members in Maternal Health Care Management Program	Monthly	5th business day of the second month following the reporting period
Unduplicated Number of Disenrolled Maternal Health Care Management Members		
Unduplicated Number of Members Enrolled in the Maternal Health Care Management Program and Contacted for Purposes of Care Management		
Number of Successful Care Management Contacts to Members Enrolled in the Maternal Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of Services for Members Enrolled in the Maternal Health Care Management Program	Quarterly	15th Business day after the close of the quarter
Care Management Staffing Ratios for Members Enrolled in the Maternal Health Care Management Program	Monthly	5th business day of second month following reporting

Medical Home Linkage for Members Enrolled in the Maternal Health Care Management Program		period
Number of Pre-Term Deliveries for Members Enrolled in the Maternal Health Care Management Program		
Type of Delivery for High-Risk Pregnant Members Enrolled in the Maternal Health Care Management Program		
Very Low Birth Weight Babies		
Foster Children Care Management		
Unduplicated Number of Newly Enrolled Members in the Care Management Program for Foster Care Members	Monthly	5th business day of second month following reporting period
Unduplicated Number of Disenrolled Foster Care Members in Care Management		
Unduplicated Number of Foster Care Members Enrolled in the Care Management Program and Contacted for Purposes of Care Management		
Number of Successful Care Management Contacts to Foster Care Members Enrolled in the Care Management Program		
Identification and Monitoring of Over-and Under-Utilization of Services for Foster Care Members Enrolled in the Care Management Program	Quarterly	15th business day after the close of the quarter
Care Management Staffing Ratios for Foster Care Members Enrolled in Care Management Program	Monthly	5th business day of second month following reporting period
Medical Home Linkage for Foster Care Members Enrolled in the Care Management Program		
Screenings and Assessments Completed within Timeframe Identified in Settlement Agreement	Quarterly	15th business day after the close of the quarter
Utilization of Ongoing Assessments and Examinations		
Utilization of Medications Categorized by Antidepressant, Antipsychotic, Attention Deficit Hyperactivity Disorder (ADHD), and Psychotropic		
Member Enrollment Statistics and Trends		
Member Enrollment Statistics and Trends	Monthly	5th business day of second month following reporting
Description of Any Member Enrollment Trends		

Medical Utilization Statistics and Trends		period
Medical Utilization Statistics and Trends		
Medical Utilization Statistics and Trends	Monthly	5th business day of second month following reporting period
Description of Any Utilization Trends		
Pharmaceutical Statistics		
Top 100 Drugs by Utilization		
Top 100 Drugs by Amount Paid		
Validation Preferred Drug List Use		
Pharmacy Prior Authorization Report		
Physician Administered Drugs and Implantable Drug System Devices		
Exception Report Clinical Trials and/or Investigative or Experimental Drugs		
Rebated Drug Volume		
Top 50 Members		
Advanced Imaging Services Utilized		
Behavioral Health Utilization Statistics and Trends		
Behavioral Health Utilization Statistics and Trends	Monthly	5th business day of second month following reporting period
Behavioral Health Utilization Statistics and Trends – Injectable Anti-Psychotics		
Description of Behavioral Health Utilization Trends		
Medical and Pharmacy Claims Processing Statistics and Trends		
Claims Processing Statistics	Monthly	5th business day of second month following reporting period
Pended and Suspended Claims	Ad Hoc	Within 7 days of request by Division
Physician Administered Drugs (PAD), Number Administered	Monthly	5th business day of second month following reporting period
Physician Administered Drug Claims, Denied Claims – Other	Ad Hoc	Within 7 days of request by Division
Medical Claims Denial Reason	Monthly	5th business day of second

Claims Processing Statistics – Pharmacy		month following reporting period
Pharmacy Claims Denial Reason		
Behavioral Health Claims Processing Statistics and Trends		
Behavioral Health Claims	Monthly	5th business day of second month following reporting period
Pended and Suspended Behavioral Health Claims	Ad Hoc	Within 7 days of request by Division
Behavioral Health Claims Denial Reason	Monthly	5th business day of second month following reporting period
Medical Call Center Statistics and Trends		
Call Center Statistics	Monthly	5th business day of second month following reporting period
Call Center Statistics – Member Hotline Calls		
Member Hotline – Types of Calls		
Call Center Statistics – Provider Hotline Calls		
Provider Hotline – Types of Calls		
Call Center Statistics – Member Nurse Line Calls		
Member Nurse Line – Types of Nurse Line Calls		
Behavioral Health Call Center Statistics and Trends		
Call Center Statistics	Monthly	5th business day of second month following reporting period
Call Center Statistics – Member Hotline Calls		
Member Hotline – Types of Calls		
Call Center Statistics – Provider Hotline Calls		
Provider Hotline – Types of Calls		
Call Center Statistics – Behavioral Health Clinical Line Calls		
Member Nurse Line – Types of Behavioral Health Clinical Line Calls		
Provider Network Statistics		
Medical Provider Network	Monthly	5th business day of second month following reporting period

Terminated Provider Report	Ad Hoc	Within 7 days of request by Division
Behavioral Health Provider Network	Monthly	5th business day of second month following reporting period
Terminated Provider Report	Ad Hoc	Within 7 days of request by Division
Medical Prior Authorizations		
Overall Prior Authorization Requests Received	Monthly	5th business day of second month following reporting period
Prior Authorization Ad-Hoc Report	Ad Hoc	Within 7 days of request by Division
Prior Authorization Turn Around Time Report	Monthly	5th business day of second month following reporting period
Prior Authorization Turn Around Time Ad Hoc Report	Ad Hoc	Within 7 days of request by Division
Pharmacy Prior Authorizations	Monthly	5th business day following the reporting month
Pharmacy Prior Authorizations Ad Hoc	Ad Hoc	Within 7 days of request by Division
Authorized Delivery Report	Monthly and Quarterly	5th Business day of each month 30th calendar day after close of the quarter
Member Encounter Data Acceptance Rate		
Member Encounter Data Acceptance Rate	Monthly	5th business day of second month following reporting period
Description of Member Encounter Data Acceptance Rate Trends		
Medical Member Grievances and Appeals		
Medical Member Grievances Summary	Monthly	5th business day of second month following reporting
Medical Member Grievances Detail		

Medical Member Appeals Summary		period
Medical Member Appeals Detail		
Behavioral Health Member Grievances and Appeals		
Behavioral Health Member Grievance Summary	Monthly	5th Business day of second month following reporting period
Behavioral Health Member Grievance Detail		
Behavioral Health Member Appeals Summary		
Behavioral Health Member Appeals Detail		
Provider Grievances and Appeals		
Provider Grievance Summary	Monthly	5th business day of second month following reporting period
Provider Appeals Summary		
Provider Grievances Detail		
Provider Appeals Detail		
Behavioral Health Provider Grievances Summary		
Behavioral Health Provider Appeals Summary		
Behavioral Health Provider Grievances Detail		
Behavioral Health Provider Appeals Detail		
State Issues and Medicaid Investigative Grievances		
Provider State Issues/MIG Summary	Monthly	5th business day of second month following reporting period
Provider State Issues/MIG Detail		
Member State Issues/MIG Summary		
Member State Issues/MIG Detail		
Provider Network Access		
Appointment Availability – PCPs	Quarterly and Annually	30th calendar day after the close of the quarter April 1st
Appointment Availability – Behavioral Health Providers		
Appointment Availability – OB/GYN Providers		
Contracted Hospitals	Quarterly	30th calendar day after the close of the quarter
GeoAccess Reporting Requirements		
Insure Kids Now Provider Data	Quarterly	CMS Deadlines
Call Center Operations		
Provider Call Center Audit	Quarterly	15th business day after the close of the quarter
Provider Call Center Issues	Ad Hoc	Within 7 days of request by

		Division
Contractor Member Call Center Audit	Quarterly	15th business day after the close of the quarter
Contractor Member Call Center Issues	Ad Hoc	Within 7 days of request by Division
Contractor Provider Services Call Center Training Report	Quarterly	15th business day after the close of the quarter
Contractor Member Services Call Center Training Report		
Contractor Nurse Line Call Center Training Report		
Marketing		
Marketing Work Plan	Annually and Quarterly	January 15th for current calendar year 30th calendar day after the close of the quarter
Marketing Activities Log	Quarterly	15th business day after the close of the quarter
Marketing Complaints Tracking Log		
Enrollment Reports		
New Member Card Report	Monthly	5th business day after the close of the reporting period
Returned Card Report		
Provider Services Report		
Provider Credentialing	Quarterly	30th calendar day after the close of the quarter
List of Providers Credentialed Over 90 Days		
Member Materials and Education		
Health Education and Prevention Work Plan	Annually and Quarterly	January 15th for the current calendar year 30th calendar day after the close of the quarter
EPSDT and PHRMS/ISS		
EPSDT Report	Quarterly and Annually	February 15th for prior reporting year 30th calendar day after the close of the quarter
Pharmacy Lock-In		
Pharmacy Lock-In Program Report	Monthly	5th business day of the month

		following reporting period
Provider Incentive and Patient-Centered Medical Home		
Provider Incentive Plan	Semi-Annually	April 30th following the October thru March reporting period October 31st following the April thru September reporting period
Patient-Centered Medical Home	As specified by the Division	As specified by the Division
Performance Measures		
HEDIS Compliance Audit	Annually	July 31st for prior calendar year
CAHPS Survey Report	Annually	September 30th
Performance Measure Results and Updates	Annually and Quarterly	August 1st following the reporting calendar year 30th calendar day after the close of the quarter
Quality Management (QM) Program		
Quality Management Program Description	Annually	August 1st for the current calendar year
Quality Management Work Plan and Updates	Annually and Quarterly	August 1st for current calendar year 30th calendar day after the close of the quarter
Quality Management Program Evaluation	Annually	August 1st following the reporting calendar year
Performance Improvement Project Updates	Quarterly	30th calendar day after the close of the quarter
Performance Improvement Project Results	Annually	August 1st of the following reporting year
Quality Management (QM) Program (Behavioral Health)		
Quality Management Program Description	Annually	August 1st for the current

		calendar year
Quality Management Work Plan and Updates	Annually and Quarterly	August 1st for current calendar year 30th calendar day after the close of the quarter
Quality Management Program Evaluation	Annually	August 1st following the reporting calendar year
Utilization Management Program		
Utilization Management Program Description	Annually	August 1st for the current calendar year
Provider Satisfaction and Training		
Provider Satisfaction Survey Questions and Methodology	Annually	March 1st for the current calendar year
Provider Satisfaction Survey Results	Annually	At least 90 calendar days following the completion of the survey and no later than December 1st for the current calendar year
Provider Services Representative Visit Log	Monthly	5th business day after the close of the reporting period
Member Encounter Data		
Member Encounter Data	Weekly	Within two (2) business days of the end of a payment cycle. The Contractor shall submit the Encounter Data to the Division no less frequently than on a weekly basis.
Cash Disbursement Journal	Monthly	15th business day of second month following the reporting period
Member Encounter Data Completeness Plan	Annually	January 15th of the calendar year following the reporting

		period
Provider Preventable Conditions	Quarterly	15th business day after the close of the quarter
Fraud and Abuse and Third Party Liability		
New Provider Investigations/Complaints	Weekly and Quarterly	Each Friday Fifteenth business day after the close of the quarter
New Member Investigations/Complaints		
Annual Provider Report of New Investigations/Complaints	Annually	30th calendar day following the year in which the cases/complaints were reported.
Annual Member Report of New Investigations/Complaints		
Semi-Annual Provider New Investigations/Complaints Activity Report	Semi-Annually	July 31st following the January thru June reporting period and January 31st following the July thru December reporting period
Semi-Annual Member New Investigations/Complaints Activity Report		
Credible Allegation of Fraud Referrals	Quarterly	15th business day after the close of the quarter
Fraud and Abuse Compliance Plan	Annually	January 15th for the current calendar year
Prepayment Review	Weekly and Quarterly	Each Friday 30th calendar day after the close of the quarter
Internal Contractor Reporting	Quarterly	15th business day after the close of the quarter
Third Party Casualty	Monthly	15th business day of the second month following reporting period
Third Party Leads	Monthly	Submit all leads by the 30th calendar day of each month
Cost Avoidance & TPL Recoveries	Monthly	30th calendar day of every month
Medical Loss Ratio: MSCAN		

Medical Loss Ratio Rebate Calculation -MSCAN	Quarterly and Annually	60th calendar day following the end of the MLR Reporting quarter April 1st of the year following the MLR Reporting year
Disenrollment Survey		
Disenrollment Survey	Annually	Prior to Contract go-live and by August 1st for current contract year
Disenrollment Survey Results	Quarterly	30th business day after the close of the quarter
Administrative		
Department of Insurance (DOI) Filings	Quarterly and Annually	15th business day after the close of the quarter January 15th of the calendar year following the reporting period
Contractor Licensures	Annually	April 1st
Small and Minority Business Reporting	Annually	Contract signature date anniversary
Fee Schedule Validation	Monthly	28 Calendar days from receipt of the monthly comprehensive Division Fee Schedule
Systems Updates of PDL Indicators		
Provider Licensure Information	Quarterly	15th business day after the close of the quarter
NCCI Savings Report		
Mississippi Hospital Access Payments (MHAP)		
MHAP Distribution Report	Monthly	1st business day of the month following the date of payment
Annual MHAP Distributions Report	Annually	May 1st
Provider Statistical and Reimbursement Report		

Inpatient Provider Statistical and Reimbursement Report	Annually, Ad Hoc	Annually: Three separate submissions (February, March & June); Ad Hoc: Within 7 days of request by Division
Outpatient Provider Statistical and Reimbursement Report		
Claims Denial Report		
Claims Denial Report	Monthly	15th business day of the second month following reporting period
Hospice Report		
Hospice Report	Monthly	15th business day of the second month following reporting period
Web Portal Usage Report		
Web Portal Usage Report	Monthly	15th business day of the second month following reporting period
Non-Emergency Transportation Operations		
NET Operations Summary	Monthly	5th business day of second month following the reporting period
Denials		
Top Five Denial Reasons		
NET Call Center Statistics		
Subcontractor Oversight Report		
Overall Vendor Timeliness	Monthly	Due Monthly for reporting period 3 months prior
Hospital Discharge Timeliness		
Will Call Timeliness		
To Trips Pickup Timeliness		
From Trips Drop Off Timeliness		
Daily Vendor Late/No-Shows		
Appointment Timeliness Detail		
Monthly Vendor Timeliness Detail		
Trip Processing Time Report	Monthly	Due by the 15th day of the month following the
Trip Processing Time Report Summary		

		reporting period
Pre and Post Transportation Validation Report		
Pre/Post Fixed/Non Fixed Verification Report	Quarterly	15th day of the month following the reporting period
Net Vehicle Inspections and Validation Check Report	Quarterly	30th calendar day after the close of the quarter
Net Driver Report		
Routine Refreshable Reports		
Summary of Allowed Amount by Medicaid Category	Monthly	5th business day of second month following reporting period
Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Stays		
Summary of Allowed Amount by APR-DRG, Top 50 DRGs by Allowed Amount		
Summary of Allowed Amount by Peer Group-Top 8 Providers		
Summary of Allowed Amount by All Hospitals sorted by Peer Group		
Highest Paying Claims-Top 100 Claims by Allowed Amount		
DRG Cost Outlier Allowed Amount-Top 25		
Allowed Amount by Patient Discharge Status		
Long Stays, Top 50 by Length of Stay		
Short Stays, Days < National ALOS * 10%		
Allowed Amount by Provider by Behavioral/Mental Health DRGs, Pediatric		
Allowed Amount by Provider by Behavioral/Mental Health DRGs, Adult		

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